
THE VIRGINIA REGISTER INFORMATION PAGE

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 new and amended sections of regulations, both as proposed and as finally adopted, 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 and executive orders issued by the Governor, the Virginia Tax Bulletin issued periodically by the Department of Taxation, and notices of 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 intended regulatory action; a basis, purpose, substance and issues statement; an economic impact analysis prepared by the Department of Planning and Budget; the agency's response to the economic impact analysis; a summary; a notice giving the public an opportunity to comment on the proposal; and the text of the proposed regulation.

Following publication of the proposal in the *Virginia Register*, the promulgating agency receives public comments for a minimum of 60 days. The Governor reviews the proposed regulation to determine if it is necessary to protect the public health, safety and welfare, and if it is clearly written and easily understandable. If the Governor chooses to comment on the proposed regulation, his comments must be transmitted to the agency and the Registrar no later than 15 days following the completion of the 60-day public comment period. The Governor's comments, if any, will be published in the *Virginia Register*. Not less than 15 days following the completion of the 60-day public comment period, the agency may adopt the proposed regulation.

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 objection will be published in the *Virginia Register*. Within 21 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 agency again publishes the text of the regulation as adopted, highlighting all changes made to the proposed regulation and explaining any substantial changes made since publication of the proposal. A 30-day final adoption period begins upon final publication in the *Virginia Register*.

The Governor may review the final regulation during this time and, if he objects, forward his objection to the Registrar and the agency. In addition to or in lieu of filing a formal objection, the Governor may suspend the effective date of a portion or all of a regulation until the end of the next regular General Assembly session by issuing a directive signed by a majority of the members of the appropriate standing committees and the Governor. The Governor's objection or suspension of the regulation, or both, will be published in the *Virginia Register*. If the Governor finds that changes made to the proposed regulation have substantial impact, he may require the agency to provide an additional 30-day public comment period on the changes. Notice of the additional public comment period required by the Governor will be published in the *Virginia Register*.

The agency shall suspend the regulatory process for 30 days when it receives requests from 25 or more individuals to solicit additional public comment, unless the agency determines that the changes have minor or inconsequential impact.

A regulation becomes effective at the conclusion of the 30-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 21-day

extension period; (ii) the Governor exercises his authority to require the agency to provide for additional public comment, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the period for which the Governor has provided for additional public comment; (iii) the Governor and the General Assembly exercise their authority to suspend the effective date of a regulation until the end of the next regular legislative session; or (iv) the agency suspends the regulatory process, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 30-day public comment period.

Proposed regulatory action may be withdrawn by the promulgating agency at any time before the regulation becomes final.

EMERGENCY REGULATIONS

If an agency demonstrates that (i) there is an immediate threat to the public's health or safety; or (ii) Virginia statutory law, the appropriation act, federal law, or federal regulation requires a regulation to take effect no later than (a) 280 days from the enactment in the case of Virginia or federal law or the appropriation act, or (b) 280 days from the effective date of a federal regulation, it then requests the Governor's approval to adopt 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 to addressing specifically defined situations and may not exceed 12 months in duration. Emergency regulations are published as soon as possible in the *Register*.

During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures. To begin promulgating the replacement regulation, the agency must (i) file the Notice of Intended Regulatory Action with the Registrar within 60 days of the effective date of the emergency regulation; and (ii) file the proposed regulation with the Registrar within 180 days of the effective date of the emergency regulation. If the agency chooses not 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 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 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. **12:8 VA.R. 1096-1106 January 8, 1996**, refers to Volume 12, Issue 8, pages 1096 through 1106 of the *Virginia Register* issued on January 8, 1996.

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PUBLICATION SCHEDULE AND DEADLINES

This schedule is available on the *Register's* Internet home page (<http://legis.state.va.us/codecomm/register/regindex.htm>).

May 2000 through March 2001

<u>Volume:Issue</u>	<u>Material Submitted By Noon*</u>	<u>Will Be Published On</u>
16:18	May 3, 2000	May 22, 2000
16:19	May 17, 2000	June 5, 2000
16:20	May 31, 2000	June 19, 2000
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17:6	November 14, 2000 (Tuesday)	December 4, 2000
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17:10	January 10, 2001	January 29, 2001
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4 VAC 20-252-120	Amended	16:14 VA.R. 1860	3/1/00
4 VAC 20-270-40 emer	Amended	16:14 VA.R. 1885	3/1/00-3/30/00
4 VAC 20-270-40	Amended	16:16 VA.R. 2041	3/30/00
4 VAC 20-430-55	Added	16:14 VA.R. 1860	3/1/00
4 VAC 20-430-70	Amended	16:14 VA.R. 1860	3/1/00
4 VAC 20-500-55	Added	16:14 VA.R. 1861	3/1/00
4 VAC 20-561-10 through 4 VAC 20-561-30 emer	Added	16:12 VA.R. 1710	2/2/00-2/22/00
4 VAC 20-620-50	Amended	16:14 VA.R. 1861	3/1/00
4 VAC 20-620-70	Amended	16:14 VA.R. 1861	3/1/00
4 VAC 20-700-20	Amended	16:16 VA.R. 2041	4/1/00
4 VAC 20-720-20	Amended	16:12 VA.R. 1671	2/4/00
4 VAC 20-720-40	Amended	16:12 VA.R. 1671	2/4/00
4 VAC 20-720-50	Amended	16:12 VA.R. 1672	2/4/00
4 VAC 20-720-60	Amended	16:12 VA.R. 1672	2/4/00
4 VAC 20-720-70	Amended	16:12 VA.R. 1673	2/4/00
4 VAC 20-720-80	Amended	16:12 VA.R. 1673	2/4/00
4 VAC 20-890-25	Amended	16:12 VA.R. 1674	2/2/00
4 VAC 20-910-45	Amended	16:14 VA.R. 1862	3/1/00
4 VAC 20-950-45	Amended	16:14 VA.R. 1862	3/1/00
4 VAC 25-130-700.5	Amended	16:15 VA.R. 1956	5/10/00
4 VAC 25-130-795.1	Amended	16:15 VA.R. 1968	5/10/00
4 VAC 25-130-795.6	Amended	16:15 VA.R. 1968	5/10/00
4 VAC 25-130-795.7	Amended	16:15 VA.R. 1968	5/10/00
4 VAC 25-130-795.8	Amended	16:15 VA.R. 1969	5/10/00
4 VAC 25-130-795.9	Amended	16:15 VA.R. 1969	5/10/00
4 VAC 25-130-795.10	Amended	16:15 VA.R. 1969	5/10/00
4 VAC 25-130-795.11	Amended	16:15 VA.R. 1970	5/10/00
4 VAC 25-130-795.12	Amended	16:15 VA.R. 1970	5/10/00
Title 6. Criminal Justice and Corrections			
6 VAC 20-171-420	Erratum	16:14 VA.R. 1911	--
Title 9. Environment			
9 VAC 5-10-20	Amended	16:17 VA.R. 2135	7/1/00
9 VAC 5-20-21	Amended	16:17 VA.R. 2161	7/1/00
9 VAC 5-20-180	Amended	16:17 VA.R. 2142	7/1/00
9 VAC 5-20-202	Amended	16:17 VA.R. 2163	7/1/00
9 VAC 5-40-10	Amended	16:17 VA.R. 2144	7/1/00
9 VAC 5-40-20	Amended	16:17 VA.R. 2145	7/1/00
9 VAC 5-40-30	Amended	16:17 VA.R. 2149	7/1/00
9 VAC 5-40-40	Amended	16:17 VA.R. 2150	7/1/00
9 VAC 5-40-50	Amended	16:17 VA.R. 2151	7/1/00
9 VAC 5-40-6000 through 9 VAC 5-40-6230	Added	16:17 VA.R. 2164-2178	7/1/00
9 VAC 5-50-10	Amended	16:17 VA.R. 2152	7/1/00
9 VAC 5-50-20	Amended	16:17 VA.R. 2152	7/1/00
9 VAC 5-50-30	Amended	16:17 VA.R. 2155	7/1/00

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9 VAC 5-50-40	Amended	16:17 VA.R. 2156	7/1/00
9 VAC 5-50-50	Amended	16:17 VA.R. 2157	7/1/00
9 VAC 5-50-400	Amended	16:14 VA.R. 1863	5/1/00
9 VAC 5-60-10	Amended	16:17 VA.R. 2158	7/1/00
9 VAC 5-60-20	Amended	16:17 VA.R. 2158	7/1/00
9 VAC 5-60-30	Amended	16:17 VA.R. 2159	7/1/00
9 VAC 5-60-60	Amended	16:14 VA.R. 1864	5/1/00
9 VAC 5-60-90	Amended	16:14 VA.R. 1864	5/1/00
9 VAC 5-60-100	Amended	16:14 VA.R. 1864	5/1/00
9 VAC 25-210 (Forms)	Amended	16:12 VA.R. 1711-1714	--
9 VAC 25-220-60	Amended	16:15 VA.R. 1971	5/10/00
9 VAC 25-220-70	Amended	16:15 VA.R. 1971	5/10/00
9 VAC 25-260-350	Amended	16:17 VA.R. 2178	6/7/00
9 VAC 25-260-400	Amended	16:17 VA.R. 2179	6/7/00
Title 12. Health			
12 VAC 5-80-10	Amended	16:16 VA.R. 2042	7/1/00
12 VAC 5-80-20	Amended	16:16 VA.R. 2043	7/1/00
12 VAC 5-80-30	Amended	16:16 VA.R. 2043	7/1/00
12 VAC 5-80-40	Amended	16:16 VA.R. 2043	7/1/00
12 VAC 5-80-50	Repealed	16:16 VA.R. 2043	7/1/00
12 VAC 5-80-80	Amended	16:16 VA.R. 2043	7/1/00
12 VAC 5-80-90	Amended	16:16 VA.R. 2045	7/1/00
12 VAC 5-80-95	Added	16:16 VA.R. 2045	7/1/00
12 VAC 5-80-100	Repealed	16:16 VA.R. 2046	7/1/00
12 VAC 5-80-110	Repealed	16:16 VA.R. 2046	7/1/00
12 VAC 5-80-120	Repealed	16:16 VA.R. 2046	7/1/00
12 VAC 5-165-10 through 12 VAC 5-165-310	Added	16:16 VA.R. 2048-2051	5/24/00
12 VAC 5-610-10	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-20	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-30	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-40	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-50	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-70	Amended	16:16 VA.R. 2052	7/1/00
12 VAC 5-610-75	Added	16:16 VA.R. 2053	7/1/00
12 VAC 5-610-80	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-90	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-100	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-110	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-120	Amended	16:16 VA.R. 2053	7/1/00
12 VAC 5-610-130	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-140	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-150	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-170	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-180	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-190	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-200	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-230	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-250	Amended	16:16 VA.R. 2055	7/1/00
12 VAC 5-610-255	Added	16:16 VA.R. 2057	7/1/00
12 VAC 5-610-260	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-270	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-280	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-290	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-300	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-330	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-340	Amended	16:16 VA.R. 2051	7/1/00

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12 VAC 5-610-360	Amended	16:16 VA.R. 2051	7/1/00
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12 VAC 5-610-380	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-390	Amended	16:16 VA.R. 2058	7/1/00
12 VAC 5-610-420	Amended	16:16 VA.R. 2058	7/1/00
12 VAC 5-610-430	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-440	Amended	16:16 VA.R. 2058	7/1/00
12 VAC 5-610-441 through 12 VAC 5-610-448	Added	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-449	Added	16:16 VA.R. 2058	7/1/00
12 VAC 5-610-449.1	Added	16:16 VA.R. 2060	7/1/00
12 VAC 5-610-450	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-470	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-480	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-490	Amended	16:16 VA.R. 2061	7/1/00
12 VAC 5-610-500	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-510 through 12 VAC 5-610-550	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-560	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-570	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-580	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-591	Added	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-592	Added	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-593	Added	16:16 VA.R. 2063	7/1/00
12 VAC 5-610-594	Added	16:16 VA.R. 2063	7/1/00
12 VAC 5-610-596	Added	16:16 VA.R. 2063	7/1/00
12 VAC 5-610-597	Added	16:16 VA.R. 2064	7/1/00
12 VAC 5-610-598	Added	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-599	Added	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-599.1 through 12 VAC 5-610-599.3	Added	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-620	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-650	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-670	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-690	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-700	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-740	Amended	16:16 VA.R. 2068	7/1/00
12 VAC 5-610-800	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-810	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-815	Added	16:16 VA.R. 2068	7/1/00
12 VAC 5-610-817	Added	16:16 VA.R. 2069	7/1/00
12 VAC 5-610-820	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-830	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-840	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-880	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-890	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-930	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-940	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-950	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-960	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-965	Added	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-980	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-1080	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-1140	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-1150	Repealed	16:16 VA.R. 2051	7/1/00
12 VAC 30-40-345	Added	16:15 VA.R. 1973	5/10/00
Title 13. Housing			
13 VAC 5-111-10	Amended	16:17 VA.R. 2189	6/8/00
13 VAC 5-111-100	Amended	16:17 VA.R. 2193	6/8/00

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
13 VAC 5-111-120	Amended	16:17 VA.R. 2193	6/8/00
13 VAC 5-111-130	Amended	16:17 VA.R. 2194	6/8/00
13 VAC 5-111-160	Amended	16:17 VA.R. 2194	6/8/00
13 VAC 5-111-165	Added	16:17 VA.R. 2194	6/8/00
13 VAC 5-111-170	Amended	16:17 VA.R. 2194	6/8/00
13 VAC 5-111-180	Amended	16:17 VA.R. 2195	6/8/00
13 VAC 5-111-190	Amended	16:17 VA.R. 2195	6/8/00
13 VAC 5-111-240	Amended	16:17 VA.R. 2196	6/8/00
13 VAC 5-111-280	Amended	16:17 VA.R. 2196	6/8/00
13 VAC 5-111-300	Amended	16:17 VA.R. 2196	6/8/00
13 VAC 5-111-310	Amended	16:17 VA.R. 2197	6/8/00
13 VAC 5-111-390	Amended	16:17 VA.R. 2197	6/8/00
Title 14. Insurance			
14 VAC 5-215-20	Erratum	16:14 VA.R. 1912	--
14 VAC 5-215-30	Erratum	16:14 VA.R. 1912	--
Title 15. Judicial			
15 VAC 10-10-10	Amended	16:16 VA.R. 2069	3/24/00
Title 18. Professional and Occupational Licensing			
18 VAC 47-10-10 through 18 VAC 47-10-90	Added	16:12 VA.R. 1675-1676	3/29/00
18 VAC 47-20-10 through 18 VAC 47-20-240	Added	16:13 VA.R. 1776-1782	4/12/00
18 VAC 76-10-65	Added	16:17 VA.R. 2198	4/19/00
18 VAC 85-20-22	Amended	16:13 VA.R. 1766	4/12/00
18 VAC 85-20-240	Amended	16:13 VA.R. 1767	4/12/00
18 VAC 85-31-10	Amended	16:13 VA.R. 1772	4/13/00
18 VAC 85-31-25	Added	16:13 VA.R. 1773	4/13/00
18 VAC 85-31-40	Amended	16:13 VA.R. 1773	4/13/00
18 VAC 85-31-50	Amended	16:13 VA.R. 1773	4/13/00
18 VAC 85-31-60	Amended	16:13 VA.R. 1774	4/13/00
18 VAC 85-31-65	Added	16:13 VA.R. 1774	4/13/00
18 VAC 85-31-80	Amended	16:13 VA.R. 1774	4/13/00
18 VAC 85-31-90	Amended	16:13 VA.R. 1774	4/13/00
18 VAC 85-31-100	Amended	16:13 VA.R. 1774	4/13/00
18 VAC 85-31-120	Amended	16:13 VA.R. 1775	4/13/00
18 VAC 85-31-130	Amended	16:13 VA.R. 1775	4/13/00
18 VAC 85-31-135	Added	16:13 VA.R. 1775	4/13/00
18 VAC 85-31-140	Amended	16:13 VA.R. 1775	4/13/00
18 VAC 85-31-160	Amended	16:13 VA.R. 1768	4/12/00
18 VAC 85-40-80	Amended	16:13 VA.R. 1769	4/12/00
18 VAC 85-50-170	Amended	16:13 VA.R. 1770	4/12/00
18 VAC 85-80-120	Amended	16:13 VA.R. 1770	4/12/00
18 VAC 85-101-160	Amended	16:13 VA.R. 1771	4/12/00
18 VAC 85-110-35	Amended	16:13 VA.R. 1771	4/12/00
18 VAC 90-20-30	Amended	16:13 VA.R. 1782	4/12/00
18 VAC 90-20-190	Amended	16:13 VA.R. 1782	4/12/00
18 VAC 90-20-230	Amended	16:13 VA.R. 1783	4/12/00
18 VAC 90-20-350	Amended	16:13 VA.R. 1783	4/12/00
18 VAC 115-20-10	Amended	16:13 VA.R. 1786	4/12/00
18 VAC 115-20-20	Amended	16:13 VA.R. 1785	4/12/00
18 VAC 115-20-30	Repealed	16:13 VA.R. 1787	4/12/00
18 VAC 115-20-35	Added	16:13 VA.R. 1787	4/12/00
18 VAC 115-20-40	Amended	16:13 VA.R. 1787	4/12/00
18 VAC 115-20-40	Erratum	16:16 VA.R. 2081	--
18 VAC 115-20-45	Added	16:13 VA.R. 1787	4/12/00
18 VAC 115-20-49	Added	16:13 VA.R. 1788	4/12/00
18 VAC 115-20-49	Erratum	16:16 VA.R. 2081	--
18 VAC 115-20-50	Amended	16:13 VA.R. 1788	4/12/00

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
18 VAC 115-20-51	Added	16:13 VA.R. 1788	4/12/00
18 VAC 115-20-52	Added	16:13 VA.R. 1788	4/12/00
18 VAC 115-20-60	Repealed	16:13 VA.R. 1790	4/12/00
18 VAC 115-20-70	Amended	16:13 VA.R. 1790	4/12/00
18 VAC 115-20-80	Repealed	16:13 VA.R. 1791	4/12/00
18 VAC 115-20-100	Amended	16:13 VA.R. 1785	4/12/00
18 VAC 115-20-110	Amended	16:13 VA.R. 1785	4/12/00
18 VAC 115-20-130	Amended	16:13 VA.R. 1791	4/12/00
18 VAC 115-20-140	Amended	16:13 VA.R. 1792	4/12/00
18 VAC 115-20-150	Amended	16:13 VA.R. 1785	4/12/00
18 VAC 115-30-30	Amended	16:13 VA.R. 1793	4/12/00
18 VAC 115-30-40	Amended	16:13 VA.R. 1793	4/12/00
18 VAC 115-30-110	Amended	16:13 VA.R. 1793	4/12/00
18 VAC 115-30-120	Amended	16:13 VA.R. 1793	4/12/00
18 VAC 115-30-160	Amended	16:13 VA.R. 1794	4/12/00
18 VAC 115-40-20	Amended	16:13 VA.R. 1794	4/12/00
18 VAC 115-40-35	Amended	16:13 VA.R. 1794	4/12/00
18 VAC 115-40-61	Added	16:13 VA.R. 1794	4/12/00
18 VAC 115-50-20	Amended	16:13 VA.R. 1795	4/12/00
18 VAC 115-50-30	Amended	16:13 VA.R. 1795	4/12/00
18 VAC 115-50-40	Amended	16:13 VA.R. 1796	4/12/00
18 VAC 115-50-90	Amended	16:13 VA.R. 1796	4/12/00
18 VAC 115-50-100	Amended	16:13 VA.R. 1796	4/12/00
18 VAC 115-50-130	Added	16:13 VA.R. 1796	4/12/00
18 VAC 120-10-10 through 18 VAC 120-10-90	Repealed	16:14 VA.R. 1867-1868	5/1/00
18 VAC 120-10-170	Amended	16:14 VA.R. 1868	5/1/00
18 VAC 125-20-30	Amended	16:13 VA.R. 1797	4/12/00
18 VAC 125-20-130	Amended	16:13 VA.R. 1797	4/12/00
18 VAC 125-20-170	Amended	16:13 VA.R. 1797	4/12/00
18 VAC 155-20-10 through 18 VAC 155-20-50	Amended	16:14 VA.R. 1869-1871	5/1/00
18 VAC 155-20-60 through 18 VAC 155-20-90	Repealed	16:14 VA.R. 1871-1872	5/1/00
18 VAC 155-20-100 through 18 VAC 155-20-160	Amended	16:14 VA.R. 1872-1874	5/1/00
18 VAC 155-20-170	Repealed	16:14 VA.R. 1874	5/1/00
18 VAC 155-20-175	Added	16:14 VA.R. 1874	5/1/00
18 VAC 155-20-180 through 18 VAC 155-20-230	Amended	16:14 VA.R. 1875-1877	5/1/00
18 VAC 155-20-240 through 18 VAC 155-20-270	Repealed	16:14 VA.R. 1879-1880	5/1/00
18 VAC 155-20-280	Amended	16:14 VA.R. 1880	5/1/00
18 VAC 155-20-290	Repealed	16:14 VA.R. 1880	5/1/00
Title 22. Social Services			
22 VAC 40-60-10 through 22 VAC 40-60-60	Amended	16:12 VA.R. 1676-1679	7/1/00
22 VAC 40-60-70	Repealed	16:12 VA.R. 1679	7/1/00
22 VAC 40-60-80	Amended	16:12 VA.R. 1679	7/1/00
22 VAC 40-60-90	Amended	16:12 VA.R. 1679	7/1/00
22 VAC 40-60-100	Repealed	16:12 VA.R. 1680	7/1/00
22 VAC 40-60-110 through 22 VAC 40-60-150	Amended	16:12 VA.R. 1680	7/1/00
22 VAC 40-60-180	Amended	16:12 VA.R. 1680	7/1/00
22 VAC 40-60-190	Amended	16:12 VA.R. 1680	7/1/00
22 VAC 40-60-200	Amended	16:12 VA.R. 1681	7/1/00
22 VAC 40-60-210	Repealed	16:12 VA.R. 1681	7/1/00
22 VAC 40-60-220	Repealed	16:12 VA.R. 1681	7/1/00
22 VAC 40-60-230	Repealed	16:12 VA.R. 1681	7/1/00
22 VAC 40-60-235	Added	16:12 VA.R. 1681	7/1/00
22 VAC 40-60-240	Repealed	16:12 VA.R. 1682	7/1/00
22 VAC 40-60-250	Repealed	16:12 VA.R. 1682	7/1/00
22 VAC 40-60-260	Amended	16:12 VA.R. 1683	7/1/00
22 VAC 40-60-270	Amended	16:12 VA.R. 1683	7/1/00

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
22 VAC 40-60-280	Amended	16:12 VA.R. 1683	7/1/00
22 VAC 40-60-290	Repealed	16:12 VA.R. 1683	7/1/00
22 VAC 40-60-300	Amended	16:12 VA.R. 1683	7/1/00
22 VAC 40-60-310	Repealed	16:12 VA.R. 1683	7/1/00
22 VAC 40-60-320	Amended	16:12 VA.R. 1684	7/1/00
22 VAC 40-60-330	Amended	16:12 VA.R. 1684	7/1/00
22 VAC 40-60-340	Amended	16:12 VA.R. 1684	7/1/00
22 VAC 40-60-350	Repealed	16:12 VA.R. 1685	7/1/00
22 VAC 40-60-360	Repealed	16:12 VA.R. 1685	7/1/00
22 VAC 40-60-370 through 22 VAC 40-60-420	Amended	16:12 VA.R. 1685	7/1/00
22 VAC 40-60-425	Added	16:12 VA.R. 1686	7/1/00
22 VAC 40-60-430 through 22 VAC 40-60-470	Amended	16:12 VA.R. 1686-1687	7/1/00
22 VAC 40-60-480	Repealed	16:12 VA.R. 1687	7/1/00
22 VAC 40-60-490	Amended	16:12 VA.R. 1687	7/1/00
22 VAC 40-60-510	Amended	16:12 VA.R. 1688	7/1/00
22 VAC 40-60-520	Amended	16:12 VA.R. 1688	7/1/00
22 VAC 40-60-530	Repealed	16:12 VA.R. 1688	7/1/00
22 VAC 40-60-540	Repealed	16:12 VA.R. 1688	7/1/00
22 VAC 40-60-550	Amended	16:12 VA.R. 1688	7/1/00
22 VAC 40-60-554	Added	16:12 VA.R. 1689	7/1/00
22 VAC 40-60-556	Added	16:12 VA.R. 1689	7/1/00
22 VAC 40-60-560	Amended	16:12 VA.R. 1689	7/1/00
22 VAC 40-60-564	Added	16:12 VA.R. 1689	7/1/00
22 VAC 40-60-570 through 22 VAC 40-60-610	Amended	16:12 VA.R. 1689-1691	7/1/00
22 VAC 40-60-620 through 22 VAC 40-60-650	Repealed	16:12 VA.R. 1691-1692	7/1/00
22 VAC 40-60-670	Repealed	16:12 VA.R. 1692	7/1/00
22 VAC 40-60-680	Amended	16:12 VA.R. 1692	7/1/00
22 VAC 40-60-690	Amended	16:12 VA.R. 1692	7/1/00
22 VAC 40-60-691	Added	16:12 VA.R. 1692	7/1/00
22 VAC 40-60-692	Added	16:12 VA.R. 1692	7/1/00
22 VAC 40-60-694	Added	16:12 VA.R. 1693	7/1/00
22 VAC 40-60-695	Added	16:12 VA.R. 1693	7/1/00
22 VAC 40-60-697	Added	16:12 VA.R. 1693	7/1/00
22 VAC 40-60-698	Added	16:12 VA.R. 1693	7/1/00
22 VAC 40-60-699	Added	16:12 VA.R. 1695	7/1/00
22 VAC 40-60-700	Amended	16:12 VA.R. 1696	7/1/00
22 VAC 40-60-705	Added	16:12 VA.R. 1696	7/1/00
22 VAC 40-60-710 through 22 VAC 40-60-760	Repealed	16:12 VA.R. 1697	7/1/00
22 VAC 40-60-770	Amended	16:12 VA.R. 1697	7/1/00
22 VAC 40-60-780	Amended	16:12 VA.R. 1697	7/1/00
22 VAC 40-60-790	Repealed	16:12 VA.R. 1697	7/1/00
22 VAC 40-60-800	Amended	16:12 VA.R. 1697	7/1/00
22 VAC 40-60-810 through 22 VAC 40-60-840	Repealed	16:12 VA.R. 1697-1698	7/1/00
22 VAC 40-60-850	Amended	16:12 VA.R. 1698	7/1/00
22 VAC 40-60-860	Amended	16:12 VA.R. 1698	7/1/00
22 VAC 40-60-870	Repealed	16:12 VA.R. 1698	7/1/00
22 VAC 40-60-880	Amended	16:12 VA.R. 1698	7/1/00
22 VAC 40-60-885	Added	16:12 VA.R. 1699	7/1/00
22 VAC 40-60-890 through 22 VAC 40-60-950	Repealed	16:12 VA.R. 1699	7/1/00
22 VAC 40-60-960	Amended	16:12 VA.R. 1699	7/1/00
22 VAC 40-60-970	Repealed	16:12 VA.R. 1700	7/1/00
22 VAC 40-60-980	Amended	16:12 VA.R. 1700	7/1/00
22 VAC 40-60-990	Repealed	16:12 VA.R. 1700	7/1/00
22 VAC 40-60-1000	Repealed	16:12 VA.R. 1700	7/1/00
22 VAC 40-60-1010	Amended	16:12 VA.R. 1700	7/1/00
22 VAC 40-60-1020	Amended	16:12 VA.R. 1700	7/1/00

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
22 VAC 40-60-1030 through 22 VAC 40-60-1060	Repealed	16:12 VA.R. 1701-1702	7/1/00
22 VAC 40-705-10	Amended	16:12 VA.R. 1705	3/29/00
22 VAC 40-705-40	Amended	16:12 VA.R. 1707	3/29/00

NOTICES OF INTENDED REGULATORY ACTION

Symbol Key

† Indicates entries since last publication of the *Virginia Register*

TITLE 8. EDUCATION

STATE BOARD OF EDUCATION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Education intends to consider amending regulations entitled: **8 VAC 20-120-10 et seq. Vocational Education Regulations**. The purpose of the proposed action is to delete nonessential regulations, reflect recent changes in state and federal law, and revise sections that exceed applicable state or federal laws. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 22.1-16 and 22.1-227 of the Code of Virginia.

Public comments may be submitted until June 7, 2000.

Contact: Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540 or FAX (804) 225-2524.

VA.R. Doc. No. R00-162; Filed April 19, 2000, 10:54 a.m.

TITLE 9. ENVIRONMENT

VIRGINIA WASTE MANAGEMENT BOARD

† Notice of Intended Regulatory Action

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 consider amending regulations entitled: **9 VAC 20-120-10 et seq. Regulated Medical Waste Management Regulations**. As a result of a periodic review, the board is considering amendment of the regulation to include, but not be limited to, storage of separately accumulated objects. The agency intends to hold a public hearing on the proposed regulation after publication.

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

Public comments may be submitted until July 7, 2000.

Contact: John E. Ely, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4249 or FAX (804) 698-4327.

VA.R. Doc. No. R00-174; Filed May 3, 2000, 11:56 a.m.

PROPOSED REGULATIONS

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.

TITLE 14. INSURANCE

CASE NO. INS000098

STATE CORPORATION COMMISSION

REGISTRAR'S NOTICE: The State Corporation Commission is exempt from the Administrative Process Act in accordance with § 9-6.14:4.1 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency which by the Constitution is expressly granted any of the powers of a court of record.

Title of Regulation: 14 VAC 5-215-10 et seq. **Rules Governing Independent External Review of Final Adverse Utilization Review Decisions (amending 14 VAC 5-215-30 through 14 VAC 5-215-70 and 14 VAC 5-215-110).**

Statutory Authority: §§ 12.1-13 and 38.2-223 of the Code of Virginia.

Summary:

The purpose of the proposed revisions is to carry out those provisions of Chapter 922 of the 2000 Acts of Assembly which amend Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 of the Code of Virginia dealing with External Review of Final Adverse Utilization Review Decisions.

Significant revisions include the following: (i) the definitions of "covered person," "final adverse decision," and "utilization review entity" or "entity" in 14 VAC 5-215-30 have been revised to track more closely the definitions in Chapter 922; (ii) the definition of "adverse decision" in 14 VAC 5-215-30 has been deleted as no longer needed; (iii) the minimum appealable amount in 14 VAC 5-215-40 and 14 VAC 5-215-50 has been changed from \$500 to \$300 in accordance with Chapter 922; (iv) 14 VAC 5-215-50 has been revised to give the appellant, the treating health care provider, and the utilization review entity more time to provide medical records to the Bureau of Insurance or its designee and to state the consequences of the failure to provide such records in accordance with Chapter 922; and (v) the time requirements for the Bureau of Insurance and the impartial health entity to act have been revised to conform to Chapter 922 in 14 VAC 5-215-40, 14 VAC 5-215-50 and 14 VAC 5-215-60.

Agency Contact: Don Beatty, Manager Utilization Review, External Appeals, Bureau of Insurance, State Corporation Commission, 1300 E. Main Street, 6th Floor, Richmond, VA 23219; mailing address P.O. Box 1157, Richmond, VA 23218; telephone (804) 371-9115 or e-mail dbeatty@scc.state.va.us.

AT RICHMOND, MAY 2, 2000

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

Ex Parte: In the matter of
Adopting Revisions to the Rules
Governing Independent External
Review of Final Adverse
Utilization Review Decisions

ORDER TO TAKE NOTICE

WHEREAS, § 12.1-13 of the Code of Virginia provides that the Commission shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction, and § 38.2-223 of the Code of Virginia provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code of Virginia;

WHEREAS, § 38.2-5905 of the Code of Virginia provides that the Commission shall promulgate regulations effectuating the purpose of Chapter 59 of Title 38.2 of the Code of Virginia;

WHEREAS, the rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code of Virginia are set forth in Title 14 of the Virginia Administrative Code;

WHEREAS, the Bureau of Insurance has submitted to the Commission proposed revisions to Chapter 215 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Independent External Review of Final Adverse Utilization Review Decisions," which amend the rules at 14 VAC 5-215-30 through 14 VAC 5-215-70 and 14 VAC 5-215-110;

WHEREAS, the proposed revisions reflect amendments to certain sections of Chapter 59 of Title 38.2 of the Code of Virginia enacted by the General Assembly of Virginia in its 2000 session; and

WHEREAS, the Commission is of the opinion that the proposed revisions should be adopted with an effective date of July 1, 2000;

THEREFORE, IT IS ORDERED THAT:

(1) The proposed revisions to the "Rules Governing Independent External Review of Final Adverse Utilization Review Decisions," which amend 14 VAC 5-215-30 through 14 VAC 5-215-70, and 14 VAC 5-215-110, be attached hereto and made a part hereof;

(2) All interested persons TAKE NOTICE that the Commission shall enter an order subsequent to June 1, 2000, adopting the revisions proposed by the Bureau of Insurance unless on or before June 1, 2000, any person objecting to the proposed revisions files a request for a hearing to oppose the adoption of the proposed revisions, with an effective date of July 1, 2000, with the Clerk of the Commission, Document Control Center, P.O. Box 2118, Richmond, Virginia 23218;

Proposed Regulations

(3) All interested persons TAKE NOTICE that on or before June 1, 2000, any person desiring to comment in support of, or in opposition to, the proposed revisions shall file such comments in writing with the Clerk of the Commission at the above address;

(4) All filings made under paragraphs (2) or (3) above shall contain a reference to Case No. INS000098.

(5) AN ATTESTED COPY hereof, together with a copy of the proposed revisions, be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who forthwith shall give further notice of the proposed adoption of the revisions to the rules by mailing a copy of this Order, together with a draft of the proposed revisions, to all insurers licensed by the Commission to write accident and sickness insurance in the Commonwealth of Virginia, and all health services plans, health maintenance organizations, and dental or optometric services plans licensed by the Commission under Chapters 42, 43, and 45, respectively, of Title 38.2 of the Code of Virginia; and

(6) The Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (5) above.

14 VAC 5-215-30. Definitions.

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

~~"Adverse decision" means a utilization review determination by the utilization review entity that the health care service rendered or proposed to be rendered was or is not medically necessary, when such determination may result in noncoverage of the health care service.~~

"Appellant" means (i) the covered person; (ii) the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person if the covered person is not a minor but is incompetent or incapacitated.

"Commission" means the Virginia State Corporation Commission.

"Commissioner" means the Commissioner of Insurance.

~~"Covered person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization an individual,~~

whether a policyholder, subscriber, enrollee, covered dependent, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan as defined in and subject to regulation under Chapter 58 (§ 38.2-5800 et seq.) of Title 38.2 of the Code of Virginia, when such coverage is provided under a contract issued in this Commonwealth.

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

"Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, the absence of which would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. "Emergency medical condition" also means a health condition or illness that if not treated within the time frame allotted for a standard review under this chapter will result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

"Evidence of coverage" means any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

~~"Final adverse decision" means a utilization review determination made by a utilization review entity in: (i) declining to grant an expedited review in a situation involving an alleged emergency medical condition; (ii) declining to provide coverage or services for an alleged emergency medical condition, whether before or after granting an expedited review; or (iii) a reconsideration of a prior adverse decision, and upon which a covered person or a treating health care provider acting with the consent of a covered person may base an appeal denying benefits or coverage, and concerning which all internal appeals available to the covered person pursuant to Title 32.1 of the Code of Virginia have been exhausted. For purposes of this chapter, a final adverse decision shall be deemed to have been made on the date that it is communicated to the covered person or treating health care provider.~~

"Treating health care provider" or "provider" means a licensed health care provider who renders or proposes to render health care services to a covered person.

"Utilization review" means a system for reviewing the necessity, appropriateness, and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person. As used herein, "utilization review" shall include, but shall not be limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the

appropriateness of the site at which services were or are to be delivered.

"Utilization review" shall also include determinations of medical necessity based upon contractual limitations regarding "experimental" or "investigational" procedures, by whatever terms designated in the evidence of coverage. "Utilization review" shall not include any: (i) denial of benefits or services for a procedure which is explicitly excluded pursuant to the terms of the contract or evidence of coverage; (ii) review of issues concerning contractual restrictions on facilities to be used for the provision of services; or (iii) determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any classes of insurance defined in §§ 38.2-117 through 38.2-119, 38.2-124 through 38.2-126, 38.2-130 through 38.2-132, and 38.2-134 of the Code of Virginia.

"Utilization review entity" or "entity" means ~~a person or entity performing utilization review~~ *an insurer or managed care health insurance plan licensee that performs utilization review or upon whose behalf utilization review is performed with regard to the health care or proposed health care that is the subject of the final adverse decision.*

14 VAC 5-215-40. Minimum appealable amount.

A. Appeals of final adverse decisions may be made to the Bureau of Insurance provided that the *actual* cost of the health care service or services to the covered person would exceed ~~\$500~~ \$300 if the final adverse decision is not reversed. The cost of the health care service or services shall be determined by the amount the covered person has paid or has incurred a legal obligation to pay for such service or services, as well as the amount that the covered person would be obligated to pay in the event that the final adverse decision is not reversed.

B. The health care service or services must meet the following criteria in order to be eligible for an external review as provided by this chapter:

1. The service or services, as described by the most recent published editions of the applicable International Classification of Diseases 9th Revision Clinical Modification, Physician's Current Procedural Terminology, Diagnostic Related Groups, or other billing code, must have a minimum value, as defined in subsection A of this section, that exceeds ~~\$500~~ \$300.
2. No covered person or provider shall engage in "bundling" techniques designed to combine the value of denied services such that the *actual* cost to the covered person of denied services artificially exceeds ~~\$500~~ \$300.
3. The commissioner, or his designee, shall have the final undisputed authority to determine if the *actual* cost to the covered person of the denied services exceeds ~~\$500~~ \$300.

14 VAC 5-215-50. Appeals.

A. An appeal of a final adverse decision made by a utilization review entity shall be submitted to the Bureau of

Insurance within 30 days of the final adverse decision. The appeal shall be made by (i) completing and signing a copy of the then current Appeal of Final Adverse Decision Form, or such other form or forms as may then be required by the Bureau of Insurance pursuant to 14 VAC 5-215-120; (ii) completing and signing an Authorization to Release Medical Information in a form and manner required by the Bureau of Insurance; and (iii) forwarding a check or money order made payable to the Treasurer of Virginia in the amount of \$50. The Bureau of Insurance shall provide a copy of the written appeal to the utilization review entity that made the final adverse decision.

B. The \$50 fee required to file an appeal may be waived or refunded for good cause shown upon a determination by the Bureau of Insurance that payment of the filing fee will cause undue financial hardship for the covered person. Such determination shall be based upon information provided on the Appeal of Final Adverse Decision Form then required by the Bureau of Insurance, and any supplemental information required by the Bureau of Insurance. The decision of the Bureau of Insurance as to whether good cause has been shown that payment of the filing fee will cause undue financial hardship shall be final.

C. A preliminary review of the appeal shall be conducted by the Bureau of Insurance or its designee to determine the following: (i) that the person on whose behalf the appeal has been filed is, or was, a covered person at the time the health care service in question was requested; (ii) that the appellant satisfies the definition of "appellant" set forth in 14 VAC 5-215-30; (iii) that the benefit or service that is the subject of the appeal reasonably appears to be a covered service for which the *actual* cost to the covered person would exceed ~~\$500~~ \$300 if the final adverse decision is not reversed; (iv) that all other appeal procedures available to the appellant have been exhausted, except in the case of an appeal accepted as one requiring expedited review; and (v) that the appeal is otherwise complete and filed in accordance with this section. The Bureau of Insurance shall not accept an appeal that does not meet the foregoing requirements.

D. The preliminary review shall be conducted within ~~five~~ 10 working days of receipt of all information and documentation necessary to conduct the preliminary review.

E. The Bureau of Insurance shall notify the appellant and the utilization review entity in writing within ~~three~~ five working days of the completion of the preliminary review whether the appeal has been accepted for review, and if not accepted, the reason or reasons therefor.

F. The appellant, the treating health care provider, if not the appellant, and the utilization review entity shall provide to the Bureau of Insurance or its designee copies of all medical records relevant to the final adverse decision within ~~40~~ 20 working days after the Bureau of Insurance has mailed, via certified mail, return receipt requested, written notice of its acceptance of the appeal. *Failure to comply with such request within the required time may result in the dismissal of the appeal or reversal of the final adverse decision, at the discretion of the commissioner.* The confidentiality of these medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

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G. The Bureau of Insurance, or its designee, may request additional medical records from the appellant, the treating health care provider, if not the appellant, or the utilization review entity. Such medical records shall be provided to the entity making the request, whether the Bureau of Insurance or its designee, within ~~40~~ 20 working days of the request. The confidentiality of these medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth. Failure to comply with the request within the required time may result in dismissal of the appeal or reversal of the final adverse decision at the discretion of the commissioner.

H. *The commissioner, upon good cause shown, may provide an extension of time for the covered person, the treating health care provider, the utilization review entity and the Bureau of Insurance to meet the time requirements set forth in this section.*

H. I. If an appeal that is reviewed as an expedited appeal by a utilization review entity results in a final adverse decision, the utilization review entity shall take the following actions immediately: (i) notify the person who requested the expedited review of the final adverse decision; and (ii) notify the appellant, by telephone, telefacsimile, or electronic mail, that the appellant is eligible for an expedited appeal to the Bureau of Insurance without the necessity of providing the justification required pursuant to subdivision 1 of 14 VAC 5-215-80. The notification shall be followed within 24 hours by written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal this decision to the Bureau of Insurance and providing the appropriate forms by which such appeal to the Bureau of Insurance may be filed. A copy of this written notice shall be retained by the utilization review entity and included with any materials forwarded to the Bureau of Insurance in the event the utilization review entity's decision is appealed to the Bureau of Insurance.

I. J. If a request for an expedited review is denied by a utilization review entity, the entity shall take the following actions immediately: (i) notify the appellant of the decision by telephone, telefacsimile, or electronic mail; and (ii) inform the appellant that the appellant has the right to file a request for an expedited appeal with the Bureau of Insurance pursuant to subdivision 1 of 14 VAC 5-215-80. This notification shall be followed within 24 hours by a written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal this decision to the Bureau of Insurance and providing the appropriate forms by which such appeal to the Bureau of Insurance may be filed. A copy of the written notice shall be retained by the utilization review entity and included with any materials forwarded to the Bureau of Insurance in the event the utilization review entity's decision is appealed to the Bureau of Insurance.

J. K. If the Bureau of Insurance, or its designee, determines that a request for an expedited review which has been reviewed in accordance with subsection I J of this section does not meet its criteria for an expedited review, the appellant shall be notified in writing by the Bureau of Insurance, or its designee, within two working days from the

time such determination is made. The notice shall instruct the appellant wishing to pursue the appeal to contact the issuer of coverage and request a review through the standard review process of the issues for which an expedited review was sought.

14 VAC 5-215-60. Impartial health entity.

The Bureau of Insurance shall contract with one or more impartial health entities to perform the review of final adverse decisions made by utilization review entities. The impartial health entity shall examine the final adverse decision and determine whether the decision is objective, clinically valid, compatible with established principles of health care, and appropriate under the terms of the contractual obligations to the covered person. The impartial health entity shall issue its written recommendation affirming, modifying, or reversing the final adverse decision within 30 working days of the ~~acceptance of the appeal by the Bureau of Insurance~~ date that the impartial health entity has received from all parties all documentation and information necessary for it to complete its review in the case of a standard review as set forth in 14 VAC 5-215-70. In the case of an expedited review, the impartial health entity shall issue its written recommendation within five working days of the acceptance of the appeal by the Bureau of Insurance.

14 VAC 5-215-70. Standard review.

A. The Bureau of Insurance, within ~~two~~ five working days following its acceptance of an appeal, shall assign an impartial health entity with which it has contracted pursuant to 14 VAC 5-215-60 to conduct an external review and to provide a written recommendation to the commissioner as to whether to affirm, modify, or reverse the final adverse decision.

B. In reaching a recommendation, the assigned impartial health entity is not bound by any decisions or conclusions reached during the utilization review entity's utilization review process.

C. In lieu of providing records to the Bureau of Insurance pursuant to 14 VAC 5-215-50 F, the utilization review entity, the appellant or the treating health care provider, if not the appellant, shall provide to the assigned impartial health entity all documents, medical records, and other information relevant to and relied upon by the utilization review entity in reaching its final adverse decision within ~~40~~ 20 working days after the Bureau of Insurance has mailed written notice of its acceptance of the appeal pursuant to 14 VAC 5-215-50 E. The confidentiality of medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

D. Except as provided in subsection E of this section, failure of the utilization review entity to provide the documents, medical records and information within the time specified in subsection C of this section shall not delay the conduct of the external review.

E. 1. Upon receipt of a notice from the assigned impartial health entity that the utilization review entity, appellant, or the treating health care provider, if not the appellant, has failed, without good cause, as determined by the

commissioner in his sole discretion, to provide the documents, medical records, and information within the time specified in subsection C of this section, the commissioner may terminate the external review and make a decision to affirm or reverse the final adverse decision.

2. Immediately upon making the decision pursuant to subdivision 1 of this subsection, the commissioner shall communicate his decision in writing to the assigned impartial health entity, the appellant and the utilization review entity.

F. The assigned impartial health entity shall review all of the relevant information and documents received pursuant to subsection C of this section and any other information submitted in writing by the appellant that has been forwarded to the impartial health entity by the Bureau of Insurance.

G. In addition to the documents and information provided pursuant to subsection C of this section, the assigned impartial health entity, to the extent the information is available and the impartial health entity considers them appropriate, shall consider the following in making its recommendation:

1. The treating health care provider's recommendation;
2. Consulting reports from appropriate health care providers and other documents submitted by the utilization review entity, the appellant, or the covered person's treating health care provider, if not the appellant;
3. The terms of coverage under the covered person's health benefit plan;
4. The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and
5. Any applicable clinical review criteria developed or used by the utilization review entity.

H. The assigned impartial health entity shall include in its recommendation provided pursuant to 14 VAC 5-215-60:

1. A general description of the reason or reasons for the request for external review;
2. The date the impartial health entity received the assignment from the Bureau of Insurance to conduct the external review;
3. The dates the external review began and concluded;
4. The date of its recommendation;
5. The principal reason or reasons for its recommendation;
6. The rationale for its recommendation; and

7. References to the evidence or documentation, including the practice guidelines or clinical criteria, considered in reaching its recommendation.

I. 1. Immediately upon receipt of the assigned impartial health entity's recommendation, the commissioner shall review the recommendation to ensure that it is not arbitrary or capricious.

2. The commissioner shall notify the appellant and the utilization review entity in writing of the decision to uphold or reverse the final adverse decision by issuing a written ruling affirming, modifying or reversing the final adverse decision. The written ruling shall bind the covered person and the issuer of the covered person's policy or contract for health benefits to the same extent to which each would have been bound by a judgment entered in an action at law or in equity with respect to the issues which the impartial health entity may examine when reviewing a final adverse decision.

3. The commissioner shall include in the notice sent pursuant to subdivision 2 of this subsection:

a. The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner that the commissioner considers appropriate, the information provided by the assigned impartial health entity supporting its recommendation; and

b. If applicable, the principal reason or reasons why the commissioner did not follow the assigned impartial health entity's recommendation.

4. Upon notice of a decision pursuant to subdivision 1 of this subsection reversing the final adverse decision, the utilization review entity immediately shall approve and provide, or provide reimbursement for, any and all medical services that were the subject of the final adverse decision.

14 VAC 5-215-110. Standards, credentials, and qualifications of the impartial health entity.

A. In order to qualify to perform either standard or expedited external reviews pursuant to this chapter and Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 of the Code of Virginia, an impartial health entity shall have and maintain written policies and procedures that govern all aspects of the standard and expedited external review processes that include, at a minimum:

1. A quality assurance mechanism in place that ensures:
 - a. ~~That~~ External reviews are conducted within the specified time frames and required notices are provided in a timely manner;
 - b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the impartial health entity and suitable matching of reviewers to specific cases;
 - c. ~~That~~ The confidentiality of medical records is maintained in accordance with the confidentiality and disclosure laws of the Commonwealth; and

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- d. ~~That~~ Any person employed by or under contract with the impartial health entity adheres to the requirements of this chapter as well as Chapter 59 of Title 38.2 of the Code of Virginia; and
2. An agreement to maintain and provide to the commission the information set out in Chapter 59 of Title 38.2 of the Code of Virginia.
- B. All clinical peer reviewers assigned by an impartial health entity to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:
1. Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;
 2. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical conditions as the covered person's;
 3. Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and
 4. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character.
- C. In addition to the requirements set forth in subsection A of this section, an impartial health entity shall not be affiliated with or a subsidiary of nor be owned or controlled by a health plan, a trade association of health plans, or a professional association of health care providers.
- D. 1. In addition to the requirements set forth in subsections A, B, and C of this section, to be qualified to perform an external review of a specified case pursuant to this chapter, neither the impartial health entity selected to conduct the external review nor any clinical peer reviewer assigned by the impartial health entity to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:
- a. The utilization review entity that made the final adverse decision that is the subject of the external review;
 - b. The covered person whose treatment is the subject of the external review;
 - c. Any officer, director or management employee of the utilization review entity that made the final adverse decision which is the subject of the external review;
 - d. The health care provider, the health care provider's medical group or independent practice association

recommending the health care service or services subject to the external review;

e. The facility at which the recommended health care service was or would be provided; or

f. The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

2. In determining whether an independent review organization or a clinical peer reviewer of the impartial health entity has a material, professional, familial or financial conflict of interest for purposes of subdivision 1 of this subsection, the commissioner may take into consideration situations where the impartial health entity to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the impartial health entity to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in subdivision 1 of this subsection, but the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest sufficient to disqualify the impartial health entity or the clinical peer reviewer from conducting the external review.

VA.R. Doc. No. R00-172; Filed May 3, 2000, 9:46 a.m.



FINAL REGULATIONS

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 change from the proposed text of the regulation.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulation: **Program of All-Inclusive Care for the Elderly (PACE).**

12 VAC 30-10-10 et seq. State Plan Under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (amending 12 VAC 30-10-140).

12 VAC 30-50-10 et seq. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-10; adding 12 VAC 30-50-320).

12 VAC 30-120-10 et seq. Waivered Services (adding 12 VAC 30-120-61 through [~~12 VAC 30-120-69~~ 12 VAC 30-120-68]).

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

Effective Date: July 1, 2000.

Summary:

The amendments add the Program of All-Inclusive Care for the Elderly (PACE) to services provided by Virginia's Medicaid program. PACE is a fully integrated, managed care system that provides long-term care for frail, elderly Medicaid recipients.

At the time that DMAS proposed these amendments, it expected a PACE provider to be ready to operate when the regulations became effective. This is now not the case so this final regulation shows that there are no full PACE providers in the Commonwealth.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Copies of the regulation may be obtained from Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

12 VAC 30-10-140. Amount, duration, and scope of services: Categorically needy.

Medicaid is provided in accordance with the requirements of 42 CFR 440, Subpart B and § 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

Services for the categorically needy are described below and in 12 VAC 30-50-10 et seq. These services include:

1. Each item or service listed in § 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, § 1905(r) and 42 CFR Part 411, Subpart B.

2. Nurse-midwife services listed in § 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under state law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

3. Pregnancy-related, including family planning service, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

4. Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

5. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of § 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

6. Home health services are provided to individuals entitled to nursing facility services as indicated in 12 VAC 30-10-220 of this plan.

7. Inpatient services that are being furnished to infants and children described in § 1902(l)(1)(B) through (D), or § 1905(n)(2) of the Act, on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

8. Respiratory care services are not provided to ventilator dependent individuals as indicated in 12 VAC 30-10-300 of this plan.

9. Services are provided to families eligible under § 1925 of the Act as indicated in 12 VAC 30-10-350 of this plan.

10. Home and community care for functionally disabled elderly individuals is not covered.

11. Program of All-Inclusive Care for the Elderly (PACE) services as described and limited in Supplement 6 to Attachment 3.1-A (12 VAC 30-50-320).

12 VAC 30-50-10 et seq. identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration, and scope of

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those service, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

12 VAC 30-50-10. Services provided to the categorically needy with limitations.

The following services are provided with limitations as described in 12 VAC 30-50-100 et seq.:

1. Inpatient hospital services other than those provided in an institution for mental diseases.
2. Outpatient hospital services.
3. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
4. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231 of the State Medicaid Manual (HCFA Pub. 45-4).
5. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.
6. Family planning services and supplies for individuals of child-bearing age.
7. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.
8. Medical and surgical services furnished by a dentist (in accordance with § 1905(a)(5)(B) of the Act).
9. Medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law: podiatrists, optometrists and other practitioners.
10. Home health services: intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area; home health aide services provided by a home health agency; and medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
11. Clinic services.
12. Dental services.
13. Physical therapy and related services, including occupational therapy and services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist).
14. Prescribed drugs, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
15. Other rehabilitative services, screening services, preventive services.

16. Reserved.

17. Nurse-midwife services.

18. Case management services as defined in, and to the group specified in, 12 VAC 30-50-95 et seq. (in accordance with § 1905(a)(19) or § 1915(g) of the Act).

19. Extended services to pregnant women: pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls (see 12 VAC 30-50-510). (Note: Additional coverage beyond limitations.)

20. Pediatric or family nurse practitioners' service.

21. Any other medical care and any other type of remedial care recognized by state law, specified by the Secretary: transportation.

22. *Program of All-Inclusive Care for the Elderly (PACE) services as described and limited in Supplement 6 to Attachment 3.1-A (12 VAC 30-50-320).*

12 VAC 30-50-320. Program of All-Inclusive Care for the Elderly (PACE).

The Commonwealth of Virginia has [not] entered into any valid program agreement or agreements with a PACE provider or providers and the Secretary of the U.S. Department of Health and Human Services [as follows] .

~~*[Sentara Senior Community Care in Virginia Beach, Virginia. The provider service area includes the cities of Chesapeake, Norfolk, Portsmouth and Virginia Beach. The program does not have a maximum number of enrollees. The maximum number of enrollees at a given program site is only limited by recognized occupancy rates.]*~~

[PART II.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).]

12 VAC 30-120-61. Definitions.

For purposes of [12 VAC 30-120-61 through 12 VAC 30-120-69 this part] and all contracts establishing PACE plans, the following definitions shall apply:

“Adult day health care center” means a facility licensed by the Department of Social Services, Division of Licensing Programs, to provide partial day supplementary care and protection to adult individuals who reside elsewhere. Facilities or portions of facilities licensed by the State Board of Health or the State Mental Health, Mental Retardation, and Substance Abuse Services Board and homes or residences of individuals who care solely for persons related by blood or marriage are not adult day health care centers under these regulations.

“Applicant” means an individual seeking enrollment in a PACE plan.

“Capitation rate” means the negotiated monthly per capita amount paid to a PACE contractor for services provided to enrollees.

“Catchment area” means the designated service area for a PACE plan.

“Contractor” means the entity contracting with the Department of Medical Assistance Services to operate a PACE plan.

“DMAS” means the Department of Medical Assistance Services.

“DSS” means the Department of Social Services.

“Enrollee” means a Medicaid eligible individual meeting PACE enrollment criteria and receiving services from a PACE plan.

“HCFA” means the federal Health Care Financing Administration.

“Full disclosure” means fully informing all PACE enrollees at the time of enrollment that, pursuant to § 32.1-330.3 of the Code of Virginia, PACE plan enrollment can only be guaranteed for a 30-day period.

“Imminent risk of nursing facility placement” means that an individual will require nursing facility care within 30 days if a community-based alternative care program, such as a PACE plan, is not available.

“Nursing home preadmission screening” means the process to: (i) evaluate the medical, nursing, and social needs of individuals referred for preadmission screening, (ii) analyze what specific services the individuals need, (iii) evaluate whether a service or a combination of existing community-based services are available to meet the individuals’ needs, and (iv) authorize Medicaid funded nursing facility or community-based care for those individuals who meet nursing facility level of care criteria and require that level of care.

“Nursing Home Preadmission Screening Committee/Team” means an entity contracting with the Department of Medical Assistance Services to perform nursing facility preadmission screenings. For individuals in the community, this entity is a committee comprised of staff from the local departments of health and social services. For individuals in an acute care facility, this entity is a team of nursing and social work staff. Each local committee and acute care team must have a physician member.

“PACE” means a Program of All-Inclusive Care for the Elderly.

“PACE plan” means a comprehensive acute and long-term care prepaid health plan, pursuant to § 32.1-330.3 of the Code of Virginia, operating on a capitated payment basis through which the contractor assumes full financial risk. PACE plans operate under both Medicare and Medicaid capitation.

“PACE plan contract” means a contract, pursuant to § 32.1-330.3 of the Code of Virginia, under which an entity assumes full financial risk for operation of a comprehensive acute and long-term care prepaid health plan with capitated payments for services provided to Medicaid enrollees being made by the Department of Medical Assistance Services. The parties to a PACE plan contract are the entity operating the PACE plan

and both the Department of Medical Assistance Services and the federal Health Care Financing Administration.

“PACE plan feasibility study” means a study performed by a research entity approved by the Department of Medical Assistance Services to determine a potential PACE plan contractor’s ability and resources or lack thereof to effectively operate a PACE plan. All study costs are the responsibility of the potential contractor.

“PACE protocol” means the protocol for the Program of All-Inclusive Care for the Elderly, as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon by the federal Secretary of Health and Human Services and On Lok, Inc.

“PACE site” means the location where the contractor both operates the PACE plan’s adult day health care center and coordinates the provision of core PACE services.

“PCP” means the primary care provider responsible for the coordination of medical care provided to an enrollee under a PACE plan.

“State Plan” means the document containing the covered groups, covered services and their limitations, and provider payment methodologies as provided for under Title XIX of the Social Security Act.

“These regulations” means 12 VAC 30-120-61 through 12 VAC 30-120-69.

“Transitional Advisory Group” means the group established by the Board of Medical Assistance Services pursuant to § 32.1-330.3 of the Code of Virginia. The group is responsible for advising the Department of Medical Assistance Services on issues of PACE plan license requirements, reviewing regulations, and providing ongoing oversight.

“Uniform Assessment Instrument (UAI)” means the standardized, multidimensional questionnaire used to assess an individual’s physical and mental health and social and functional abilities. Under these regulations, the UAI is used to gather the information needed to determine an individual’s long-term care needs and PACE plan service eligibility, for planning the care to be provided, and for monitoring care as it is provided.

12 VAC 30-120-62. General PACE plan requirements.

A. DMAS, the state agency responsible for administering Virginia’s Medicaid program, shall only enter into PACE plan contracts with approved PACE plan contractors.

B. A PACE plan feasibility study shall be performed before DMAS enters into any PACE plan contract. DMAS shall contract only with those entities it determines to have the ability and resources to effectively operate a PACE plan.

C. PACE plans shall offer a voluntary alternative to enrollees who would otherwise be placed in a nursing facility. PACE plan services shall be comprehensive and offered as an alternative to nursing facility admission.

D. All enrollees shall meet the nonfinancial and financial Medicaid eligibility criteria established by federal law and

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these regulations. To the extent federal law or regulations are inconsistent with these regulations, the federal law and regulations shall control.

E. Each PACE plan shall operate a PACE site that is in continuous compliance with all state licensure requirements for that site.

F. Each PACE plan shall offer core PACE services through a coordination site that is licensed as an adult day care center by DSS.

G. Each PACE plan shall ensure that services are provided by health care providers and institutions that are in continuous compliance with state licensure and certification requirements.

H. Each PACE plan shall meet the requirements of §§ 32.1-330.2 and 32.1-330.3 of the Code of Virginia.

12 VAC 30-120-63. Criteria for PACE enrollment.

A. Eligibility shall be determined in the manner provided for in the State Plan and these regulations. To the extent these regulations differ from other provisions of the State Plan for purposes of PACE eligibility and enrollment, these regulations shall control.

B. Individuals meeting the following nonfinancial criteria shall be eligible to enroll in PACE plans approved by DMAS:

1. Individuals who are age 55 or older;
2. Individuals who require nursing facility level of care and are at imminent risk of nursing facility placement as determined by a Nursing Home Preadmission Screening Team through a Nursing Home Preadmission Screening performed using the UAI;
3. Individuals for whom PACE plan services are medically appropriate and necessary because without the services the individual is at imminent risk of nursing facility placement.
4. Individuals who reside in a PACE plan catchment area;
5. Individuals who meet other criteria specified in a PACE plan contract;
6. Individuals who participate in the Medicaid or Medicare programs as specified in § 32.1-330.3 E of the Code of Virginia; and
7. Individuals who voluntarily enroll in a PACE plan and agree to the terms and conditions of enrollment.

C. To the extent permitted by federal law and regulation, individuals meeting the following financial criteria shall be eligible to enroll in PACE plans approved by DMAS:

1. Individuals whose income is determined by DMAS under the provision of the State Plan to be equal to or less than 300% of the current Supplemental Security Income payment standard for one person; and
2. Individuals whose resources are determined by DMAS under the provisions of the State Plan to be equal to or

less than the current resource allowance established in the State Plan.

D. For purposes of a financial eligibility determination, applicants shall be considered as if they are institutionalized for the purpose of applying institutional deeming rules.

E. DMAS shall not pay for services provided to an applicant by a PACE contractor if such services are provided prior to the PACE plan authorization date set by the Nursing Home Preadmission Screening team.

12 VAC 30-120-64. PACE enrollee rights.

A. PACE plan contractors shall ensure that enrollees are fully informed of their rights and responsibilities in accordance with all state and federal requirements. These rights and responsibilities shall include, but not be limited to:

1. The right to be fully informed at the time of enrollment that PACE plan enrollment can only be guaranteed for a 30-day period pursuant to [~~§ 32.1-330.2~~ § 32.1-330.3 F] of the Code of Virginia;
2. The right to receive PACE plan services directly from the contractor or under arrangements made by the contractor; and
3. The right to be fully informed in writing of any action to be taken affecting the receipt of PACE plan services.

B. Contractors shall notify enrollees of the full scope of services available under a PACE plan. The services shall include, but not be limited to:

1. Medical services, including the services of a PCP and other specialists;
2. Transportation services;
3. Outpatient rehabilitation services, including physical, occupational and speech therapy services;
4. Hospital (acute care) services;
5. Nursing facility (long-term care) services;
6. Prescription drugs;
7. Home health services;
8. Laboratory services;
9. Radiology services;
10. Ambulatory surgery services;
11. Respite care services;
12. Personal care services;
13. Hospice services;
14. Adult day health care services, to include social work services;
15. Multidisciplinary case management services;
16. Outpatient mental health and mental retardation services;
17. Outpatient psychological services;

18. Prosthetics; and

19. Durable medical equipment and other medical supplies.

C. Contractors shall ensure that PACE plan services are at least as accessible to enrollees as they are to other Medicaid eligible individuals residing in the applicable catchment area.

D. Contractors shall provide enrollees with access to services 24 hours per day every day of the year.

E. Contractors shall provide enrollees with all information necessary to facilitate easy access to services.

F. Contractors shall provide enrollees with identification documents approved by DMAS. PACE plan identification documents shall give notice to others of enrollees' coverage under PACE plans.

G. Contractors shall clearly and fully inform enrollees of their right to disenroll at will upon giving 30 days notice.

H. Contractors shall make available to enrollees a mechanism whereby disputes relating to enrollment and services can be considered. This mechanism shall be one that is approved by DMAS.

I. Contractors shall fully inform enrollees of the individual contractors' policies regarding accessing care generally, and in particular, accessing urgent or emergency care both within and without the catchment area.

J. Contractors shall maintain the confidentiality of enrollees and the services provided to them.

12 VAC 30-120-65. PACE enrollee responsibilities.

A. Enrollees shall access services through an assigned PCP. Enrollees shall be given the opportunity to choose a PCP affiliated with the applicable PACE plan. In the event an enrollee fails to choose a PCP, one shall be assigned by the contractor.

B. Enrollees shall be responsible for co-payments, if any.

C. Enrollees shall raise complaints relating to PACE plan coverage and services directly with the contractor. The contractor shall have a DMAS approved enrollee complaint process in place at all times.

D. Enrollees shall raise complaints pertaining to Medicaid eligibility and PACE plan eligibility directly to DMAS. These complaints shall be considered under DMAS' Client Appeals regulations (12 VAC 30-110-10 et seq.).

12 VAC 30-120-66. PACE plan contract requirements and standards.

~~[A. DMAS shall, as determined necessary, establish minimum contract requirements and standards for PACE plan contractors.~~

~~B. PACE plan contracts shall be governed and construed in accordance with Title 32.1 of the Code of Virginia.~~

A. Pursuant to 42 CFR Part 460 and § 32.1-330.3 of the Code of Virginia, DMAS shall establish contract requirements and standards for PACE plan contractors.

B. At the point of PACE plan contract agreement, DMAS shall modify 12 VAC 30-50-320 accordingly and submit it to the Health Care Financing Administration for approval.]

12 VAC 30-120-67. PACE catastrophic coverage limitation.

A. DMAS shall limit contractors' liability for Medicaid covered services required by individual enrollees when the need for services arises from a catastrophic occurrence or disease.

B. If, during a single state fiscal year period (July 1 through June 30), an enrollee receives medically necessary PACE plan services necessitated by a catastrophic occurrence or disease and the cost of those services, calculated using DMAS' applicable provider payment schedules, exceeds the catastrophic coverage limitation established in the PACE plan contract for the Medicaid capitated portion of the payments, DMAS shall compensate the contractor for Medicaid covered services provided beyond the limitation amount.

C. When this provision is invoked, DMAS shall compensate the contractor for Medicaid covered services at the rates established under the applicable Medicaid provider payment schedules.

12 VAC 30-120-68. PACE sanctions.

A. DMAS shall apply sanctions to contractors for violations of PACE contract provisions and federal or state law and regulation.

B. Permissible state sanctions shall include, but need not be limited to, the following:

1. A written warning to the contractor;
2. Withholding all or part of the contractor's capitation payments;
3. Suspension of new enrollment in the PACE plan;
4. Restriction of current enrollment in the PACE plan; and
5. Contract termination.

[12 VAC 30-120-69. Effective date.

~~These regulations shall only be effective upon federal approval, with the concomitant guarantee of federal matching funds, of the Commonwealth's submitted amendment to the State Plan for Medical Assistance.]~~

VA.R. Doc. No. R99-167; Filed May 2, 2000, 2:30 p.m.

REGISTRAR'S NOTICE: The agency is claiming an exemption from the Administrative Process Act in accordance with § 9-6.14:4.1 C 4 (a) of the Code of Virginia, which excludes regulations necessary to conform to changes in Virginia statutory law where no agency discretion is involved. 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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Title of Regulation: **2000 Omnibus State Plan Amendments: HIV, Organ Transplantation, Colorectal Cancer Screenings.**

12 VAC 30-50-10 et seq. Amount, Duration and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-100, 12 VAC 30-50-105, 12 VAC 30-50-140, 12 VAC 30-50-220, 12 VAC 30-50-560, and 12 VAC 30-50-570; adding 12 VAC 30-50-580).

12 VAC 30-100-10 et seq. State Programs (amending 12 VAC 30-100-260).

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

Effective Date: July 1, 2000.

Summary:

The amendments (i) increase the income standard for the HIV Premium Assistance Program from 200% to 250% of the federal poverty level; (ii) add coverage for heart, lung, and liver transplantation procedures, and bone marrow transplantation procedures for myeloma for individuals over the age of 21 when preauthorized by DMAS; and (iii) provide coverage of screening procedures for colorectal cancer for asymptomatic individuals.

Agency Contact: Copies of the regulation may be obtained from Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

12 VAC 30-50-100. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; enrolled providers.

A. Preauthorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and freestanding psychiatric hospitals. Nonauthorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS). Preauthorization shall be based on criteria specified by DMAS. In conjunction with preauthorization, an appropriate length of stay will be assigned using the HCIA, Inc., Length of Stay by Diagnosis and Operation, Southern Region, 1996, as guidelines.

1. Admission review.

a. Planned/scheduled admissions. Review shall be done prior to admission to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned at the time of this review. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

b. Unplanned/urgent admissions. Review shall be performed within one working day to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned for those admissions which have been determined to be appropriate. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

2. Concurrent review shall end for nonpsychiatric claims with dates of admission and services on or after July 1, 1998, with the full implementation of the DRG reimbursement methodology. Concurrent review shall be done to determine that inpatient hospitalization continues to be medically necessary. Prior to the expiration of the previously assigned initial length of stay, the provider shall be responsible for obtaining authorization for continued inpatient hospitalization. If continued inpatient hospitalization is determined necessary, an additional length of stay shall be assigned. Concurrent review shall continue in the same manner until the discharge of the patient from acute inpatient hospital care. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

3. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for covered days prior to billing DMAS for these services. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

4. Reconsideration process.

a. Providers requesting reconsideration must do so upon verbal notification of denial.

b. This process is available to providers when the nurse reviewers advise the providers by telephone that the medical information provided does not meet DMAS specified criteria. At this point, the provider must request by telephone a higher level of review if he disagrees with the nurse reviewer's findings. If higher level review is not requested, the case will be denied and a denial letter generated to both the provider and recipient identifying appeal rights.

c. If higher level review is requested, the authorization request will be held in suspense and referred to the Utilization Management Supervisor (UMS). The UMS shall have one working day to render a decision. If the UMS upholds the adverse decision, the provider may accept that decision and the case will be denied and a denial letter identifying appeal rights will be generated to both the provider and the recipient. If the provider continues to disagree with the UMS' adverse decision, he must request physician review by DMAS medical support. If higher level review is requested, the authorization request will be held in suspense and referred to DMAS medical support for the last step of reconsideration.

d. DMAS medical support will review all case specific medical information. Medical support shall have two working days to render a decision. If medical support upholds the adverse decision, the request for authorization will then be denied and a letter identifying appeal rights will be generated to both the provider and the recipient. The entire reconsideration process must be completed within three working days.

5. Appeals process.

a. Recipient appeals. Upon receipt of a denial letter, the recipient shall have the right to appeal the adverse decision. Under the Client Appeals regulations, Part I (12 VAC 30-110-10 et seq.) of 12 VAC 30-110, the recipient shall have 30 days from the date of the denial letter to file an appeal.

b. Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. The appeal shall be held in accordance with the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia).

B. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

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

D. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be authorized for payment. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically indicated. Except as previously noted, regardless of authorization for the hospitalization, the claims will be processed in accordance with the limit for 21 days in a 60-day period. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days for nonpsychiatric admissions shall cease with dates of service on or after July 1, 1998.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric hospitals in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent or retrospective review processes described in subsection A of this section. Medically unjustified days in such hospitalizations shall not be authorized for payment.

E. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

F. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12 VAC 30-50-105.

G. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys ~~and~~, corneas, *hearts, lungs, and livers* shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer ~~or~~, leukemia, *or myeloma*. Transplant services for ~~liver, heart,~~ *and* any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require preauthorization at the time of admission and, concurrently, for length of stay. Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants will require preauthorization for admission and, concurrently, for length of stay. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow transplant/stem cell services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from

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admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12 VAC 30-50-540 through 12 VAC 30-50-570.

H. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review. Hospitals must submit the required DMAS forms corresponding to the procedures. Regardless of authorization for the hospitalization during which these procedures were performed, the claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

12 VAC 30-50-105. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; nonenrolled providers (nonparticipating/out of state).

A. The full DRG inpatient reimbursement methodology shall become effective July 1, 1998, for general acute care hospitals and freestanding psychiatric hospitals which are nonenrolled providers (nonparticipating/out of state) and the same reviews, criteria, and requirements shall apply as are applied to enrolled, in-state, participating hospitals in 12 VAC 30-50-100.

B. Inpatient hospital services rendered by nonenrolled providers shall not require preauthorization with the exception of transplants as described in subsection K of this section. However, these inpatient hospital services claims will be suspended from payment and manually reviewed for medical necessity as described in subsections C through K of this section using criteria specified by DMAS.

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

D. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

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

F. Hospital claims with an admission date prior to the first surgical date, regardless of the number of days prior to surgery, must be medically justified. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for all pre-operative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

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

H. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be reimbursed. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically justified. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent review processes described in subsection A of 12 VAC 30-50-100. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days shall cease with dates of service on or after July 1, 1998. Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age who are Medicaid eligible for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination.

I. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified.

Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically necessary.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

J. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the DMAS outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions.

K. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys ~~and~~, corneas, *hearts, lungs, and livers* shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer ~~or~~, leukemia *or myeloma*. Transplant services for ~~liver, heart, and~~ any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover: procurement costs; all hospital costs from admission to discharge for the transplant procedure; total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and

cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12 VAC 30-50-540 through 12 VAC 30-50-570.

L. In compliance with 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

12 VAC 30-50-140. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

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

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

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

D. Outpatient psychiatric services.

1. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to DMAS' approval) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by DMAS. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary psychiatric services shall be covered when prior authorized by DMAS for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening.

2. Psychiatric services can be provided by psychiatrists or by a licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric under the direct supervision of a psychiatrist.*

3. Psychological and psychiatric services shall be medically prescribed treatment which is directly and specifically related to an active written plan designed and signature-dated by either a psychiatrist or by a licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric under the direct supervision of a psychiatrist.*

*Licensed clinical social workers, licensed professional counselors, and licensed clinical nurse specialists-psychiatric

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may also directly enroll or be supervised by psychologists as provided for in 12 VAC 30-50-150.

4. Psychological or psychiatric services shall be considered appropriate when an individual meets the following criteria:

- a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels which have been impaired;
- b. Exhibits deficits in peer relations, dealing with authority; is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, ability to learn, or ability to participate in employment, educational, or social activities;
- c. Is at risk for developing or requires treatment for maladaptive coping strategies; and
- d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

5. Psychological or psychiatric services may be provided in an office or a mental health clinic.

E. Any procedure considered experimental is not covered.

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

G. Physician visits to inpatient hospital patients over the age of 21 are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses or treatment plan and is further restricted to medically necessary authorized (for enrolled providers)/approved (for nonenrolled providers) inpatient hospital days as determined by the Program.

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

H. (Reserved.)

I. Reimbursement shall not be provided for physician services provided to recipients in the inpatient setting whenever the facility is denied reimbursement.

J. (Reserved.)

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys ~~and~~, corneas, *hearts, lungs, and livers* shall be covered for all eligible persons. High dose chemotherapy and

bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer ~~or~~, leukemia, *or myeloma*. Transplant services for ~~liver, heart,~~ *and* any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12 VAC 30-50-540 through 12 VAC 30-50-570.

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If prior authorized, breast reconstruction surgery and prostheses may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized, for all medically necessary indications. Such procedures shall be considered noncosmetic.

2. Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated or are intended solely to preserve, restore, confer, or enhance the aesthetic appearance of the breast.

12 VAC 30-50-220. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

A. Diagnostic services are provided but only when necessary to confirm a diagnosis.

B. Screening services.

1. Screening mammograms for the female recipient population aged 35 and over shall be covered, consistent with the guidelines published by the American Cancer Society.

2. Screening PSA (prostate specific antigen) and the related DRE (digital rectal examination) for males shall be covered, consistent with the guidelines published by the American Cancer Society.

3. Screening Pap smears shall be covered annually for females, consistent with the guidelines published by the American Cancer Society.

4. *Screening services for colorectal cancer, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.*

C. Maternity length of stay and early discharge.

1. If the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery, DMAS will cover one early discharge follow-up visit as recommended by the physicians in accordance with and as indicated by the "Guidelines for Perinatal Care", 4th Edition, August 1997, as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The mother and newborn, or the newborn alone if the mother has not been discharged, must meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge follow-up visit does not affect or apply to any usual postpartum or well-baby care or any other covered care to which the mother or newborn is entitled; it is tied directly to an early discharge.

2. The early discharge follow-up visit must be provided as directed by a physician. The physician may coordinate with the provider of his choice to provide the early discharge follow-up visit, within the following limitations. Qualified providers are those hospitals, physicians, nurse midwives, nurse practitioners, federally qualified health clinics, rural health clinics, and health departments' clinics that are enrolled as Medicaid providers and are qualified by the appropriate state authority for delivery of the service. The staff providing the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health. The visit must be provided within 48 hours of discharge.

12 VAC 30-50-560. Liver, heart, lung, allogeneic and autologous bone marrow transplantation and any other medically necessary transplantation procedures that are determined to not be experimental or investigational (coverage for persons younger than 21 years).

A. Patient selection criteria for provision of liver, heart, allogeneic and autologous bone marrow transplantation and

~~any other medically necessary transplantation procedures that are determined to not be experimental or investigational.~~

1. The following general conditions shall apply to these services:

a. Coverage shall not be provided for procedures that are provided on an investigational or experimental basis.

b. There must be no effective alternative medical or surgical therapies available with outcomes that are at least comparable.

c. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective and ~~not experimental or investigational.~~

d. Prior authorization by the Department of Medical Assistance Services (DMAS) is required. The prior authorization request must contain the information and documentation as required by DMAS.

2. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement:

~~a. The patient must be under 21 years of age at time of surgery.~~

~~b.~~ The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be pre-authorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by DMAS of information submitted by the transplant team or center.

The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

(1) a. Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management;

(2) b. The patient is not in an irreversible terminal state, and

(3) c. The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living.

B. Facility selection criteria for liver, heart, allogeneic and autologous bone marrow transplantation and ~~any other medically necessary transplantation procedures that are determined to not be experimental or investigational (coverage for persons younger than 21 years).~~

1. The following general conditions shall apply:

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- a. Procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant can not be performed in the necessary time period.
 - b. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities.
2. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:
- a. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific transplant procedure;
 - b. The transplant surgeons have been trained in the specific transplant technique at an institution with a well established transplant program for the specific procedure;
 - c. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;
 - d. The facility has staff or access to staff with expertise in tissue typing, immunological and immunosuppressive techniques;
 - e. Adequate blood bank support services are available;
 - f. Adequate arrangements exist for donor procurement services;
 - g. Current full membership in the United Network for Organ Sharing, for the facilities where solid organ transplants are performed;
 - h. Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;
 - i. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;
 - j. Transplant volume at the facility is consistent with maintaining quality services;
 - k. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

12 VAC 30-50-570. High dose chemotherapy and bone marrow/stem cell transplantation (coverage for persons over 21 years of age).

- A. Patient selection criteria for high dose chemotherapy and bone marrow/stem cell transplantation (coverage for persons over 21 years of age).
1. The following general conditions shall apply to these services:
- a. This must be the most effective medical therapy available yielding outcomes that are at least comparable to other therapies.

- b. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective.
- c. Prior authorization by the Department of Medical Assistance Services (DMAS) is required. The prior authorization request must contain the information and documentation as required by DMAS. The nearest approved and appropriate facility will be considered.

2. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement for individuals who have been diagnosed with lymphoma, breast cancer, ~~or~~ leukemia, or myeloma and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high dose chemotherapy and bone marrow/stem cell transplant:

- a. The patient selection criteria of the transplant center where the treatment is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be preauthorized only if the selection of the patient adheres to the transplant center's patient selection criteria based upon review by DMAS of information submitted by the transplant team or center.
- b. The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:
 - (1) The patient is not in an irreversible terminal state (as demonstrated in the facility's patient selection criteria); and
 - (2) The transplant is likely to prolong life and restore a range of physical and social functions suited to activities of daily living.

- B. Facility selection criteria for high dose chemotherapy and bone marrow/stem cell transplantation for individuals diagnosed with lymphoma, breast cancer, ~~or~~ leukemia, or myeloma.

1. The following general conditions shall apply:
- a. Unless it is cost effective and medically appropriate, procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period.
 - b. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities.
2. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

- a. The transplant program staff has demonstrated expertise and experience in the medical treatment of the specific transplant procedure;
- b. The transplant physicians have been trained in the specific transplant technique at an institution with a well established transplant program for the specific procedure;
- c. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;
- d. The facility has staff or access to staff with expertise in tissue typing, immunological and immunosuppressive techniques;
- e. Adequate blood bank support services are available;
- f. Adequate arrangements exist for donor procurement services;
- g. The facility has a membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;
- h. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;
- i. Transplant volume at the facility is consistent with maintaining quality services; and
- j. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

12 VAC 30-50-580. Other medically necessary transplantation procedures that are determined to not be experimental or investigational (coverage for persons younger than 21 years).

A. Patient selection criteria for any other medically necessary transplantation procedures that are determined to not be experimental or investigational.

1. The following general conditions shall apply to these services:
 - a. Coverage shall not be provided for procedures that are provided on an investigational or experimental basis.
 - b. There must be no effective alternative medical or surgical therapies available with outcomes that are at least comparable.
 - c. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective and not experimental or investigational.
 - d. Prior authorization by the Department of Medical Assistance Services is required. The prior authorization request must contain the information and documentation as required by DMAS.

2. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement:

- a. The patient must be under 21 years of age at time of surgery.
- b. The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be preauthorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by DMAS of information submitted by the transplant team or center.

The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

- (1) Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management;
- (2) The patient is not in an irreversible terminal state, and
- (3) The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living.

B. Facility selection criteria.

1. The following general conditions shall apply:

- a. Procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period.
- b. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities.

2. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

- a. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific transplant procedure;
- b. The transplant surgeons have been trained in the specific transplant technique at an institution with a well established transplant program for the specific procedure;
- c. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;
- d. The facility has staff or access to staff with expertise in tissue typing, immunological and immunosuppressive techniques;

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e. Adequate blood bank support services are available;

f. Adequate arrangements exist for donor procurement services;

g. Current full membership in the United Network for Organ Sharing, for the facilities where solid organ transplants are performed;

h. Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

i. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

j. Transplant volume at the facility is consistent with maintaining quality services;

k. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

12 VAC 30-100-260. Eligibility requirements.

An applicant will be determined to be eligible for the HIV Premium Assistance Program if the individual:

1. Is a Virginia resident at the time of application and is:
 - a. A citizen of the United States;
 - b. An alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, including an alien who is lawfully present in the United States pursuant to 8 USC § 1101 et seq.; or
 - c. An alien lawfully admitted under authority of the Indochina Migration and Refugee Assistance Act of 1975, 22 USC § 2601 et seq.;
2. Is certified by a licensed physician to be HIV positive;
3. Is certified by a licensed physician to be unable to work or to have a substantial likelihood of being unable to work within three months of the date of the physician's certification due to the HIV infection;
4. Is eligible for continuation of group health insurance plan benefits through the employer and the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, or for continuation of benefits under any type of health insurance plan unless DMAS has reason to believe it is not cost effective;
5. Has family income no greater than 200% 250% of the poverty level;
6. Has countable liquid assets no more than \$10,000 in value; and
7. Is not eligible for Medicaid.

VA.R. Doc. No. R00-173; Filed May 3, 2000, 11:44 a.m.

Title of Regulation: 12 VAC 30-70-10 et seq. **Methods and Standards for Establishing Payment Rates--Inpatient Hospital Care (Diagnosis Related Groups)** (amending 12 VAC 30-70-400, 12 VAC 30-70-410, 12 VAC 30-70-420, 12 VAC 30-70-450, and 12 VAC 30-70-460; adding 12 VAC 30-70-201, [~~12 VAC 30-70-205,~~] 12 VAC 30-70-211, 12 VAC 30-70-221, 12 VAC 30-70-231, 12 VAC 30-70-241, 12 VAC 30-70-251, 12 VAC 30-70-261, 12 VAC 30-70-271, 12 VAC 30-70-281, 12 VAC 30-70-291, 12 VAC 30-70-301, 12 VAC 30-70-311, 12 VAC 30-70-321, 12 VAC 30-70-331, 12 VAC 30-70-341, 12 VAC 30-70-351, 12 VAC 30-70-361, 12 VAC 30-70-371, 12 VAC 30-70-381, [and] 12 VAC 30-70-391 [, and 12 VAC 30-70-435] ; and repealing 12 VAC 30-70-200, 12 VAC 30-70-210, 12 VAC 30-70-220, 12 VAC 30-70-230, 12 VAC 30-70-240, 12 VAC 30-70-250, 12 VAC 30-70-260, 12 VAC 30-70-270, 12 VAC 30-70-280, 12 VAC 30-70-290, 12 VAC 30-70-300, 12 VAC 30-70-310, 12 VAC 30-70-320, 12 VAC 30-70-330, 12 VAC 30-70-340, 12 VAC 30-70-350, 12 VAC 30-70-360, 12 VAC 30-70-370, 12 VAC 30-70-380, and 12 VAC 30-70-390).

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

Effective Date: July 1, 2000.

Summary:

The regulations amend the existing inpatient hospital payment methodology regulations to remove transition period rules and fully implement the new Diagnosis Related Grouping (DRG) methodology. These amendments fulfill a directive by the 1996 General Assembly to implement a DRG methodology (Chapter 912, Item 322 J), and the settlement terms of a case brought under the federal Boren Amendment which required DMAS and the then Virginia Hospital Association to jointly develop a replacement reimbursement method.

These regulations contain the following changes from the proposed regulation: (i) reference to the onset of the automated claims processing system has been deleted; (ii) the operating cost-to-charge ratio has been modified; (iii) the source of charges for psychiatric care has been modified; (iv) long-range design of capital cost payments has been deleted; (v) the method of calculating direct medical education has been revised; (vi) the disproportionate share adjustment formula and the formula for calculating operating costs have been modified; (vii) DRG method of reimbursing noncost-reporting general acute care hospitals has been modified; and (viii) the lump sum payment provided by the 2000 General Assembly, which was mandated in the 2000 Appropriations Act, has been added.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the Office of the Registrar of Regulations.

Agency Contact: Copies of the regulation may be obtained from Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad

Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

PART V.
INPATIENT HOSPITAL PAYMENT SYSTEM.

Article 1.
Application of Payment Methodologies.

12 VAC 30-70-200. Application of payment methodologies. (Repealed.)

The state agency will pay for inpatient hospital services under the methodologies and during the time periods specified in this part. During state fiscal years (SFY) 1997 and 1998, the state agency's methodology for inpatient hospital services in general acute care hospitals will transition from a per diem methodology to a DRG-based methodology. Article 2 (12 VAC 30-70-210) describes the special rules that apply during the transition period. Article 3 (12 VAC 30-70-220 et seq.) describes the DRG methodology that will apply (at a specified transition percentage) during the transition period and that will remain after the transition is over. Article 4 (12 VAC 30-70-400 et seq.) describes the revised per diem methodology that will apply in part during the transition, but that will cease to apply after the transition is over.

For inpatient hospital services in general acute care hospitals and rehabilitation hospitals occurring before July 1, 1996, reimbursement shall be based on the methodology described in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130), which language, until July 1, 1996, was Attachment 4.19-A of the State Plan for Medical Assistance Services. The provisions contained in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130) shall not be effective after June 30, 1996, except as otherwise provided in this part.

For inpatient hospital services that are psychiatric or rehabilitation services and that are provided in general acute care hospitals, distinct part units of general acute care hospitals, freestanding psychiatric facilities licensed as hospitals, or rehabilitation hospitals on and after July 1, 1996, reimbursement shall be based on a methodology described in Articles 2, 3 and 4 of this part. This methodology implements a transition from revised per diem rates taken from the previous methodology (12 VAC 30-70-10 through 12 VAC 30-70-130) to different per diem rates that will be used in the context of the DRG methodology. These services shall not be reimbursed by means of DRG per case rates. For freestanding psychiatric facilities licensed as hospitals there shall be no transition period, but the new per diem rates are to be implemented effective July 1, 1996. Also effective for those services rendered on or after July 1, 1996, the professional component for the care rendered in such freestanding psychiatric facilities licensed as hospitals may be billed separately by the attending professional who is enrolled in Medicaid. Inpatient hospital services that are provided in long stay hospitals and state-owned rehabilitation hospitals shall be subject to the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, which until July 1, 1996, was Attachment 4.19-A of the State Plan for Medical Assistance Services.

Transplant services shall not be subject to the provisions of this part. They shall continue to be subject to 12 VAC

~~30-50-100 through 12 VAC 30-50-310 and 12 VAC 30-50-540.~~

Article 2.
Transition Period.

12 VAC 30-70-210. Transition period reimbursement rules. (Repealed.)

A. Effective July 1, 1996, the state agency's reimbursement methodology for inpatient hospital services shall begin a transition from a prospective per diem to a prospective diagnosis related groupings (DRG) methodology. During the transition period, reimbursement of operating costs shall be a blend of a prospective DRG methodology (described in Article 3 of this part) and a revised prospective per diem methodology (described in Article 4 of this part). The transition period shall be SFY1997 and 1998, after which a DRG methodology alone shall be used.

B. Tentative payment during the transition period. During the transition period claims will be tentatively paid on the basis of the revised per diem methodology only. Payment of claims based on DRG rates shall begin July 1, 1998.

C. Final operating reimbursement during the transition period. During the transition period settlement of each hospital fiscal year will be carried out as provided in 12 VAC 30-70-460. Each hospital's final reimbursement for services that accrue to each state fiscal year of the transition shall be based on a blend of the prospective DRG methodology and the revised per diem methodology. For services to patients admitted and discharged in SFY1997 the blend shall be 1/3 DRG and 2/3 revised per diem. For services to patients admitted after June 30, 1996, and discharged during SFY1998 the blend shall be 2/3 DRG and 1/3 revised per diem. Settlements shall be completed according to hospital fiscal years, but after June 30, 1996, changes in rates and in the percentage of reimbursement that is based on DRGs vs. per diem rates, shall be according to state fiscal year. Services in freestanding psychiatric facilities licensed as hospitals shall not be subject to the transition period phase in of new rates, or to settlement at year end; the new system rates for these providers shall be fully effective on July 1, 1996. In hospital fiscal years that straddle the implementation date (years starting before and ending after July 1, 1996) operating costs must be settled partly under the old and partly under the new methodology:

1. Days related to discharges occurring before July 1, 1996, shall be settled under the previous reimbursement methodology (see 12 VAC 30-70-10 through 12 VAC 30-70-130).

2. Stays with admission date before July 1, 1996, and discharge date after June 30, 1996, shall be settled in two parts, with days before July 1, 1996, settled on the basis of the previous reimbursement methodology (see 12 VAC 30-70-10 through 12 VAC 30-70-130), and days after June 30, 1996, settled at 100% of the hospital's revised per diem rate as described in Article 4 (12 VAC 30-70-400 et seq.) of this part. The DRG reimbursement methodology shall not be used in the settlement of any days related to a stay with an admission date before July 1, 1996.

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3. Stays with admission dates on and after July 1, 1996, shall be settled under the transition methodology. All cases admitted from July 1, 1996, onward shall be settled based on the rates and transition rules in effect in the state fiscal year in which the discharge falls. The only exception shall be claims for rehabilitation cases with length of stay sufficient that one or more interim claims are submitted. Such claims for rehabilitation cases shall be settled based on rates and rules in effect at the time of the end date ("through" date) of the claim, whether or not it is the final or discharge claim.

D. Capital cost reimbursement. During the transition period capital cost shall be reimbursed as a pass-through as described in 12 VAC 30-70-10 through 12 VAC 30-70-130, except that paid days and charges used to determine Medicaid allowable cost in a fiscal period for purposes of capital cost reimbursement shall be the same as those accrued to the fiscal period for operating cost reimbursement. Effective July 1, 1998, capital cost shall be reimbursed as described in Article 4 (12 VAC 30-70-400 et seq.) of this part. Until capital costs are fully included in prospective rates the provisions of 12 VAC 30-70-70 regarding recapture of depreciation shall remain in effect. Reimbursement of capital cost for freestanding psychiatric facilities licensed as hospitals shall be included in their per diem rates as provided in Article 4 (12 VAC 30-70-400 et seq.) of this part, and shall not be treated as a pass-through during the transition period or afterward.

E. Disproportionate Share Hospital (DSH) payments during the transition. Effective July 1, 1996, DSH payments shall be fully prospective amounts determined in advance of the state fiscal year to which they apply, and shall not be subject to settlement or revision based on changes in utilization during the year to which they apply. Payments prospectively determined for each state fiscal year shall be considered payment for that year, and not for the year from which data used in the calculation was taken. Payment of DSH amounts determined under this methodology shall be made on a quarterly basis.

For patient days occurring before July 1, 1996, DSH reimbursement shall be determined under the previous methodology and settled accordingly (12 VAC 30-70-10 through 12 VAC 30-70-130). Effective for days occurring July 1, 1996, and after, DSH reimbursement made through prospective lump sum amounts as described in this section shall be final and not subject to settlement except when necessary due to the limit in subdivision 2 e of this subsection. After July 1, 1998, DSH reimbursement shall be as provided in Article 4 (12 VAC 30-70-400 et seq.) of this part.

1. Definition. A disproportionate share hospital shall be a hospital that meets the following criteria:

a. A Medicaid utilization rate in excess of 15%, 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

b. 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.

c. Subdivision 1 b of this subsection does not apply to a hospital:

(1) At which the inpatients are predominantly individuals under 18 years of age; or

(2) Which does not offer nonemergency obstetric services as of December 21, 1987.

2. Payment adjustment.

a. A disproportionate share hospital's additional payment shall be based on the type of hospital and on the hospital's Medicaid utilization percentage. There shall be two types of hospitals: (i) Type One, consisting of hospitals that were state-owned teaching hospitals on January 1, 1996, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization percentage is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days. Each eligible hospital with a Medicaid utilization percentage above 15% shall receive a disproportionate share payment.

b. For Type One hospitals, the disproportionate share payment shall be equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 15%, times 11, times the hospital's Medicaid operating reimbursement, times 1.3186 in SFY1997, and 1.3782 in SFY1998 and (ii) the hospital's Medicaid utilization percentage in excess of 30%, times 11, times the hospital's Medicaid operating reimbursement, times 1.3186 in SFY1997, and 1.3782 in SFY1998.

c. For Type Two hospitals, the disproportionate share payment shall be equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 15%, times the hospital's Medicaid operating reimbursement, times 1.0964 in SFY1997, and 1.1476 in SFY1998 and (ii) the hospital's Medicaid utilization percentage in excess of 30%, times the hospital's Medicaid operating reimbursement, times 1.0964 in SFY1997, and 1.1476 in SFY1998.

d. For hospitals which do not qualify under the 15% inpatient Medicaid utilization rate, but do qualify under the low-income patient utilization rate, exceeding 25% in subdivision 1 a of this subsection, the disproportionate share payment amount for Type One hospitals shall be equal to the product of the hospital's low-income utilization in excess of 25%, times 11, times the hospital's Medicaid operating reimbursement. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of

the hospital's low-income utilization in excess of 25% times the hospital's Medicaid operating reimbursement.

e. OBRA 1993 § 13621 Disproportionate Share Adjustment Limit.

(1) Limit on amount of payment. No payments made under subdivision E 2 of this section shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 § 13621. A payment adjustment during a fiscal year shall not exceed the sum of:

(a) Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year, and

(b) Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

(2) During state fiscal year 1995, the limit in this section shall apply only to hospitals which are owned or operated by a state or an instrumentality or unit of government within the state. During this year such a hospital, if it is one whose Medicaid inpatient utilization rate is at least one standard deviation above the mean inpatient utilization rate in the state or if it has the largest number of Medicaid days of any such hospital in the Commonwealth for the previous state fiscal year, shall be allowed a limit that is 200% of the limit described above which the Governor certifies to the Secretary of the U.S. Department of Health and Human Services that such amount (the amount by which the hospital's payment exceeds the limit described above) shall be used for health services during the year.

3. Source data for calculation of eligibility and payment adjustment. Each hospital's eligibility for DSH payment, and the amount of the DSH payment in state fiscal year 1997, shall be based upon Medicaid utilization in hospital fiscal years ending in calendar year 1994, and on projected operating reimbursement in state fiscal year 1997, estimated on the basis of 1994 utilization. After state fiscal year 1997, each new year's DSH payments shall be calculated using the most recent reliable utilization and projection data available. For the purpose of calculating DSH payments, each hospital with a Medicaid-recognized Neonatal Intensive Care Unit (NICU) (a unit having had a unique NICU operating cost limit under subdivision 6 of 12 VAC 30-70-60), shall have its DSH payment calculated separately for the NICU and for the remainder of the hospital as if the two were separate and distinct providers.

For freestanding psychiatric facilities licensed as hospitals, DSH payment shall be based on the most recent filed

Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.

F. Direct medical education (DMedEd). During the transition period (July 1996 through June 1998), DMedEd costs shall be reimbursed in the same way as under the previous methodology (12 VAC 30-70-10 through 12 VAC 30-70-130). This methodology does not and shall not include the DMedEd reimbursement limitation enacted for the Medicare program effective July 1, 1985. Reimbursement of DMedEd shall include an amount to reflect DMedEd associated with services to Medicaid patients provided in hospitals but reimbursed by capitated managed care providers. This amount shall be estimated based on the number of days of care provided by the hospital that are reimbursed by capitated managed care providers. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals. DMedEd will be paid in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end settlement.

G. Final payment adjustment fund (PAF) payment for certain hospitals. Hospitals receiving payments for Medicaid patients from managed care providers enrolled in Modallion II shall be paid a separate lump sum amount, based on the continuation of capitation rates during July 1, 1996, through December 31, 1996, that do not reflect adjustments made to hospital per diem and DRG payments on July 1, 1996. Each of these hospitals shall be paid a final PAF amount. It shall be equal to a hospital specific PAF per diem times the number of Modallion II days that occur in the hospital in July 1, 1996, through December 31, 1996. The PAF per diem shall be based on a revision of the PAF calculation that was carried out for the SFY1996 PAF payment that was made in August 1995. The revision shall be the hospital ceiling, DSH per diem, and cost report data used in the calculation from the cost reports that would be used under the PAF methodology if a SFY1997 PAF calculation were to be done. The "paid days" data used in this calculation shall be the same as that used in the SFY1996 calculation. Pending the calculation of the final PAF payment in the settlement of the relevant time period for the affected hospitals, an interim payment shall be made. The interim payment shall be equal to 1/2 the PAF payment made to the same hospitals for SFY1996.

H. Adjusting DRG rates for length of stay (LOS) reductions from 1995 Appropriations Act. If it is demonstrated that there are savings directly attributable to LOS reductions resulting from utilization initiatives directed by the 1995 Appropriations Act as agreed to and evaluated by the Medicaid Hospital Payment Policy Advisory Council, these savings, up to a maximum of \$16.9 million in SFY1997, shall be applied as a reduction to SFY1997 and 1998 DRG rates used for settlement purposes.

I. Service limits during the transition period. The limit of coverage for adults of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply in the processing of claims and in the per diem portion of settlement during the transition period. This limit shall not apply in the DRG portion of reimbursement, except for covered psychiatric cases. Psychiatric cases are cases with a principal diagnosis

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that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see 12 VAC 30-50-100 through 12 VAC 30-50-310.

Article 3.

Diagnosis Related Groups (DRG) Reimbursement Methodology.

12 VAC 30-70-220. General. (Repealed.)

A. Reimbursement of operating costs for cases which are subject to DRG rates shall be equal to the relative weight of the DRG in which the patient falls, times the hospital specific operating rate per case. Reimbursement of outliers, transfer cases, cases still subject to per diem reimbursement, capital costs, and medical education costs shall be as provided in this article.

B. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG reimbursement methodology. Effective July 1, 1996, and until notification of a change is given, Version 12 of this grouper shall be used. DMAS shall notify hospitals by means of a Medicaid memo when updating the system to later grouper versions.

12 VAC 30-70-230. Calculation of DRG weights and hospital case mix indices. (Repealed.)

A. The relative weight measures the cost and, therefore, the reimbursement level of each DRG relative to all other DRGs. The hospital case mix index measures the hospital's average case mix complexity (costliness) relative to all other hospitals.

B. The relative weight for each DRG was determined by calculating the average standardized cost for cases assigned to that DRG, divided by the average standardized cost for cases assigned to all DRGs. For the purpose of calculating relative weights, groupable cases (cases having coding data of sufficient quality to support DRG assignment) and transfer cases (groupable cases where the patient was transferred to another hospital) were used. Ungroupable cases and rehabilitation, psychiatric, and transplant cases were not used. DMAS' hospital computerized claims history file for discharges in hospital fiscal years ending in calendar year 1993 was used. All available data from all enrolled, cost-reporting general acute care hospitals were used, including data from state-owned teaching hospitals. Cost report data from hospital fiscal years ending in calendar year 1993 were also used.

C. Before relative weights were calculated for each DRG, each hospital's total charges were disaggregated into operating charges and capital charges, based on the ratio of operating and capital cost to total cost. Operating charges and capital charges were standardized for regional variation, and then both operating charges and capital charges were reduced to costs using ratios of costs to charges (RCCs) obtained from the Medicaid cost report database. Direct medical education costs were eliminated from the relative weight calculations since such costs will be addressed outside the DRG rates. These steps, detailed in subsection D of this section, were completed on a case-by-case basis using the data elements identified in the following table.

Data Elements for Relative Weight and Case Mix Index Calculations

Data Elements	Source
Total charges for each groupable case	Claims Database
Ratio of operating costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of capital costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of direct medical education costs to total costs for each hospital	Medicaid Cost Report Database
Statewide average labor portion of operating costs	Virginia Health Services Cost Review Council
Medicare wage index for each hospital	Federal Register
Medicare Geographic Adj. Factor (GAF) for each hospital	Federal Register
RCC for each hospital	Medicaid Cost Report Database

D. Steps in calculation of relative weights.

1. The total charges for each case were split into operating charges, capital charges, and direct medical education charges using hospital specific ratios obtained from the cost report database.
2. The operating charges obtained in Step 1 were standardized for regional variations in wages. This involved three substeps:
 - a. The operating charges were multiplied by 59.77% yielding the labor portion of operating charges.
 - b. The labor portion of operating charges was divided by the hospital specific Medicare wage index yielding the standardized labor portion of operating charges.
 - c. The standardized labor portion of operating charges was added to the nonlabor portion of operating charges (40.23%) yielding standardized operating charges.
3. The standardized operating charges were multiplied by the hospital specific RCC yielding standardized operating costs.
4. The capital charges obtained in Step 1 were divided by the hospital specific Medicare geographic adjustment factor (GAF) yielding standardized capital charges.
5. The standardized capital charges were multiplied by the hospital specific cost to charge ratio yielding standardized capital costs.

These five steps were repeated for all groupable cases and transfer cases. Once this was done, the cases were sorted by DRG category resulting in the total cases and the total standardized cost of each DRG. Total cost divided by total cases yielded the average standardized cost of each DRG. The average standardized cost of each DRG was divided by the average standardized cost across all DRGs yielding the relative weight for each DRG. To address the unavailability of charge data related to adult hospital days beyond 21 days, an

adjustment was estimated for certain DRGs and added to the weights as calculated above. This adjustment for adult days over 21 is necessary only until the first recalibration of weights becomes effective in July 1998 (see 12 VAC 30-70-380).

The relative weights were then used to calculate a case-mix index for each hospital. The case-mix index for a hospital was determined by summing for all DRGs the product of the number of groupable cases and transfer cases in each DRG and the relative weight for each DRG. This sum was then divided by the total number of cases yielding the case-mix index. This process was repeated on a hospital-by-hospital basis.

12 VAC 30-70-240. Calculation of standardized costs per case. (Repealed.)

A. Standardized costs per case were calculated using all DRG cases (groupable, ungroupable, and transfer cases). Cases entirely subject to per diem rather than DRG reimbursement and cases from state-owned teaching hospitals were not used. Using the data elements identified in the following table, the seven steps outlined in subsection B of this section were completed on a case-by-case basis.

Data Elements for Standardized Costs Per Case Calculations

Data Elements	Source
Total charges for each groupable case	Claims Database
Total charges for each ungroupable case	Claims Database
Total charges for each transfer case	Claims Database
Ratio of operating costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of capital costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of direct medical education costs to total costs for each hospital	Medicaid Cost Report Database
Statewide average labor portion of operating costs	Virginia Health Services Cost Review Council
Medicare wage index for each hospital	Federal Register
Medicare GAF for each hospital RCC for each hospital	Federal Register Medicaid Cost Report Database
Case-mix index for each hospital	Calculated
Total number of groupable cases	Claims Database
Total number of ungroupable cases	Claims Database
Total number of transfer cases	Claims Database

B. Steps in calculation of standardized cost per case.

1. The total charges for each case were split into operating charges, capital charges, and direct medical education charges using hospital-specific ratios obtained from the cost report database.
2. The operating charges obtained in Step 1 were standardized for regional variations in wages. This involved three substeps:

a. The operating charges were multiplied by 59.77% yielding the labor portion of operating charges.

b. The labor portion of operating charges was divided by the hospital-specific Medicare wage index yielding the standardized labor portion of operating charges.

c. The standardized labor portion of operating charges was added to the nonlabor portion of operating charges (40.23%) yielding standardized operating charges.

3. The standardized operating charges were multiplied by the hospital-specific RCC yielding standardized operating costs.

4. The capital charges obtained in Step 1 were divided by the hospital-specific Medicare geographic adjustment factor (GAF) yielding standardized capital charges.

5. The standardized capital charges were multiplied by the hospital-specific cost-to-charge ratio yielding standardized capital costs.

6. The standardized operating costs obtained in Step 3 were divided by the hospital-specific case-mix index yielding case-mix neutral standardized operating costs.

7. The standardized capital costs obtained in Step 5 were divided by the hospital-specific case-mix index yielding case-mix neutral standardized capital costs.

These seven steps were repeated for all DRG cases. Once this was done, the case-mix neutral standardized operating costs for all DRG cases were summed and an average was calculated. This yielded what is referred to as standardized operating costs per case. A similar average was computed for capital yielding standardized capital costs per case.

12 VAC 30-70-250. Calculation of statewide operating rate per case for SFY1997. (Repealed.)

The statewide operating rate per case that shall be used to calculate the DRG portion of operating reimbursement for cases admitted and discharged in state fiscal year 1997 is equal to the standardized operating cost per case, updated to the midpoint of SFY1997 and multiplied by an additional factor. The update shall be done by multiplying the standardized operating cost per case by the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS. The additional factor is equal to 0.6247. This factor is the ratio of two numbers:

1. The numerator of the factor is the aggregate amount of operating reimbursement for hospitals included in the data base used for the calculations described above that DMAS and the Virginia Hospital and Healthcare Association (VHHA) jointly determined would be made by Medicaid in state fiscal year 1997 if the rate methodology in effect on June 30, 1996, were to continue. This amount was further adjusted by agreement between DMAS and the VHHA to carry out specific policy agreements with respect to various elements of reimbursement.

2. The denominator of the factor is the estimated aggregate operating amount for the same hospitals

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identified in subdivision 1 of this section, calculated using the standardized operating cost per case and standardized operating cost per day as calculated in 12 VAC 30-70-230 and 12 VAC 30-70-320, and adjusted for inflation as in subdivision 1.

12 VAC 30-70-260. ~~[Reserved] (Repealed.)~~

12 VAC 30-70-270. ~~Hospital specific operating rate per case. (Repealed.)~~

~~Each hospital specific operating rate per case shall be the labor portion of the statewide operating rate per case multiplied by the Medicare wage index applicable to the hospital's geographic location plus the nonlabor portion of the statewide operating rate per case. The Medicare wage index shall be the one in effect for Medicare in the base period used in the calculation of the standardized costs per case (1993 for the calculation of 1997 rates).~~

12 VAC 30-70-280. ~~[Reserved] (Repealed.)~~

12 VAC 30-70-290. ~~Outliers. (Repealed.)~~

~~A. An outlier case shall be one whose estimated cost exceeds the applicable DRG payment plus the applicable fixed loss threshold.~~

~~B. Total payment for an outlier case shall be calculated according to the following methodology (an example of the application of this methodology is found in 12 VAC 30-70-500):~~

~~1. The operating cost for the case shall be estimated. Operating cost for the case shall be the charges for the case times the hospital's operating cost-to-charge ratio based on the hospital's cost report data in the base period used to establish the rates in effect in the period for which outlier payment is being calculated.~~

~~2. The hospital specific operating cost amount for the DRG shall be calculated. This shall be equal to the sum of the labor portion of the standardized operating cost per case times the Medicare wage index, and the nonlabor portion of the standardized operating cost per case, multiplied by the relative weight applicable to the case.~~

~~3. The hospital specific operating cost outlier threshold is calculated as follows:~~

~~a. An outlier fixed loss threshold times the statewide average labor portion of operating cost times the Medicare wage index for the hospital, plus~~

~~b. The nonlabor portion of the fixed loss threshold, plus~~

~~c. The DRG operating cost amount for the case (subdivision 2 of this subsection).~~

~~4. The case specific excess over the hospital specific operating outlier threshold is calculated. This shall be equal to the difference between the estimated operating cost for the case (subdivision 1 of this subsection) and the hospital specific operating cost outlier threshold (subdivision 3 of this subsection), multiplied by the cost adjustment factor for outliers.~~

~~5. The total payment for the case is calculated. This shall be equal to the sum of the DRG operating cost amount for the case (subdivision 2 of this subsection) and the case specific excess over the hospital specific operating threshold (subdivision 4 of this subsection), multiplied by the factor that is used to adjust the standardized operating cost per case in 12 VAC 30-70-250.~~

~~C. Data element definitions. Factors and variables used in the above calculation and not already defined are defined as follows:~~

~~1. The "outlier fixed loss threshold" is a fixed dollar amount in SFY1997, applicable to all hospitals, that shall be adjusted each year. It shall be calculated each year, based on the most recent available estimates so as to result in a total operating expenditure for outliers equal to 5.1% of total operating expenditures, including outliers. In SFY1997, this amount shall be \$15,483. If in any year revised estimates are unavailable the previous year's value shall be used updated for inflation using the same factor applied to hospital rates.~~

~~2. The "statewide average labor proportion of operating cost" is a fixed percentage, equal to .5977. This figure may be updated with revised data when rates are rebased/recalibrated.~~

~~3. The "adjustment factor for outliers" is a fixed factor, published by Medicare in the Federal Register, and equal to 0.80. This figure shall be updated based on changes to the Medicare factor, upon the next rebasing of the system described in this part.~~

~~4. The "Medicare wage index applicable to the hospital" is as published by the Health Care Financing Administration in the year used as the base period.~~

12 VAC 30-70-300. ~~Transfers and readmissions. (Repealed.)~~

~~A. Transfer cases shall be defined as (i) patients transferred from one general acute care hospital to another and (ii) patients discharged from one general acute care hospital and admitted to another for the same or similar diagnosis (similar diagnoses shall be defined as ones with the first three digits the same) within five days of that discharge.~~

~~B. Readmissions shall be defined as cases readmitted to the same hospital for the same or similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as a new admission or case (a separate DRG payment shall not be made).~~

~~C. Exceptions:~~

~~1. Cases falling into DRGs 456, 639, or 640 shall not be treated as transfer cases, but the full DRG rate shall be paid to the transferring hospital. These DRGs are designed to be populated entirely with transfer patients.~~

~~2. Cases transferred to or from a distinct part psychiatric or rehabilitation units of a general acute care hospital shall not be treated as transfer cases.~~

D. ~~Transfer methodology. When two general acute care hospitals provide inpatient services to a patient defined as a transfer case:~~

~~1. The transferring hospital shall receive the lesser of (i) a per diem payment equal to the DRG payment for the transferring hospital, divided by the arithmetic mean length of stay for the DRG in all hospitals for which data are available, times the patient's length of stay at the transferring hospital or (ii) the full DRG payment for the transferring hospital. The transferring hospital shall be eligible for outlier payments if the applicable criteria are met.~~

~~2. The receiving hospital, if it is the final discharging hospital, shall receive DRG payment. A receiving hospital that later transfers the patient to another hospital, including the first transferring hospital, shall be reimbursed as a transferring hospital. Only the final discharging hospital shall receive DRG payment. The receiving hospital shall be eligible for outlier payments if the applicable criteria are met.~~

12 VAC 30-70-310. Per diem reimbursement in the DRG methodology. (Repealed.)

~~Cases that will continue to be reimbursed on a per diem basis are (i) covered psychiatric cases in general acute care hospitals and psychiatric units of general acute care hospitals, (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals, and (iii) rehabilitation cases in both general acute care and rehabilitation hospitals. Psychiatric cases are cases with a principal diagnosis that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see the Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1A&B (12 VAC 30-50-95 through 12 VAC 30-50-310).~~

12 VAC 30-70-320. Calculation of standardized costs per day. (Repealed.)

~~A. Standardized operating costs per day and standardized capital costs per day were calculated separately, but using the same calculation methodology, for psychiatric cases in general acute care hospitals, psychiatric acute care in freestanding psychiatric facilities licensed as hospitals, and rehabilitation cases (per diem cases). Using the data elements identified in the following table, the first five steps outlined below were completed on a case-by-case basis.~~

Data Elements for Calculating Total Costs for Per Diem Cases

Data Elements	Source
Total charges for each acute care 1 psychiatric case	Claims Database
Total charges for each freestanding acute care psychiatric case	Claims Database
Total charges for each rehabilitation case	Claims Database
Ratio of operating costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of capital costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of direct medical education costs to	Medicaid Cost

~~total costs for each hospital
Statewide average labor portion of operating costs~~

~~Medicare wage index for each hospital
Medicare GAF for each hospital
RCC for psychiatric distinct part unit for each hospital
RCC for each hospital~~

~~Number for acute care psychiatric days at each hospital~~

~~Number of freestanding acute care psychiatric days at freestanding psychiatric facilities licensed as hospitals
Number of rehabilitation days at each acute care hospital and freestanding rehabilitation hospital~~

~~Report Database
Virginia Health Services Cost Review Council
Federal Register
Federal Register
Medicaid Cost Report Database
Medicaid Cost Report Database
Claims Database~~

~~Claims Database~~

~~Claims Database~~

~~B. Steps in calculation of standardized cost per day.~~

~~1. The total charges for the case were split into operating charges, capital charges, and direct medical education charges using hospital specific ratios obtained from the cost report database.~~

~~2. The operating charges obtained in Step 1 were standardized for regional variations in wages. This involved three substeps.~~

~~a. The operating charges were multiplied by 59.77% yielding the labor portion of operating charges.~~

~~b. The labor portion of operating charges was divided by the hospital specific Medicare wage index yielding the standardized labor portion of operating charges.~~

~~c. The standardized labor portion of operating charges was added to the nonlabor portion of operating charges (40.23%) yielding standardized operating charges.~~

~~3. The standardized operating charges were multiplied by the hospital specific RCCs yielding standardized operating costs.~~

~~4. The capital charges obtained in Step 1 were divided by the hospital specific Medicare geographic adjustment factor (GAF) yielding standardized capital charges.~~

~~5. The standardized capital charges were multiplied by the hospital specific RCCs yielding standardized capital costs.~~

~~These five steps were repeated for all per diem cases. The standardized operating costs for per diem cases were then summed and divided by the total number of per diem days yielding the standardized operating costs per day for per diem cases. Similarly, the standardized capital costs for per diem cases were summed and divided by the total number of per diem days yielding the standardized capital costs per day for per diem cases. These two calculations were done separately for psychiatric cases in freestanding psychiatric facilities licensed as hospitals, for psychiatric cases in general acute care hospitals (including distinct part units) and for rehabilitation cases.~~

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~~C. Where general acute care hospitals had psychiatric distinct part units (DPUs) reported on their cost reports, separate RCCs were calculated for the DPUs and used in lieu of the hospital specific RCCs. Since DPU specific RCCs are generally higher than hospital specific RCCs, this had the effect of increasing the estimated costs of acute care psychiatric cases. Overall hospital RCCs were used for freestanding acute care psychiatric cases and rehabilitation cases, as well as for psychiatric cases at general acute care hospitals without a psychiatric DPU.~~

12 VAC 30-70-330. Calculation of statewide operating rate per day. (Repealed.)

~~The statewide hospital operating rate per day that shall be used to calculate the DRG system portion of operating reimbursement for psychiatric and rehabilitation cases admitted and discharged in SFY1997 is equal to the standardized operating cost per day updated to the midpoint of SFY1997 and multiplied by an additional factor. The update shall be done by multiplying the standardized operating cost per day by the DRI Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS. The additional factor for per diem cases in general acute care hospitals and rehabilitation hospitals is equal to 0.6290, and 0.6690 for freestanding psychiatric facilities licensed as hospitals. These factors were calculated so that per diem cases will be reimbursed the same percentage of cost as DRG cases based on the data used for rate calculation.~~

~~Per diem rates used for acute care hospitals during the transition shall be operating rates only and capital shall be reimbursed on a pass-through basis. Per diem rates used for freestanding psychiatric facilities licensed as hospitals shall be inclusive of capital. The capital-inclusive statewide per diem rate for freestanding psychiatric facilities licensed as hospitals shall be the standardized cost per day calculated for such hospitals adjusted for the wage index and the geographic adjustment factor (GAF) and multiplied by the factor above.~~

12 VAC 30-70-340. Calculation of hospital specific operating rate per day. (Repealed.)

~~Each hospital specific operating rate per day shall be the labor portion of the statewide operating rate per day multiplied by the Medicare wage index applicable to the hospital's geographic location plus the nonlabor portion of the statewide operating rate per day. The Medicare wage index shall be the one in effect for Medicare in the base period used in the calculation of the standardized costs per case (1993 for the calculation of 1997 rates).~~

~~The hospital specific rate per day for freestanding psychiatric facilities licensed as hospitals shall be inclusive of capital cost, and shall have a capital portion which shall be adjusted by the GAF and added to the labor and nonlabor operating elements calculated as described above. The geographic adjustment factor shall be taken from the same time period as the Medicare wage index.~~

12 VAC 30-70-350. [Reserved] (Repealed.)

12 VAC 30-70-360. Indirect medical education (IME). (Repealed.)

~~Hospitals with programs in graduate medical education shall receive a rate adjustment for associated indirect costs. This reimbursement for IME costs recognizes the increased use of ancillary services associated with the educational process and the higher case mix intensity of teaching hospitals. The IME adjustment shall employ the equation shown below.~~

$$\text{IME percentage} = 1.89 \times ((1+r)^{0.405} - 1)$$

~~In this equation, r is the ratio of interns and residents to staffed beds. The IME adjustment shall be the IME percentage, times 0.4043, times operating reimbursement for DRG cases and per diem cases.~~

12 VAC 30-70-370. Updating rates for inflation. (Repealed.)

~~DRG system rates in SFY1997 shall be as provided in 12 VAC 30-70-270 and 12 VAC 30-70-340. Rates for state fiscal years after SFY1997 shall be updated for inflation as follows:~~

~~1. The statewide operating rate per case as calculated in 12 VAC 30-70-250 and the statewide rates per day as calculated in 12 VAC 30-70-310 shall be converted to a price level at the midpoint of state fiscal year 1993, using the same inflation values as were used to establish the amounts used in subdivision 1 of 12 VAC 30-70-250. The resulting rates are the base period operating rates per case and the base period rates per day.~~

~~2. Rates shall be updated each July first by increasing the 1993 base period rates to the midpoint of the upcoming state fiscal year using the DRI Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS. The most current table available prior to the effective date of the new rates shall be used. By means of this method, each year, corrections made by DRI/McGraw-Hill in the moving averages that were used to update rates for previous years shall automatically be incorporated as adjustments to the update calculation used for the upcoming year. For each new year's rate calculation that uses a base year prior to 1997, the inflation values shall be the DRI/McGraw-Hill values plus two percentage points for each year through SFY1997.~~

12 VAC 30-70-380. Recalibration/rebasing policy. (Repealed.)

~~DMAS recognizes that claims experience during the transition period or modifications in federal policies may require adjustment to the DRG system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the weights assigned to cases) and rebase (review and update as appropriate the cost basis on which the rate is developed) the DRG system at least every other year. The first such recalibration and rebasing shall be done prior to full implementation of the DRG methodology in SFY1999. Recalibration and rebasing shall be done in consultation with~~

the Medicaid Hospital Payment Policy Advisory Council noted in 12 VAC 30-70-490.

12 VAC 30-70-390. [Reserved] (Repealed.)

Article 4.

Revised Per Diem Methodology.

12 VAC 30-70-201. Application of payment methodologies.

A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12 VAC 30-70-221 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12 VAC 30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals and state-owned rehabilitation hospitals shall be subject to the provisions of Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130). ~~[Until claims can be processed and paid by the DRG payment methodology, interim payments to hospitals will continue to be made by the per diem payment methodology described in Article 3 (12 VAC 30-70-400 et seq.) and cost settled at the DRG amount when the hospitals' cost reports are settled at year end. The limit of coverage for adults of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply in the processing of claims (interim payments).]~~

C. Transplant services shall not be subject to the provisions of this part. These services shall continue to be subject to 12 VAC 30-50-100 through 12 VAC 30-50-310 and 12 VAC 30-50-540.

~~**[12 VAC 30-70-205. Prior notice of onset of claims processing system.**~~

~~DMAS shall provide prior notice to the onset of the DRG claims process system by direct notices to all affected hospitals.]~~

Article 2.

Prospective (DRG-Based) Payment Methodology.

12 VAC 30-70-211. (Reserved.)

12 VAC 30-70-221. General.

A. Effective July 1, [1999 2000], the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

1. As stipulated in 12 VAC 30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times relative weight of the DRG to which the case is assigned.

2. As stipulated in 12 VAC 30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12 VAC 30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12 VAC 30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12 VAC 30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12 VAC 30-70-281, payments for direct medical education costs shall be made on an allowable cost basis.

7. As stipulated in 12 VAC 30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12 VAC 30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated. In subsequent rebasing, the Commonwealth shall notify affected providers of the base year to be used in this calculation. ~~[For State Fiscal Year 1999, the base year shall be State Fiscal Year 1997.]~~ In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" reflects the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in

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wages [~~and geography~~] from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" reflects the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages [~~and geography~~] from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid utilization rate in excess of 15%, 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. Number 2 of this definition 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.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal

Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric DPU, divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. [~~In the base year, this ratio shall be calculated for each hospital by (i) calculating the average of the ratio over the most recent five years for which data are available and (ii) trending the hospital specific average forward from the mid-point of the five year period with a statewide trend factor. The statewide trend factor shall be the average of the four annual statewide aggregate factors of change that occurred in the five year period. This trend factor shall be compounded from the mid point of the five year period to the base year. The separate treatment of DRG costs and charges provided in this section shall begin when those data become available through the cost report. Until then, a single all-inclusive ratio shall be used for each hospital. The operating cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year~~] .

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and include (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

["] Psychiatric cases [~~are~~] means] cases with a principal diagnosis that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A&B (12 VAC 30-50-95 through 12 VAC 30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year,

this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" occur when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Type One" hospitals means those hospitals that were state-owned teaching hospitals on January 1, 1996. "Type Two" hospitals means all other hospitals.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. ~~[As of the effective date of these regulations and]~~ Until notification of a change is given, Version 14.0 of this grouper shall be used. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology

Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file

Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	[Claims history file Medicare cost reports]
Total number of psychiatric days for each freestanding psychiatric hospital	[Claims history file Medicare cost reports]
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	[VHI Medicare cost reports]
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims History File
Outlier adjustment factor	Federal Register

12 VAC 30-70-231. Operating payment for DRG cases.

A. The operating payment for DRG cases that are not transfer cases shall be equal to the hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the DRG relative weight, as determined in 12 VAC 30-70-381.

B. Exceptions.

1. Special provisions for calculating the operating payment for transfer cases are provided in 12 VAC 30-70-251.

2. Readmissions shall be considered a continuation of the same stay and shall not be treated as a new case.

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12 VAC 30-70-241. Operating payment for per diem cases.

A. The operating payment for acute care psychiatric cases and rehabilitation cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321, times the covered days for the case.

B. The payment for freestanding psychiatric cases shall be equal to the hospital specific rate per day for freestanding psychiatric cases, as determined in subsection B of 12 VAC 30-70-321, times the covered days for the case.

12 VAC 30-70-251. Operating payment for transfer cases.

A. The operating payment for transfer cases shall be determined as follows:

1. A transferring hospital shall receive the lesser of (i) a per diem payment equal to the hospital's DRG operating payment for the case, as determined in 12 VAC 30-70-231, divided by the arithmetic mean length of stay for the DRG into which the case falls times the length of stay for the case at the transferring hospital or (ii) the hospital's full DRG operating payment for the case, as determined in 12 VAC 30-70-231. The transferring hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.

2. The final discharging hospital shall receive the hospital's full DRG operating payment, as determined in 12 VAC 30-70-231. The final discharging hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.

B. Exceptions.

1. Cases falling into DRG 456, 639, or 640 shall not be treated as transfer cases. Both the transferring hospital and the final discharging hospital shall receive the full DRG operating payment.

2. Cases transferred to or from a psychiatric or rehabilitation DPU of a general acute care hospital, a freestanding psychiatric facility licensed as a hospital, or a rehabilitation hospital shall not be treated as transfer cases.

12 VAC 30-70-261. Outlier operating payment.

A. An outlier operating payment shall be made for outlier cases. This payment shall be added to the operating payments determined in 12 VAC 30-70-231 and 12 VAC 30-70-251. Eligibility for the outlier operating payment and the amount of the outlier operating payment shall be determined as follows:

1. The hospital's adjusted operating cost for the case shall be estimated. This shall be equal to the hospital's total charges for the case times the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221, times the adjustment factor specified in 12 VAC 30-70-331 B.

2. The adjusted outlier operating fixed loss threshold shall be calculated as follows:

a. The outlier operating fixed loss threshold shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of the outlier operating fixed loss threshold. Hence, the nonlabor portion of the outlier operating fixed loss threshold shall constitute one minus the statewide average labor portion of operating costs times the outlier operating fixed loss threshold.

b. The labor portion of the outlier operating fixed loss threshold shall be multiplied by the hospital's Medicare wage index, yielding the wage adjusted labor portion of the outlier operating fixed loss threshold.

c. The wage adjusted labor portion of the outlier operating fixed loss threshold shall be added to the nonlabor portion of the outlier operating fixed loss threshold, yielding the wage adjusted outlier operating fixed loss threshold.

3. The hospital's outlier operating threshold for the case shall be calculated. This shall be equal to the wage adjusted outlier operating fixed loss threshold times the adjustment factor specified in 12 VAC 30-70-331 B plus the hospital's operating payment for the case, as determined in 12 VAC 30-70-231 or 12 VAC 30-70-251.

4. The hospital's outlier operating payment for the case shall be calculated. This shall be equal to the hospital's adjusted operating cost for the case minus the hospital's outlier operating threshold for the case. If the difference is less than or equal to zero, then no outlier operating payment shall be made. If the difference is greater than zero, then the outlier operating payment shall be equal to the difference times the outlier adjustment factor.

B. An illustration of the above methodology is found in 12 VAC 30-70-500.

C. The outlier operating fixed loss threshold shall be recalculated using base year data when the DRG payment system is recalibrated and rebased. The threshold shall be calculated so as to result in an expenditure for outlier operating payments equal to 5.1% of total operating payments, including outlier operating payments, for DRG cases. The methodology described in subsection A of this section shall be applied to all base year DRG cases on an aggregate basis, and the amount of the outlier operating fixed loss threshold shall be calculated so as to exhaust the available pool for outlier operating payments.

12 VAC 30-70-271. Payment for capital costs.

A. [~~Until regulations for prospective payment of capital costs are promulgated,~~] Capital costs shall continue to be paid on an allowable cost basis and settled at the hospital's fiscal year end, following the methodology described in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130).

B. The exception to the policy in subsection A of this section is that the hospital specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12 VAC 30-70-321 B, shall be an all-inclusive payment for operating and capital costs.

~~[C. DMAS plans to implement prospective payment for capital costs for all DRG cases, acute care psychiatric cases, and rehabilitation cases. The implementation date will be determined later. Under prospective payment for capital costs, the department will calculate a hospital specific capital rate and a statewide capital rate, and the two rates will be blended during a transition period. In successive years of the transition period, the statewide capital rate will comprise an increasing portion of the blended rate, until payment for capital costs is entirely based on the statewide capital rate. The two rates will be calculated as follows:~~

~~1. The hospital specific capital rate will approximate the hospital's average capital cost per case for DRG cases or the hospital's average capital cost per day for per diem cases. Initially, this rate will be based on settled cost reports for hospital fiscal years ending in a state fiscal year to be established in future regulations. Capital obligated after July 1, 1997, shall not be included in the calculation of the hospital specific capital rate.~~

~~2. The statewide capital rate will approximate the statewide average capital cost per case for DRG cases or the statewide average capital cost per day for per diem cases. Initially, this rate will be based on settled cost reports for hospital fiscal years ending in state Fiscal Year 1997.~~

~~⊖ C.] Until prospective payment for capital costs is implemented, the provisions of 12 VAC 30-70-70 regarding recapture of depreciation shall remain in effect.~~

12 VAC 30-70-281. Payment for direct medical education costs.

~~A. [Until the department notifies hospitals otherwise,] Direct medical education shall continue to be paid on an allowable cost basis. Payments for direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.~~

~~B. Final payment for direct medical education [(DMedEd)] costs shall be [equal to the hospital's Medicaid utilization percentage times the hospital's total direct medical education costs. As defined in subsection C of 12 VAC 30-70-221, the Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days] .~~

~~C. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.~~

12 VAC 30-70-291. Payment for indirect medical education costs.

~~A. Hospitals shall be eligible to receive payments for indirect medical education. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical~~

~~education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.~~

~~B. Final payment for IME shall be determined as follows:~~

~~1. Type One hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:~~

$$\text{IME Percentage for Type One Hospitals} = [1.89 \times ((1 + r)^{0.405} - 1)]$$

~~2. Type Two hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:~~

$$\text{IME Percentage for Type Two Hospitals} = [1.89 \times ((1 + r)^{0.405} - 1)] \times 0.4043$$

~~In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.~~

~~C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.~~

12 VAC 30-70-301. Payment to disproportionate share hospitals.

~~A. Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis, shall be final, and shall not be subject to settlement except when necessary due to the limit in subsection [⊖ D] of this section.~~

~~B. Hospitals qualifying under the 15% inpatient Medicaid utilization percentage shall receive a DSH payment based on the hospital's type and the hospital's Medicaid utilization percentage.~~

~~1. Type One hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of [45% 10.5%], times [44 17], times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of [30% 21%], times [44 17], times the hospital's Medicaid operating reimbursement, times 1.4433.~~

~~2. Type Two hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of [45% 10.5%], times the hospital's Medicaid operating reimbursement, times 1.2074 and (ii) the hospital's Medicaid utilization percentage in excess of [30% 21%], times the hospital's Medicaid operating reimbursement, times 1.2074.~~

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C. Hospitals qualifying under the 25% low-income patient utilization rate shall receive a DSH payment based on the hospital's type and the hospital's low-income utilization rate.

1. Type One hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times [~~44~~ 17], times the hospital's Medicaid operating reimbursement.
2. Type Two hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.
3. Calculation of a hospital's low-income patient utilization percentage is defined in 42 USC § 1396r-4(b)(3).

D. No DSH payments shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 §13621. A DSH payment during a fiscal year shall not exceed the sum of:

1. Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year. Costs and payments for Medicaid recipients enrolled in capitated managed care programs shall be considered Medicaid costs and payments for the purposes of this section.
2. Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

E. Each hospital's eligibility for DSH payment and the amount of the DSH payment shall be calculated [~~each year~~ at the time of each rebasing] using the most recent reliable utilization data and projected operating reimbursement data available. The utilization data used to determine eligibility for DSH payment and the amount of the DSH payment shall include days for Medicaid recipients enrolled in capitated managed care programs. [In years when DSH payments are not rebased in the way described above, the previous year's amounts shall be adjusted for inflation.]

1. Each hospital with a Medicaid-recognized Neonatal Intensive Care Unit (NICU), a unit having had a unique NICU operating cost limit under subdivision 6 of 12 VAC 30-70-50, shall have its DSH payment calculated separately for the NICU and for the remainder of the hospital as if the two were separate and distinct providers. This calculation shall follow the methodology provided in [~~12 VAC 30-70-300~~ this section] .
2. For freestanding psychiatric facilities licensed as hospitals, DSH payment shall be based on the most recently settled Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.

12 VAC 30-70-311. Hospital specific operating rate per case.

The hospital specific operating rate per case shall be equal to the labor portion of the statewide operating rate per case, as determined in 12 VAC 30-70-331, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per case.

12 VAC 30-70-321. Hospital specific operating rate per day.

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12 VAC 30-70-341, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per day.

B. The hospital specific rate per day for freestanding psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of this section plus the hospital specific capital rate per day for freestanding psychiatric cases.

C. The hospital specific capital rate per day for freestanding psychiatric cases shall be equal to the Medicare geographic adjustment factor for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases.

D. The statewide capital rate per day for freestanding psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of freestanding psychiatric facilities licensed as hospitals.

E. The capital cost per day of freestanding psychiatric facilities licensed as hospitals shall be the average charges per day of psychiatric cases times the ratio total capital cost to total charges of the hospital, using data available from [~~VH~~ Medicare cost report] .

12 VAC 30-70-331. Statewide operating rate per case.

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals and shall be the ratio of the following two numbers:

1. The numerator of the factor is the aggregate total Medicaid operating payments to affected hospitals in hospital fiscal years ending in the [~~calendar year ending six months prior to the start of the state fiscal year used as the~~] base year. [~~For example, for state Fiscal Year 1999, the base year shall be state Fiscal Year 1997, and the calendar year that ends six months prior to the start of state Fiscal Year 1997 is Calendar Year 1995.~~]
2. The denominator of the factor is the aggregate total Medicaid allowable operating cost as determined from settled cost reports from the same hospitals in the same year.

12 VAC 30-70-341. Statewide operating rate per day.

A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in subsection B of 12 VAC 30-70-371, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor for acute care psychiatric cases and rehabilitation cases shall be the one specified in subsection B of 12 VAC 30-70-331.

12 VAC 30-70-351. Updating rates for inflation.

Each July, the DRI-Virginia moving average values as compiled and published by DRI/McGraw-Hill under contract with the department shall be used to update the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, and the base year standardized operating costs per day, as determined in 12 VAC 30-70-371, to the midpoint of the upcoming state fiscal year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by DRI/McGraw-Hill in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year.

12 VAC 30-70-361. Base year standardized operating costs per case.

A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per case:

1. The operating costs for each DRG case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.
2. The standardized operating costs for each DRG case shall be calculated as follows:
 - a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs.

3. The case-mix neutral standardized operating costs for each DRG case shall be calculated by dividing the standardized operating costs for the case by the hospital's case-mix index.

4. The base year standardized operating costs per case shall be calculated by summing the case-mix neutral standardized operating costs for all DRG cases and dividing by the total number of DRG cases.

5. The base year standardized operating costs per case shall be reduced by 5.1% to create a pool for outlier operating payments. Eligibility for outlier operating payments and the amount of the outlier operating payments shall be determined in accordance with 12 VAC 30-70-261.

C. Because the current cost report format does not separately identify psychiatric costs, claims data shall be used to calculate the base year standardized operating costs per case, as well as the base year standardized operating costs per day described in 12 VAC 30-70-321. At such time as the cost report permits the separate identification of psychiatric costs and the DRG payment system is recalibrated and rebased, cost report data shall be used to calculate the base year standardized operating costs per case and base year standardized operating costs per day.

12 VAC 30-70-371. Base year standardized operating costs per day.

A. For the purpose of calculating the base year standardized operating costs per day, base year claims data for per diem cases shall be used. Base year claims data for DRG cases shall not be used. Separate base year standardized operating costs per day shall be calculated for Type One and Type Two hospitals.

B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per day:

1. The operating costs for each per diem case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.
2. The standardized operating costs for each per diem case shall be calculated as follows:
 - a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

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b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs.

3. The base year standardized operating costs per day for acute care psychiatric cases shall be calculated by summing the standardized operating costs for acute care psychiatric cases and dividing by the total number of acute care psychiatric days. This calculation shall be repeated separately for freestanding psychiatric cases and rehabilitation cases.

C. For general acute care hospitals with psychiatric DPUs, the psychiatric operating cost-to-charge ratio shall be used in the above calculations.

12 VAC 30-70-381. DRG relative weights and hospital case-mix indices.

A. For the purposes of calculating DRG relative weights and hospital case-mix indices, base year claims data for all groupable cases shall be used. Base year claims data for ungroupable cases and per diem cases shall not be used. In calculating the DRG relative weights, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the DRG relative weights:

1. The operating costs for each groupable case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.

~~[Similarly, the capital costs for each groupable case shall be calculated by multiplying the hospital's total charges for the case by the hospital's capital cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.]~~

2. The standardized operating costs for each groupable case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding the standardized operating costs.

~~[3. The standardized capital costs for each groupable case shall be calculated by dividing the capital costs for the case by the hospital's Medicare geographic adjustment factor.~~

~~4. 3.] The average standardized cost per DRG shall be calculated by [summing dividing] the standardized operating costs [and the standardized capital costs] for all groupable cases in the DRG [and dividing that amount] by the number of groupable cases classified in the DRG.~~

~~[5. 4.] The average standardized cost per case shall be calculated by [summing dividing] the standardized operating costs [and standardized capital costs] for all groupable cases [and dividing that amount] by the total number of groupable cases.~~

~~[6. 5.] The average standardized cost per DRG shall be divided by the average standardized cost per case to determine the DRG relative weight.~~

C. Statistical outliers shall be eliminated from the calculation of the DRG relative weights. Within each DRG, cases shall be eliminated if (i) their standardized costs per case are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per case and (ii) their standardized costs per day are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per day. To eliminate a case, both conditions must be satisfied.

D. In calculating the DRG relative weights, a threshold of five cases shall be set as the minimum number of cases required to calculate a reasonable DRG relative weight. In those instances where there are five or fewer cases, the department's Medicaid claims data shall be supplemented with Medicaid claims data from another state or other available sources. The DRG relative weights calculated according to this methodology will result in an average case weight that is different from the average case weight before the supplemental claims data was added. Therefore, the DRG relative weights shall be normalized by an adjustment factor so that the average case weight after the supplemental claims data were added is equal to the average case weight before the supplemental claims data were added.

E. The DRG relative weights shall be used to calculate a case-mix index for each hospital. The case-mix index for a hospital is calculated by summing, across all DRGs, the product of the number of groupable cases in each DRG and the relative weight for each DRG and dividing this amount by the total number of groupable cases occurring at the hospital.

12 VAC 30-70-391. Recalibration and rebasing policy.

The department recognizes that claims experience or modifications in federal policies may require adjustment to the DRG payment system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the DRG relative weights and hospital case-mix indices) and rebase (review and update the base year standardized operating costs per case and the base year standardized operating costs per day) the DRG payment system at least every [other year three years]. Recalibration and rebasing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12 VAC 30-70-490. When rebasing is carried out, if new rates are not calculated before their required effective date, hospitals required to file cost reports and freestanding psychiatric facilities licensed as hospitals

shall be settled at the new rates, for discharges on and after the effective date of those rates, at the time the hospitals' cost reports for the year in which the rates become effective are settled.

Article 3.

Other Provisions for Payment of Inpatient Hospital Services.

12 VAC 30-70-400. Determination of per diem rates.

This [~~article~~ section] shall be applicable to only those claims for discharges prior to July 1, 1999. Each hospital's revised per diem rate or rates to be used during the transition period (SFY 1997 and SFY 1998) shall be based on the hospital's previous peer group ceiling or ceilings that were established under the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, with the following adjustments:

1. All operating ceilings will be increased by the same proportion to effect an aggregate increase in reimbursement of \$40 million in SFY 1997. This adjustment incorporates in per diem rates the systemwide aggregate value of payment that otherwise would be made through the payment adjustment fund. This adjustment will be calculated using estimated 1997 rates and 1994 days.
 2. Starting July 1, 1996, operating ceilings will be increased for inflation to the midpoint of the state fiscal year, not the hospital fiscal year. Inflation shall be based on the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS, increased by two percentage points per year. The most current table available prior to the effective date of the new rates shall be used.
- For services to be paid at SFY 1998 rates, per diem rates shall be adjusted consistent with the methodology for updating rates under the DRG methodology (~~+2 VAC 30-70-370~~ 12 VAC 30-70-351).
3. There will be no disproportionate share hospital (DSH) per diem.
 4. To pay capital cost through claims, a hospital specific adjustment to the per diem rate will be made. At settlement of each hospital fiscal year, this per diem adjustment will be eliminated and capital shall be paid as a pass-through.
 5. *This methodology shall be used after the transition period to reimburse days of hospital stays with admission dates before July 1, 1996.*
 6. *This methodology shall be used after the transition period to make interim payments until such time as the DRG payment methodology is operational.*

12 VAC 30-70-410. State university teaching hospitals.

For hospitals that were state owned teaching hospitals on January 1, 1996, all the calculations which support the determination of hospital specific rate per case and rate per day amounts under the ~~DRG reimbursement prospective payment~~ methodology shall be carried out separately from other hospitals, using cost data taken only from state university teaching hospitals. Rates to be used ~~effective July~~

~~1, 1996~~, shall be determined on the basis of cost report and other applicable data pertaining to the facility fiscal year ~~ending June 30, 1993~~ from the most recent year for which reliable data are available at the time of rebasing. For these hospitals the factors used to establish rates shall be as listed below according to the section in Article 3 (12 VAC 30-70-220 ~~et seq.~~) of this part where corresponding factors for other hospitals are set forth:

1. ~~12 VAC 30-70-250. 0.8432~~
2. ~~12 VAC 30-70-330. 0.8470~~

12 VAC 30-70-420. Reimbursement of nonenrolled noncost-reporting general acute care hospital providers.

~~During the transition period, nonenrolled general acute care hospitals (general acute care hospitals that are not required to file cost reports) shall be reimbursed according to the previous methodology for such hospitals (12 VAC 30-70-120 A). Effective with discharges after June 30, 1998, these hospitals shall be paid based on DRG rates unadjusted for geographic variation. [Noncost-reporting general acute care hospitals (general acute care hospitals that are not required to file cost reports) shall be paid based on the methodology specified in 12 VAC 30-70-120 until such time as the department can implement the DRG claims payment methodology. Once the DRG claims payment methodology is operational, noncost-reporting general acute care hospitals shall be paid based on the statewide operating rate per case (12 VAC 30-70-331) increased by the average capital percentage among hospitals filing cost reports in a recent year. Effective with discharges after the operational date of the DRG claims payment system, these hospitals shall be paid based on DRG rates unadjusted for geographic variation. Effective January 1, 2000, noncost-reporting (general acute care hospitals that are not required to file cost reports) shall be paid based on DRG rates unadjusted for geographic variation increased by the average capital percentage among hospitals filing cost reports in a recent year.] General acute care hospitals shall not file cost reports if they have less than 1,000 days per year (in the most recent provider fiscal year) of inpatient utilization by Virginia Medicaid recipients, inclusive of patients in managed care capitation programs.~~

Prior approval must be received from DMAS 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.

[12 VAC 30-70-435. Lump sum payment.

A. *Effective July 1, 2000, the Department of Medical Assistance Services (DMAS) shall make a one-time, lump sum payment of \$12,243,204 to eligible Virginia hospitals participating in the Medicaid program to mitigate the estimated impact of the rebased Diagnosis Related Groupings rates effective July 1, 1998, on each individual hospital for services provided between July 1, 1998, through December 31, 1999. The payment shall be made in two equal, semi-annual amounts during fiscal year 2001. For purposes of distribution, each hospital's share of the total amount shall be determined as follows:*

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1. DMAS shall determine the total operating payments due each hospital for inpatient hospital services provided from January 1, 2000, through June 30, 2000, using hospital claims data from discharges in that period.

2. DMAS shall determine the total operating payments that would have been due each hospital for the same services had the inpatient hospital rates and weights applicable in fiscal year 1998 been continued with inflation for fiscal years 1999 and 2000.

3. The difference between the two values calculated in subdivisions 1 and 2 of this subsection, summed across all hospitals, is the statewide difference. Each hospital-specific difference divided by the statewide difference is the hospital-specific percent share of the statewide difference.

4. The hospital-specific percent share of the statewide difference, times the total funds provided by this appropriation, is the hospital-specific lump sum payment to be paid in two equal semi-annual payments during fiscal year 2001.

B. The Department of Medical Assistance Services shall provide the data used, specific calculation, and mechanics of the payment adjustment to the Virginia Medicaid Hospital Policy Advisory Council.]

12 VAC 30-70-450. Cost reporting requirements.

Except for ~~nonenrolled~~ *noncost-reporting* general acute care hospitals and freestanding psychiatric facilities licensed as hospitals, all hospitals shall submit cost reports. All cost reports shall be submitted on uniform reporting forms provided by the state agency and by Medicare. Such cost reports shall cover a 12-month period. Any exceptions must be approved by the state agency. The cost reports are due not later than 150 days after the provider's fiscal year end. All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the program shall take action in accordance with its policies to ensure that an overpayment is not being made. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. The reductions shall start on the first day of the following month when the cost report is due. After the delinquent 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 the state agency. The cost report will be judged complete when the state agency has all of the following:

1. Completed cost reporting form or forms provided by DMAS, with signed certification or certifications.
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. Multi-level

facilities shall be governed by subdivision 5 of this subsection.

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

5. Hospitals which are part of a chain organization must also file:

a. Home office cost report;

b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report, and footnotes to the financial statements;

c. The hospital'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;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value.

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

12 VAC 30-70-460. Hospital settlement.

A. During the transition period claims will be processed and tentative payment made using per diem rates. Settlements will be carried out to ensure that the correct blend of DRG and per diem-based payment is received by each general acute care and rehabilitation hospital and to settle reimbursement of pass-through costs. There shall be no settlement of freestanding psychiatric facilities licensed as hospitals except with respect to disproportionate share hospital (DSH) payment, if necessary (see ~~12 VAC 30-70-210~~ 12 VAC 30-70-301 E 3).

B. The transition blend percentages which determine the share of DRG system and of revised per diem system reimbursement that is applicable in a given period shall change with the change of the state fiscal year, not the hospital fiscal year.

C. If a hospital's fiscal year does not end June 30, its first year ending after June 30, 1996, contains one or more months under the previous methodology, a "split" settlement shall be done of that hospital's fiscal year. Services rendered through June 30, 1996, shall be reimbursed under the previous reimbursement methodology and services rendered after June 30, 1996, will be reimbursed as described in subsection G of this section.

D. For cases subject to settlement under the blend of DRG and per diem methodologies (cases with an admission date after June 30, 1996), the date of discharge determines the year in which any inpatient service or claim related to the case shall be settled. This shall be true for both the DRG and the per diem portions of settlement. Interim claims tentatively

paid in one hospital fiscal year that relate to a discharge in a later hospital fiscal year, shall be voided and reprocessed in the latter year so that the interim claim shall not be included in the settlement of the first year, but in the settlement of the year of discharge. An exception to this shall be rehabilitation cases, the claims for which shall be settled in the year of the "through" date of the claim.

E. A single group of cases with discharges in the appropriate time period shall be the basis of both the DRG and the per diem portion of settlement. These cases shall be based on claims submitted and, if necessary corrected by 120 days after the providers FYE. Cases which are based on claims that lack sufficient information to support grouping to a DRG category, and which the hospital cannot correct, shall be settled for purposes of the DRG portion of settlement based on the lowest of the DRG weights.

F. Reimbursement for services in freestanding psychiatric facilities licensed as hospitals shall not be subject to settlement.

G. During the transition period settlements shall be carried out according to the following formulas.

1. Settlement of a hospital's first fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Paid days occurring in the hospital's fiscal year before July 1, 1996, times the per diem in effect before July 1, 1996.

(2) Paid days occurring after June 30, 1996, but in the hospital fiscal year, that are related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective on July 1, 1996.

(3) DRG system payment for DRG and psychiatric cases admitted after June 30, 1996, and discharged within the hospital fiscal year times 1/3.

(4) DRG system payment for rehabilitation claims having a "from" date of July 1, 1996, or later and a "through" date within the hospital fiscal year times 1/3.

(5) Paid days from the cases and claims in subdivisions 1 a (3) and (4) of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

b. DSH reimbursement shall be equal to paid days from the start of the hospital fiscal year through June 30, 1996, times the DSH per diem effective before July 1, 1996. There shall be no settlement of DSH after July 1, 1996, as the lump sum amount shall be final.

c. Pass-throughs shall be settled as previously based on allowable cost related to days paid in subdivisions 1 a (1), (2), and (5) of this subsection.

2. Settlement of a hospital's second fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Days occurring in the hospital fiscal year related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective at the time.

(2) DRG system payment for DRG and psychiatric cases discharged in the hospital fiscal year, but before July 1, 1997, times 1/3.

(3) DRG system payment for rehabilitation claims having a "through" date within the hospital fiscal year but before July 1, 1997, times 1/3.

(4) Covered days from the cases and claims and in subdivisions 2 b and c of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

(5) DRG system payment for DRG and psychiatric cases discharged from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(6) DRG system payment for rehabilitation claims having a "through" date from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(7) Covered days from the cases and claims and in subdivisions 2 a (5) and (6) of this subsection, times the revised system per diem that is effective on July 1, 1997, times 1/3.

b. DSH reimbursement shall be the predetermined lump sum amount.

c. Pass-throughs shall be settled as previously, based on allowable cost related to days paid in subdivisions 2 a (1), (4), and (7) of this subsection.

VA.R. Doc. No. R00-16; Filed May 3, 2000, 11:45 a.m.

TITLE 16. LABOR AND EMPLOYMENT

DEPARTMENT OF LABOR AND INDUSTRY

REGISTRAR'S NOTICE: The following regulation is exempt from the Administrative Process Act in accordance with § 9-6.14:4.1 C 4 (a) of the Code of Virginia, which excludes regulations necessary to conform to changes in Virginia statutory law where no agency discretion is involved, 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 regulation, provided such regulations do not differ materially from those required by federal law or regulation. The Department of Labor and Industry will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 16 VAC 15-40-10 et seq. Virginia Hours of Work for Minors (amending 16 VAC 15-40-10 and 16 VAC 15-40-50).

Final Regulations

Statutory Authority: § 40.1-80.1 of the Code of Virginia.

Effective Date: June 22, 2000.

Summary:

The amendments add an exemption from the hours of work requirements for minors age 13 or more that are engaged as youth referees and for minors performing sports-attending services, such as batboys.

Agency Contact: Copies of the regulation may be obtained from Dennis G. Merrill, Department of Labor and Industry, Powers-Taylor Building, 13 South 13th Street, Richmond, VA 23219, telephone (804) 786-3224.

16 VAC 15-40-10. Definitions.

The following terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Employ" means to put to work, use or service, or to engage the services of, and shall include to permit or suffer to work. "To permit or suffer to work" means to knowingly allow by failure to stop or to protest, as well as to employ by oral or written contract, by any person having authority over a minor in connection with the services being performed. As used in this chapter, the term "employ" is broader than the common law concept of employment and must be interpreted broadly in the light of the mischief to be corrected. Neither the technical relationship between the parties nor the fact that the minor is unsupervised or receives no compensation is controlling in determining whether an employer-employee relationship exists for the purpose of this chapter.

"Employer" means an individual, partnership, association, corporation, legal representative, receiver, trustee, or trustee in bankruptcy doing business in or operating within this Commonwealth who employs another to work for wages, salaries, or on commission and shall include any similar entity acting directly or indirectly in the interest of an employer in relation to an employee. For purposes of this chapter, it shall not include the government of the United States, the Commonwealth of Virginia or any of its agencies, institutions, or political subdivisions or any public body.

"School hours" means those periods when the school attended by the minor is in regular session, and does not include hours before and after school, Saturdays and Sundays, holidays, or school vacations, including summer vacations. If the minor does not attend school, "school hours" shall mean the school hours of the school district in which the minor is currently living.

"Sports-attending services" means *pre- and post-game or practice setup of balls, items and equipment; supplying and retrieving balls, items and equipment during a sporting event; clearing the field or court of debris, moisture, etc., during play; providing ice, drinks, towels, etc., to players during play; running errands for trainers, managers, coaches, and players before, during, and after a sporting event; and returning and/or storing balls, items and equipment in club house or locker room after a sporting event. The following activities are not included in the definition and are, therefore, impermissible duties: grounds or field maintenance such as grass mowing,*

spreading or rolling tarpaulins used to cover playing areas, etc.; cleaning and repairing equipment; cleaning locker rooms, showers, lavatories, rest rooms, team vehicles, club houses, dugouts or similar facilities; loading and unloading balls, items, and equipment from team vehicles before and after a sporting event; doing laundry; and working in concession stands or other selling and promotional activities.

16 VAC 15-40-50. Exceptions.

This chapter does not apply whenever the Code of Virginia exempts a minor from hours-of-work limitations or provides different hours of work. ~~As of July 17, 1991,~~ These exemptions are as follows:

1. Minors employed in the following situations are exempt from hours-of-work limitations contained in 16 VAC 15-40-30 and 16 VAC 15-40-40:

- a. A minor under 16 years of age may be employed by his parent, or a person standing in place of his parent, in a business owned by such parent or person, except in manufacturing.
- b. A page or clerk for either the House of Delegates or the Senate of Virginia.
- c. Domestic duties in and around a minor's own home when duties are performed directly for the minor's parent or other person standing in place of the parent.
- d. Work performed for the state or any of its agencies, institutions, or political subdivisions, or any public body.
- e. Theatrical performers, provided a theatrical permit is obtained from the Department of Labor and Industry.
- f. Activities performed for a volunteer rescue squad.

g. A minor 14 or 15 years old employed to perform sports-attending services at professional sporting events (baseball, basketball, football, soccer, tennis, etc.) as defined in 16 VAC 15-40-10.

h. A child 13 years of age or older employed by an eleemosynary organization or unit of state or local government as a referee for sports programs sponsored by that eleemosynary, state, or local organization or by an organization of referees sponsored by an organization recognized by the United States Olympic Committee under 36 USC § 391.

2. Minors engaged in occasional work performed around the home of the employer (not in connection with the employer's trade, business, or profession) may not work during school hours, but are otherwise exempt from the hours-of-work limitations contained in 16 VAC 15-40-30.

3. Minors 14 years and 15 years of age enrolled in a regular school work-training program in accordance with §§ 40.1-88 and 40.1-89 of the Code of Virginia may work during school hours as part of this program, but are otherwise subject to the hours-of-work limitations contained in 16 VAC 15-40-30 and 16 VAC 15-40-40.

4. Minors at least 12 years of age may deliver newspapers as early as 4 a.m., but are otherwise subject to the hours-of-work limitations contained in 16 VAC 15-40-30.

VA.R. Doc. No. R00-166; Filed April 21, 2000, 2:49 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Title of Regulation: 18 VAC 30-20-10 et seq. Regulations of the Board of Audiology and Speech-Language Pathology (amending 18 VAC 30-20-10, 18 VAC 30-20-80, 18 VAC 30-20-170, 18 VAC 30-20-180, and 18 VAC 30-20-230).

Statutory Authority: § 54.1-2400 and Chapter 26 (§ 54.1-2600 et seq.) of Title 54.1 of the Code of Virginia.

Effective Date: June 21, 2000.

Summary:

The amendments provide for the Board of Audiology and Speech-Language Pathology to license school speech-language pathologists upon review of credentials and payment of an application fee. Pursuant to a statutory mandate in Chapters 967 and 1005 of the 1999 Acts of the Assembly, the qualifications for licensure are licensure by the Department of Education with an endorsement in speech-language pathology and a master's degree in speech-language pathology. An application fee of \$50 and a renewal fee of \$60 per biennium are established.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Copies of the regulation may be obtained from Elizabeth Young Tisdale, Board of Audiology and Speech-Language Pathology, 6606 W. Broad Street, 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9111.

18 VAC 30-20-10. Definitions.

The words and terms "audiologist," "board," "practice of audiology," "practice of speech-language pathology," "speech-language disorders," and "speech-language pathologist," when used in this chapter, shall have the meanings ascribed to them in § 54.1-2600 of the Code of Virginia.

The following ~~word~~, words when used in this chapter, shall have the following ~~meaning~~ meanings, unless the context clearly indicates otherwise:

"School speech-language pathologist" means a person licensed pursuant to § 54.1-2603 of the Code of Virginia to provide speech-language pathology services solely in public school divisions.

"Supervision" means that the audiologist or speech-language pathologist is responsible for the entire service being rendered or activity being performed, is available for consultation, and is providing regular monitoring of clinical activities and competencies of the person being supervised.

18 VAC 30-20-80. Fees.

A. The following fees shall be paid as applicable for licensure:

- 1. Application for audiology or speech-language pathology license \$100
- 2. Application for school speech-language pathology license \$50
- ~~2-~~ 3. Verification of licensure requests from other states \$20
- ~~3-~~ 4. Biennial renewal \$60
- 4. 5. Reinstatement fee \$50
- ~~5-~~ 6. Duplicate wall certificates \$50
- ~~6-~~ 7. Duplicate license \$10
- ~~7-~~ 8. Returned check \$25

B. Fees shall be made payable to the Treasurer of Virginia and shall not be refunded once submitted.

18 VAC 30-20-170. Requirements for licensure.

A. The board may grant a license to an applicant who:

- 1. Holds a current and unrestricted Certificate of Clinical Competence in the area in which he seeks licensure issued by the American Speech-Language-Hearing Association. Verification of currency shall be in the form of a certified letter from the American Speech-Language-Hearing Association issued within six months prior to licensure; and
- 2. Has passed the qualifying examination for the Certificate of Clinical Competence within three years preceding the date of licensure, or has held employment in the area for which he seeks licensure for one of the past three consecutive years or two of the past five consecutive years.

B. The board may grant a license to an applicant who:

- 1. Holds a master's or doctoral degree from a college or university whose audiology and speech-language program is accredited by the American Speech-Language-Hearing Association or an equivalent accrediting body; and
- 2. Has passed a qualifying examination approved by the board. The applicant shall have passed the examination within three years preceding the date of applying for licensure in Virginia or have been actively engaged in the respective profession during the 24 months immediately preceding the date of application.

C. The board may grant a license to an applicant as a school speech-language pathologist who:

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1. Holds a master's degree in speech-language-pathology; and
2. Holds an endorsement in speech-language pathology from the Virginia Department of Education.

18 VAC 30-20-180. Application process.

A. Prior to seeking licensure as an audiologist or, a speech-language pathologist, or a school speech-language pathologist, an applicant shall submit:

1. A completed and signed application;
2. The applicable fee prescribed in 18 VAC 30-20-80; and
3. Additional documentation as may be required by the board to determine eligibility of the applicant.

B. An incomplete application package shall be retained by the board for a period of one year.

18 VAC 30-20-230. Prohibited conduct.

A. No person unless otherwise licensed to do so, shall prepare, order, dispense, alter or repair hearing aids or parts of or attachments to hearing aids for consideration. However, audiologists licensed under this chapter may make earmold impressions and prepare and alter earmolds for clinical use and research.

B. No person licensed as a school speech-language pathologist shall conduct the practice of speech-language pathology outside the scope of the public school setting.

NOTICE: The forms used in administering 18 VAC 30-20-10 et seq., Regulations of the Board of Audiology and Speech-Language Pathology, are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS

Application for Licensure, 7/97.

Application for School Speech-Language Pathologist Licensure, 11/99.


Licensure Reinstatement Application, 7/97.

[~~Endorsement Certification Form, 7/97.~~]

Endorsement Certification Form A, 11/99.

Renewal Notice [*and Application*], [~~7/97~~ 5/00] .

DEPARTMENT OF HEALTH PROFESSIONS
VIRGINIA BOARD OF AUDIOLOGY AND SPEECH-
LANGUAGE PATHOLOGY
 6606 W. BROAD STREET, 4TH FL
 RICHMOND, VIRGINIA 23230-1717
 (804) 662-7390 [TELEPHONE]
 (804) 662-9523 [FAX]



APPLICATION FOR SCHOOL
SPEECH-LANGUAGE PATHOLOGIST
LICENSURE

INSTRUCTIONS:

- Please type or print clearly.
- Enclose Application Fee of \$100, made payable to Treasurer of Virginia. All fees are non-refundable.
- Include all applicable documents.
- A resume is not an acceptable substitute for any questions on this application.
- You will be advised, in writing, the status of your application within 5 to 7 days from the date your application is received.

DISCLOSURE OF SOCIAL SECURITY OR VIRGINIA DMV CONTROL NUMBER. In accordance with § 54.1-116 of the Code of Virginia, you are required to submit your social security number or your control number" issued by the Virginia Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. **NO LICENSE, CERTIFICATION OR REGISTRATION WILL BE ISSUED TO ANY INDIVIDUAL WHO FAILS TO DISCLOSE ONE OF THESE NUMBERS.** * In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure of your Social Security Number will be required.

PART I - PERSONAL INFORMATION

NAME: First _____ Middle _____ Last _____ (Maiden)

HOME ADDRESS: Street _____ City _____ State _____ Zip _____

✓ NAME YOU WISH PRINTED ON LICENSE:

HOME PHONE: () _____ OFFICE PHONE: () _____

DATE OF BIRTH: / / SOCIAL SECURITY OR * VA DMV CONTROL #:

PART II - EDUCATION

List all colleges and universities attended. For each college or university attended, you must attach an OFFICIAL transcript of academic course work.

UNIVERSITY/COLLEGE	CITY/STATE	DATES ATTENDED	DEGREE

PART III - PROFESSIONAL BACKGROUND

INSTRUCTIONS:

- If you answer "Yes" to any of the following questions, attach an explanation, relevant documents and a description of the current status.
- For the purpose of the following questions, the terms "licensee," "registration," and "certification" are synonymous.

Yes No Do you now hold, or have you in the past held anywhere a professional license?

License Title _____ Date issued _____ Exp. Date _____
 State _____

Yes No Have you had revoked or suspended or otherwise sanctioned any license issued to you by any Board or agency in Virginia or any other state? or

Yes No Were you denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license or the privilege of taking an examination by any state licensing board?


Yes No To the best of your knowledge, is there any disciplinary action pending against you by any licensing board or professional organization?

Yes No Have you been convicted of a felony or any crime involving moral turpitude?

Yes No Have you ever been convicted of a felony or misdemeanor (other than a traffic violation)?

FOR OFFICE USE ONLY

APPROVED _____ LICENSE # _____

	<p style="text-align: center;">DEPARTMENT OF HEALTH PROFESSIONS VIRGINIA BOARD OF AUDIOLOGY AND SPEECH- LANGUAGE PATHOLOGY 6606 W. BROAD STREET, 4TH FL RICHMOND, VIRGINIA 23230-1717 (804) 662-7390 [TELEPHONE] (804) 662-9523 [FAX]</p>
<p>ENDORSEMENT CERTIFICATION FORM A</p>	
<ul style="list-style-type: none"> ▪ Applicant - Complete Part I. Mail a form to the jurisdiction by which you are currently certified as a speech-language pathologist. ▪ Virginia Department of Education - Complete Part II. Return to the address given above. 	
<p>PART I - APPLICANT</p>	
Full Name: _____	
Address: _____	
Date of Birth: _____ Social Security Number: _____	
Endorsement: _____ License Number: _____	
Date Issued: _____ Expiration Date: _____	
<p>TO WHOM IT MAY CONCERN</p> <p>I, the undersigned applicant, am applying for a license with the Virginia State Board of Nursing Home Administrators. I hereby consent to the release of any information, favorable or otherwise, which you may have, concerning my license to practice. Please return the completed form directly to the Virginia Board at the above address.</p>	
Date _____	Signature of Applicant _____
<p>PART II - LICENSURE BOARD OR REGULATORY AGENCY CERTIFICATION</p>	
<p><input type="checkbox"/> Yes <input type="checkbox"/> No The information contained in Part I conforms with our records. <input type="checkbox"/> Yes <input type="checkbox"/> No The Applicant obtained the original license from our state/jurisdiction. <input type="checkbox"/> Yes <input type="checkbox"/> No The Applicant took a written examination for licensure. If "Yes," please state: Name of Examination: _____ Examination Series# _____ Score: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No The license is current. If "Yes," give Expiration Date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No The Applicant is in good standing at this time. If "No," please explain.</p>	
Date _____	Signature of Board Officer/Designated Official _____
Title of Board _____ Street Address _____	
City/State/Zip _____	
<p>BOARD SEAL</p>	

<p style="text-align: center;">PART IV - AFFIDAVIT</p> <p>State of _____ County/City of _____</p> <p>I, _____ am applying to be licensed to practice Audiology or Speech-Language Pathology in the Commonwealth of Virginia. I will, at all times, abide by the laws of the Commonwealth and Regulations of the Board of Audiology and Speech-Language Pathology governing such practice.</p> <p>I understand that should I violate any of these laws or regulations, that action may be taken against my license by due process.</p> <p>I hereby certify that all statements contained in this application, and all representations and documents presented by me in connection with this application are true and correct.</p>	<p style="text-align: center;">_____ Signature of Applicant</p> <p>Subscribed and sworn to before me this _____ day of _____,</p> <p>My Commission expires _____</p> <p style="text-align: center;">_____ Notary Public</p>
<p>SEAL</p>	

Department of Health Professions
 6606 West Broad Street, Fourth Floor
 Richmond, Virginia 23230-1717

TURN ENVELOPE OVER FOR OPENING INSTRUCTIONS

TURN ENVELOPE OVER FOR OPENING INSTRUCTIONS

«License_No»

RENEWAL NOTICE AND APPLICATION

«First_Name» «Last_Name»
 «L_Address_Line_1»
 «L_Address_Line_2»
 «L_Address_Line_3»

Department of Health Professions
 6606 West Broad Street, Fourth Floor
 Richmond, Virginia 23230-1717

Place
 Postage
 Stamp
 Here

Department of Health Professions
 P.O. Box 26566
 Richmond, VA 23261-6566



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Current Expiration Date:
 «L_Expiration_Date»

INSTRUCTIONS:

- For name* or address changes, cross out any incorrect information on the front, and write the correct name/address on the back of the renewal form.
 - Detach "renewal form" portion, and return completed form with your check in attached response envelope.
 - Make checks payable to "Treasurer of Virginia." Do not staple check to application for renewal.
- *Enclose a copy of your marriage license or court order
- When making the return envelope, please cross out your name and address, leaving only the Department's name and address on one side of the envelope

Type of Renewal:	«License_Type»	Amount Due:
«License_No»	Renewal Period: «begin_period» to «end_period»	«renewal_fee»
«First_Name» «Middle_Name» «Last_Name»		
«L_Address_Line_1», «L_Address_Line_2», «L_Address_Line_3»		
If Payment Is Received by Board After «L_Expiration_Date», Amount Due «combined_late_fee»		
<input type="checkbox"/> Check here if you do not wish to renew, and sign below.		
Signature _____		

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----- Please fold and tear on perforated line. -----
 Receipt: Keep this portion for your records—Do not return

«First_Name» «Last_Name»	Renewal Fee--Amount Paid: «renewal_fee»
«License_Type»	«License_No» Renewal Period: «begin_period» to «end_period»

VA.R. Doc. No. R99-187; Filed May 3, 2000, 11:43 a.m.

Final Regulations

BOARD OF DENTISTRY

REGISTRAR'S NOTICE: The following regulation is exempt from the Administrative Process Act in accordance with § 9-6.14:4.1 C 9 of the Code of Virginia, which excludes regulations of the regulatory boards served by the Department of Health Professions pursuant to Title 54.1 which are limited to reducing fees charged to regulants and applicants. The Board of Dentistry will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 18 VAC 60-20-10 et seq. **Regulations Governing the Practice of Dentistry and Dental Hygiene (amending 18 VAC 60-20-30).**

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

Effective Date: June 21, 2000.

Agency Contact: Copies of the regulation may be obtained from Marcia J. Miller, Board of Dentistry, 6606 W. Broad Street, 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9906.

Summary:

The amendment eliminates the fee for administration of an examination. Since the jurisprudence examination has now been outsourced to a private agency, the fee is no longer necessary in board regulations.

18 VAC 60-20-30. Other fees.

A. Dental licensure application fees. The application fee for a dental license, a license to teach dentistry, or a temporary permit as a dentist shall be \$225.

B. Dental hygiene licensure application fees. The application fee for a dental hygiene license by examination, a license to teach dental hygiene, or a temporary permit as a dental hygienist shall be \$160.

C. Duplicate wall certificate. Licensees desiring a duplicate wall certificate shall submit a request in writing stating the necessity for such duplicate wall certificate, accompanied by a fee of \$15.

D. Duplicate license. Licensees desiring a duplicate license shall submit a request in writing stating the necessity for such duplicate license, accompanied by a fee of \$10. If a licensee maintains more than one office, a notarized photocopy of a license may be used.

E. Licensure certification. Licensees requesting endorsement or certification by this board shall pay a fee of \$25 for each endorsement or certification.

F. Restricted license. Restricted license issued in accordance with § 54.1-2714 of the Code of Virginia shall be at a fee of \$100.

~~G. Examination. Each examination administered by the board shall be at a fee of \$25.~~

~~H. G. Endorsement license. License by endorsement issued in accordance with 18 VAC 60-20-80 for dental hygienists shall be at a fee of \$225.~~

~~I. H. Restricted volunteer license. The application fee for licensure as a restricted volunteer dentist or dental hygienist issued in accordance with § 54.1-2712.1 or § 54.1-2726.1 of the Code of Virginia shall be \$25.~~

NOTICE: The forms used in administering 18 VAC 60-20-10 et seq., Regulations Governing the Practice of Dentistry and Dental Hygiene, are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS

Outline and Explanation of Documentation Required for Dental Licensure by Exam, Teacher's License, Restricted License, Full Time Faculty License, and Temporary Permit (eff. 11/98).

Application for Licensure to Practice Dentistry (eff. 3/98).

Application for Restricted Volunteer Licensure to Practice Dentistry and Dental Hygiene (eff. 7/7/98).

Form A, Certification of Dental/Dental Hygiene School (rev. 3/98).

Form AA, Sponsor Certification for Dental/Dental Hygiene Volunteer License (eff. 7/98).

Form B, Chronology (rev. 3/98).

Form C, Certification of Dental/Dental Hygiene Boards (rev. 3/98).

Outline and Explanation of Documentation Required for Dental Hygiene Licensure by Exam, Teacher's License, Dental Hygiene by Endorsement, and Dental Hygiene Temporary Permit (rev. 11/98).

Application for Licensure to Practice Dental Hygiene (rev. 3/98).

Reinstatement Application for Dental/Dental Hygiene Licensure (rev. 3/98).

Expiration letter to licensee (rev. 7/98).

Radiology Information for Dental Assistants (rev. 7/97).

~~Application for Radiology Exam for Dental Assistants (rev. 7/97).~~

Renewal Notice and Application (*Active licensure*) (rev. 9/97/3/00).

Renewal Notice and Application (Inactive licensure) (rev. 3/00).

Department of Health Professions

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717

First Class Mail
Zip+4 Barcoded
US Postage Paid
Richmond, VA
Permit No. 1902

TURN ENVELOPE OVER FOR OPENING INSTRUCTIONS

TURN ENVELOPE OVER FOR OPENING INSTRUCTIONS

«License_No»

RENEWAL NOTICE AND APPLICATION

«First Name» «Last Name»
«L_Address_Line_1»
«L_Address_Line_2»
«L_Address_Line_3»

Department of Health Professions

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717



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Department of Health Professions
P.O. Box 26566
Richmond, VA 23261-6566



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Current Expiration Date:
«L_Expiration_Date»

INSTRUCTIONS:

1. Check the appropriate box (check only 1) and sign;
 2. For name* or address changes, cross out any incorrect information on the front, and write the correct name/address on the back of the renewal form.
 3. Detach "renewal form" portion, and return with your check in attached response envelope.
 4. Make checks payable to "Treasurer of Virginia." Do not staple check to application for renewal.
- *Enclose a copy of your marriage license or court order. When making the return envelope, please cross out your name and address, leaving only the Department's name and address on one side of the envelope.

Renewal Form for:	«License_Type»	Amount Due:
«License_No»	Renewal Period: «begin_period» to «end_period»	«renewal_fee»
«First Name» «Middle Name» «Last Name» «Degree_Sup»		
«L_Address_Line_1», «L_Address_Line_2», «L_Address_Line_3»		
If Received After «L_Expiration_Date», Amount Due «combined_late_fee»		
<input type="checkbox"/> I wish to renew and I certify that I have met all continuing education requirements to renew this license. <input type="checkbox"/> I wish to take inactive status and enclose the fee of \$65.00 <input type="checkbox"/> I do not wish to renew.		
I swear that I have not made any misrepresentation on this renewal application and understand that furnishing false information constitutes cause for loss of licensure to practice.		
Signature: _____		

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***** Please fold and tear on perforated line. *****

Receipt: Keep this portion for your records—Do not return

«First Name» «Last Name»	Renewal Fee—Amount Paid:	«renewal_fee»
«License_Type»	«License_No»	Renewal Period: «begin_period» to «end_period»

Final Regulations

Department of Health Professions

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Richmond, VA
Permit No. 1902

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 - Make checks payable to "Treasurer of Virginia." Do not staple check to application for renewal.
- *Enclose a copy of your marriage license or court order
- When making the return envelope, please cross out your name and address, leaving only the Department's name and address on one side of the envelope

*Inactive Renewal:	«License_Type»	Amount Due:
«License_No»	Renewal Period: «begin_period» to «end_period»	«renewal_fee»
«First_Name» «Middle_Name» «Last_Name» «Degree_Sup»		
«L_Address_Line_1», «L_Address_Line_2», «L_Address_Line_3»		
If Payment Is Received by Board After «L_Expiration_Date», Amount Due \$115		
This renewal is for an INACTIVE license. You may not practice with your license in inactive status. If you wish to reactivate your license at this time, contact the Board office for instructions at (804)662-9906.		
<input type="checkbox"/> Check here if you do not wish to renew, and sign: _____ Signature		

«Scan_Line»

***** Please fold and tear on perforated line. *****
Receipt: Keep this portion for your records—Do not return

«First_Name» «Last_Name»	Renewal Fee--Amount Paid:	«renewal_fee»
«License_Type»	«License_No»	Renewal Period: «begin_period» to «end_period»

VA.R. Doc. No. R00-168; Filed May 1, 2000, 9:12 a.m.

REGISTRAR'S NOTICE: The agency is claiming an exemption from the Administrative Process Act in accordance with § 9-6.14:4.1 C 3 of the Code of Virginia, which excludes regulations that consist of changes in style or form or corrections of technical errors. The Department of Health Professions will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 18 VAC 60-20-10 et seq. **Regulations Governing the Practice of Dentistry and Dental Hygiene (amending 18 VAC 60-20-110 and 18 VAC 60-20-120).**

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

Effective Date: June 21, 2000.

Agency Contact: Copies of the regulation may be obtained from Marcia J. Miller, Board of Dentistry, 6606 W. Broad Street, 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9906.

Summary:

The amendments change the reference to the guidance document of the American Dental Association on teaching control of anxiety and pain in dentistry. The most recent edition of the guidelines was published in October 1999 and is incorporated by reference into these regulations.

18 VAC 60-20-110. Requirements to administer general anesthesia.

A. Educational requirements. A dentist may employ or use general anesthesia on an outpatient basis by meeting one of the following educational criteria and by posting the educational certificate, in plain view of the patient, which verifies completion of the advanced training as required in subdivision 1 or 2 of this subsection. The foregoing shall not apply nor interfere with requirements for obtaining hospital staff privileges.

1. Has completed a minimum of one calendar year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program in conformity with published guidelines by the American Dental Association (Guidelines for Teaching the Comprehensive Control of ~~Pain and Anxiety and Pain~~ in Dentistry, effective ~~July 1993~~ October 1999), which are incorporated by reference in this chapter; or

2. Completion of an American Dental Association approved residency in any dental specialty which incorporates into its curriculum the standards of teaching comparable to those set forth in published guidelines by the American Dental Association (Guidelines for Teaching the Comprehensive Control of ~~Pain and Anxiety and Pain~~ in Dentistry, effective ~~July 1993~~ October 1999), which are incorporated by reference in this chapter.

B. Exemptions. A dentist who has not met the requirements specified in subsection A of this section may treat patients under general anesthesia in his practice if a qualified anesthesiologist, or a dentist who fulfills the requirements specified in subsection A of this section, is present and is responsible for the administration of the anesthetic. If a dentist fulfills requirements himself to use general anesthesia and conscious sedation, he may employ the services of a certified nurse anesthetist.

18 VAC 60-20-120. Conscious sedation; intravenous and intramuscular.

A. Automatic qualification. Dentists qualified to administer general anesthesia may administer conscious sedation.

B. Educational requirements. A dentist may administer conscious sedation upon completion of training for this treatment modality according to guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of ~~Pain and Anxiety and Pain~~ in Dentistry, effective ~~July 1993~~ October 1999) and incorporated by reference in this chapter, while enrolled at an approved dental school or while enrolled in a post-doctoral university or teaching hospital program.

DOCUMENTS INCORPORATED BY REFERENCE

Guidelines for Teaching the Comprehensive Control of ~~Pain and Anxiety and Pain~~ in Dentistry (1993 October 1999), American Dental Association.

1995 Current Dental Terminology, Second Edition, 1995-2000, Code on Dental Procedures and Nomenclature, American Dental Association.

Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, October 1995, American Dental Association.

VA.R. Doc. No. R00-169; Filed May 1, 2000, 9:12 a.m.

TITLE 22. SOCIAL SERVICES

CHILD DAY-CARE COUNCIL

REGISTRAR'S NOTICE: The agency is claiming an exclusion from the Administrative Process Act in accordance with § 9-6.14:4.1 C 4 (a) of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law where no agency discretion is involved. The Department of Social Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 22 VAC 15-30-10 et seq. **Minimum Standards for Licensed Child Day Centers (amending 22 VAC 15-30-10).**

Statutory Authority: § 63.1-202 of the Code of Virginia.

Effective Date: June 21, 2000.

Final Regulations

Summary:

The amendments (i) allow children of on-duty, part-time employees working less than two hours a day to attend a child-minding service without making the program subject to licensure and (ii) add the various organizations that accredit preschool programs. The amendments are necessary to conform the regulation to the state legislative mandate set out in Chapter 61 of the 2000 Virginia Acts of Assembly and Chapter 454 of the 1999 Virginia Acts of Assembly.

Agency Contact: Copies of the regulation may be obtained from Arlene Kasper, Department of Social Services, Division of Licensing Programs, 730 E. Broad Street, Richmond, VA 23219, telephone (804) 692-1791.

22 VAC 15-30-10. Definitions.

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

"Adult" means any individual 18 years of age or older.

"Age and stage appropriate" means the curriculum, environment, equipment, and adult-child interactions are suitable for the ages of the children within a group and the individual needs of any child.

"Age groups"

"Infant" means children from birth to 16 months.

"Toddler" means children from 16 months up to two years.

"Preschool" means children from two years up to the age of eligibility to attend public school, five years by September 30.

"School age" means children eligible to attend public school, age five or older by September 30 of that same year. Four- or five-year-old children included in a group of school age children may be considered school age during the summer months if the children will be entering kindergarten that year.

"Attendance" means the actual presence of an enrolled child.

"Balanced mixed-age grouping" means a program planned for three- through five-year-old children in which the enrollment in the group is comprised of 1/3 of each of three ages and is designed for children and staff to remain together with turnover planned only for the replacement of graduating older children with incoming younger children.

"Camp" means a child day camp.

"Center" means a child day center.

"Child" means any individual under 18 years of age.

"Child day camp" means a child day center for school age children that operates during the summer vacation months only. Four-year-old children who will be five by September 30 of that same year may be included in a camp for school age children.

"Child day center" means a child day program offered to (i) two or more children under the age of 13 in a facility that is not the residence of the provider or of any of the children in care or (ii) 13 or more children at any location.

Exemptions: (§ 63.1-196.001 of the Code of Virginia).

1. A child day center that has obtained an exemption pursuant to § 63.1-196.3 of the Code of Virginia;

2. A program where, by written policy given to and signed by a parent or guardian, children are free to enter and leave the premises without permission or supervision. A program that would qualify for this exemption except that it assumes responsibility for the supervision, protection and well-being of several children with disabilities who are mainstreamed shall not be subject to licensure;

3. A program of instructional experience in a single focus, such as, but not limited to, computer science, archaeology, sport clinics, or music, if children under the age of six do not attend at all and if no child is allowed to attend for more than 25 days in any three-month period commencing with enrollment. This exemption does not apply if children merely change their enrollment to a different focus area at a site offering a variety of activities and such children's attendance exceeds 25 days in a three-month period;

4. Programs of instructional or recreational activities wherein no child under age six attends for more than six hours weekly with no class or activity period to exceed 1-1/2 hours, and no child six years of age or above attends for more than six hours weekly when school is in session or 12 hours weekly when school is not in session. Competition, performances and exhibitions related to the instructional or recreational activity shall be excluded when determining the hours of program operation;

5. A program that operates no more than a total of 20 program days in the course of a calendar year provided that programs serving children under age six operate no more than two consecutive weeks without a break of at least a week;

6. Instructional programs offered by public and private schools that satisfy compulsory attendance laws or the Individuals with Disabilities Education Act (20 USC § 1470 et seq.), and programs of school-sponsored extracurricular activities that are focused on single interests such as, but not limited to, music, sports, drama, civic service, or foreign language;

7. Education and care programs provided by public schools which are not exempt pursuant to subdivision 6 under the child day center definition in this section shall be regulated by the State Board of Education using regulations that incorporate, but may exceed, the regulations for child day centers licensed by the commissioner;

8. Early intervention programs for children eligible under Part H of the Individuals with Disabilities Education Act (20 USC § 1470 et seq.), wherein no child attends for more than a total of six hours per week;

9. Practice or competition in organized competitive sports leagues;

10. Programs of religious instruction, such as Sunday schools, vacation Bible schools, and Bar Mitzvah or Bat Mitzvah classes, and child-minding services provided to allow parents or guardians who are on site to attend religious worship or instructional services;

11. Child-minding services which are not available for more than three hours per day for any individual child offered on site in commercial or recreational establishments if the parent or guardian (i) is not an on-duty employee, *except for part-time employees working less than two hours per day*, (ii) can be contacted and can resume responsibility for the child's supervision within 30 minutes, and (iii) is receiving or providing services or participating in activities offered by the establishment;

12. A certified preschool or nursery school program operated by a private school which is accredited by a statewide accrediting organization recognized by the State Board of Education or accredited by the National Association for the Education of Young Children's National Academy of Early Childhood Programs; *the Association of Christian Schools International; the National Early Childhood Program Accreditation; the National Accreditation Council for Early Childhood Professional Personnel and Programs; the International Academy for Private Education; Standards for the American Montessori Society Accreditation; the International Accreditation and Certification of Childhood Educators, Programs, and Trainers; or the National Accreditation Commission* and which complies with the provisions of § 63.1-196.3:1 of the Code of Virginia; or

13. By policy, a child day center that is required to be programmatically licensed by another state agency for that service.

"Child day program" means a regularly operating service arrangement for children where, during the absence of a parent or guardian, a person or organization has agreed to assume responsibility for the supervision, protection, and well-being of a child under the age of 13 for less than a 24-hour period.

Note: This does not include programs such as drop-in playgrounds or clubs for children when there is no service arrangement with the child's parent.

"Children with disabilities" means those children evaluated as having autism, deaf-blindness, a developmental delay, a hearing impairment which may include deafness, mental retardation, multiple disabilities, an orthopedic impairment, a serious emotional disturbance, a severe or profound disability, a specific learning disorder, a speech or language impairment, a traumatic brain injury, or a visual impairment which may include blindness.

"Commissioner" means the Commissioner of Social Services, also known as the Director of the Virginia Department of Social Services.

"Department" means the Virginia Department of Social Services.

"Department's representative" means an employee or designee of the Virginia Department of Social Services, acting as the authorized agent of the commissioner.

"Evening care" means care provided in a center after 7 p.m. but not through the night.

"Good character and reputation" means knowledgeable and objective people agree that the individual (i) maintains business, professional, family, and community relationships which are characterized by honesty, fairness, and truthfulness, and (ii) demonstrates a concern for the well-being of others to the extent that the individual is considered suitable to be entrusted with the care, guidance, and protection of children. Relatives by blood or marriage and people who are not knowledgeable of the individual, such as recent acquaintances, shall not be considered objective references.

"Independent contractor" means an individual who enters into an agreement to provide specialized services for a specified period of time.

"Individual service, education or treatment plan" means a plan identifying the child's strengths, needs, general functioning and plan for providing services to the child. The service plan includes specific goals and objectives for services, accommodations and intervention strategies. The service, education or treatment plan clearly shows documentation and reassessment/evaluation strategies.

"Intervention strategies" means a plan for staff action that outlines methods, techniques, cues, programs, or tasks that enable the child to successfully complete a specific goal.

"Licensee" means any individual, partnership, association, public agency, or corporation to whom the license is issued.

"Minor injury" means a wound or other specific damage to the body such as, but not limited to, a small scratch, cut or scrape, minor bruise or discoloration of the skin.

"Overnight care" means care provided after 7 p.m. and through the night.

"Parent" means the biological or adoptive parent or parents or legal guardian or guardians of a child enrolled in or in the process of being admitted to a center.

"Physician" means an individual licensed to practice medicine in any of the 50 states or the District of Columbia.

"Primitive camp" means a camp where places of abode, water supply system, permanent toilet and cooking facilities are not usually provided.

"Programmatic experience in the group care of children" means time spent working directly with children in a group, in a child day center or family day home regulated by the state Department of Social Services, the state Department of Mental Health, Mental Retardation and Substance Abuse Services, or the state Department of Education; provided that "regulated" shall specifically include, without limitation, day care centers qualifying for exemption from licensure under §§

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63.1-196.3 and 63.1-196.3:1 of the Code of Virginia. Work time shall be computed on the basis of full-time work experience during the period prescribed or equivalent work time over a longer period.

"Resilient surfacing" means (i) for outdoor use underneath and surrounding equipment, mats manufactured for such use that meet the guidelines of the Consumer Product Safety Commission and the standards of the American Society for Testing Materials or at least six inches of materials, such as, but not limited to, loose sand, wood chips, wood mulch, or pea gravel, and (ii) for indoor use underneath and surrounding equipment, padding of two or more inches. Natural grass and compacted materials do not qualify as resilient surfacing.

"Sanitized" means washed to reduce the amount of filth and harmful micro-organisms through the use of (i) hot water with soap, detergent or abrasive cleaners or (ii) a chemical sanitizing solution.

"Serious injury" means a wound or other specific damage to the body such as, but not limited to, unconsciousness; broken bones; deep cut requiring stitches; concussion; foreign object lodged in eye, nose, ear, or other body orifice.

"Short-term program" means a child day center that operates less than 12 weeks a year.

"Significant injury" means a wound or other specific damage to the body such as, but not limited to, head injuries, dislocations, sprains.

"Special needs child day program" means a program exclusively serving children with disabilities.

"Specialty camps" means those centers which have an educational or recreational focus on one subject such as dance, drama, music, or sports.

"Sponsor" means an individual, partnership, association, public agency, corporation or other legal entity in whom the ultimate authority and legal responsibility is vested for the administration and operation of a center subject to licensure.

"Staff" means administrative, activity, and service personnel including the licensee when the licensee is an individual who works in the center, and any persons counted in the staff-to-children ratios or any persons working with a child without sight and sound supervision of a staff member.

"Staff positions" are defined as follows:

"Aide" means the individual designated to be responsible for helping the program leader/child care supervisor in supervising children and in implementing the activities and services for children.

"Program leader" or "child care supervisor" means the individual designated to be responsible for the direct supervision of children and for implementation of the activities and services for a group of children.

"Program director" means the primary, on-site director or coordinator designated to be responsible for developing and implementing the activities and services offered to children, including the supervision, orientation, training,

and scheduling of staff who work directly with children, whether or not the program director personally performs these functions.

EXCEPTION: The administrator may perform staff orientation or training or program development functions if the administrator meets the qualifications of 22 VAC 15-30-230 and a written delegation of responsibility specifies the duties of the program director.

"Administrator" means a manager or coordinator designated to be in charge of the total operation and management of one or more centers. The administrator may be responsible for supervising the program director or, if appropriately qualified, may concurrently serve as the program director.

"Therapeutic child day program" means a specialized program, including but not limited to therapeutic recreation programs, exclusively serving children with disabilities when an individual service, education or treatment plan is developed and implemented with the goal of improving the functional abilities of the children in care.

"Universal precautions" means an approach to infection control. According to the concept of universal precautions, all human blood and certain human body fluids are treated as if known to be infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens.

"Volunteer" means a person who works at the center and:

1. Is not paid;
2. Is not counted in the staff-to-children ratios; and
3. Is in sight and sound supervision of a staff member when working with a child.

Any unpaid person not meeting this definition shall be considered "staff."

VA.R. Doc. No. R00-170; Filed May 2, 2000, 2:29 p.m.

STATE BOARD OF SOCIAL SERVICES

Title of Regulation: 22 VAC 40-30-10 et seq. **Food Stamp Program - Resource Exclusion (REPEALED).**

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

Effective Date: June 21, 2000.

Summary:

This regulation expanded the list of resources that are excluded from consideration in the Food Stamp Program by allowing each food stamp household an interest-bearing savings account up to \$5,000. The exclusion was allowed if households established the accounts for purposes of education or toward the purchase of a residence. The regulation is repealed because Virginia no longer has federal support to allow the expansion of the resource exclusion.

Agency Contact: Patricia Duva, Department of Social Services, 730 E. Broad Street, Richmond, VA 23219, telephone (804) 692-1712.

VA.R. Doc. No. R99-86; Filed May 2, 2000, 2:29 p.m.

◆ ————— ◆

TITLE 24. TRANSPORTATION AND MOTOR VEHICLES

COMMONWEALTH TRANSPORTATION BOARD

REGISTRAR'S NOTICE: The following regulation is exempt from the Administrative Process Act in accordance with § 9-6.14:4.1 C 4 (a) of the Code of Virginia, which excludes regulations necessary to conform to changes in Virginia statutory law where no agency discretion is involved, 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 regulation, provided such regulations do not differ materially from those required by federal law or regulation. The Commonwealth Transportation Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **24 VAC 30-40-10 et seq. Rules and Regulations Governing Relocation Assistance (amending 24 VAC 30-40-30, 24 VAC 30-40-580, and 24 VAC 30-40-600 through 24 VAC 30-40-640).**

Statutory Authority: §§ 25-253 and 33.1-12 (5) of the Code of Virginia.

Effective Date: July 1, 2000.

Summary:

The amendments (i) revise the definitions of "small business" and "state agency"; (ii) increase payments made for reestablishment and moving expenses to displacees; (iii) eliminate maximum allowable amounts for eligible reestablishment expenses to small businesses, nonprofit organizations, or farms; (iv) reduce the list of reasonable and necessary expenses that are ineligible for reimbursement; and (v) increase the maximum allowable fixed payments in lieu of moving expenses for displaced businesses, displaced farms, and nonprofit organizations.

Agency Contact: Copies of the regulation may be obtained from Ms. Beverly Fulwider, Department of Transportation, Right of Way and Utilities Division, 1401 E. Broad Street, Richmond, VA 23219, telephone (804) 786-4366.

24 VAC 30-40-30. Definitions.

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

"*Business*" means any lawful activity, except a farm operation, conducted primarily (signs not included since normally considered as real property):

1. For the purchase, sale, lease, or rental or any combination of these, of personal or real property or both, or for the manufacturing, processing or marketing of products, commodities or any other personal property;
2. For the sale of services to the public; or
3. By a nonprofit organization.

"*Comparable replacement dwelling*" means a dwelling which is:

1. Decent, safe and sanitary as defined in 24 VAC 30-40-40;
2. Functionally equivalent to the displacement dwelling. The term functionally equivalent means that it performs the same function, provides the same utility, and is capable of contributing to a comparable style of living. While a comparable replacement dwelling need not possess every feature of the displacement dwelling, the principal features must be present. Generally, functional equivalency is an objective standard, reflecting the range of purposes for which the various physical features of a dwelling may be used. However, in determining whether a replacement dwelling is functionally equivalent to the displacement dwelling, the department may consider reasonable trade-offs for specific features when the replacement unit is "equal to or better than" the displacement dwelling;
3. Fair housing, open to all persons regardless of race, color, religion, sex or national origin and consistent with the requirements of Title VIII of the Civil Rights Act of 1968;
4. In areas not generally less desirable than the dwelling to be acquired with regard to:
 - a. Public utilities;
 - b. Public and commercial facilities;
5. Adequate in size to accommodate the occupants and reasonably accessible to the displacee's place of employment;
6. In an equal or better neighborhood which is not subject to unreasonable adverse environmental conditions;
7. Available on the market to the displaced person;
8. Within the financial means of the displaced family or individual:
 - a. A replacement dwelling purchased by a homeowner in occupancy for at least 180 days prior to initiation of negotiations (180-day homeowner) is considered to be within the homeowner's financial means if the homeowner is paid the full price differential, all increased mortgage interest costs, and all incidental expenses, plus any additional amount required to be paid under Replacement Housing of Last Resort.
 - b. A replacement dwelling rented by a displaced person is considered to be within financial means if the monthly rent and estimated average utility costs at the replacement dwelling does not exceed the base

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monthly rent at the displacement dwelling, after taking into account any rental assistance which the person receives under this chapter; or

For a displaced person who is not eligible to receive a replacement housing payment because of the person's failure to meet length-of-occupancy requirements, comparable replacement rental housing is considered to be within the person's financial means if the department pays that portion of the monthly housing costs of a replacement dwelling which exceeds 30% of such person's gross monthly household income. Such rental assistance must be paid under 24 VAC 30-40-1180 (Last Resort Housing) for a period of 42 months; and

9. On a site that is typical in size for residential development with normal site improvements, including customary landscaping. The site need not include special improvements such as outbuildings, swimming pools and greenhouses. If replacement dwellings meeting the above requirements are not available on the market, dwellings which exceed those requirements may be treated as comparable replacement dwellings.

"Contributes materially" means that during the two taxable years prior to the taxable year in which displacement occurs, or during such other period as the department determines to be more equitable, a business or farm operation:

1. Had average annual gross receipts of at least \$5,000; or
2. Had average annual net earnings of at least \$1,000; or
3. Contributed at least 33 1/3% of the owner's or operator's average annual gross income from all sources.

If the application of the above criteria creates an inequity or hardship in any given case, the department may approve the use of other criteria as determined appropriate.

"Displaced person" means any person who moves from real property or moves personal property from real property as a direct result of a written notice of intent to acquire, the initiation of negotiations for, or the acquisition of the real property, in whole or in part, for a project; or as a direct result of rehabilitation or demolition for a project; or as a direct result of a written notice of intent to acquire, or the acquisition, rehabilitation or demolition of, in whole or in part, other real property on which the person conducts a business or farm operation, for a project. If the move occurs after a written order to vacate is issued, the occupant is considered a displaced person even though the property is not acquired.

"Dwelling" means the place of permanent or customary and usual abode. It includes a single family house, a single family unit in a multi-family building, a unit of a condominium or cooperative housing project, a mobile home, or any other residential unit.

"Family" means two or more individuals living together in a single family dwelling unit who:

1. Are related by blood, adoption, marriage or legal guardianship who live together as a family unit, plus all

other individuals regardless of blood or legal ties who live with and are a part of the family unit, or

2. Are not related by blood or legal ties, but live together by mutual consent.

"Farm operation" means any activity conducted solely or primarily for the production of one or more agricultural products or commodities, including timber for sale or home use, and customarily producing such products or commodities in sufficient quantity to be capable of contributing materially to the operator's support.

"Initiation of negotiations for a parcel" means the date the department makes the first personal contact with the owner or the owner's representative of the property to be acquired and makes a written offer of just compensation.

"Last resort housing project" means a project authorized for the construction, purchase or rehabilitation or any combination of these, of dwellings as replacement housing units for displacees.

"Mortgage" means such classes of liens as are commonly given to secure advances on, or the unpaid purchase price of, real property, together with the credit instruments, if any, secured thereby.

"90-day owner" means an occupant who has owned and occupied the dwelling from which displacement occurs for less than 180 days, but not less than 90 consecutive days immediately prior to initiation of negotiations for the parcel.

"Nonprofit organization" means a corporation, partnership, individual or other public or private entity engaged in a business, professional or institutional activity on a nonprofit basis necessitating fixtures, equipment, stock-in-trade, or other tangible property for the carrying on of the business, professional or institutional activity on the premises and is exempt from paying federal income taxes.

"Notice of intent to acquire" means a notice establishing a displacee's eligibility for relocation benefits prior to the initiation of negotiations for a parcel when considered to be in the best interest of the displacee and the department.

"180-day owner" means an occupant who has owned and occupied the dwelling from which displacement occurs for at least 180 consecutive days immediately prior to the initiation of negotiations.

"Owner" means any person that holds any of the following interests in real property acquired for a project:

1. Fee title, a life estate, a 99-year lease, or a lease, including any options for extension with at least 50 years to run from the date of acquisition;
2. An interest in a cooperative housing project which includes the right to occupy a dwelling;
3. A contract to purchase any of the interests or estates described in subdivisions 1 and 2 of this definition; or
4. Any other interest, including a partial interest, which in the judgment of the department warrants consideration as ownership.

"Person" means a partnership, company, corporation or association as well as an individual or family.

"Persons not displaced" means, but is not limited to, the following persons who do not qualify as displaced persons under this chapter:

1. A person who moves before the initiation of negotiations, unless the department determines that the person was displaced as a direct result of the project; or
2. A person who initially enters into occupancy of their property after the date of its acquisition for the project; or
3. A person who is not required to relocate permanently as a direct result of a project. Such determination shall be made by the department after weighing the facts on a case by case basis; or
4. A person who has occupied the property for the purpose of obtaining assistance under the Uniform Act; or
5. A person who, after receiving a notice of relocation eligibility, is notified in writing that it will not be necessary to relocate. Such notice shall not be issued unless the person has not moved and the department agrees to reimburse the person for any expenses incurred to satisfy any binding contractual relocation obligations entered into after the effective date of the notice of relocation eligibility; or
6. An owner-occupant who voluntarily conveys a property after being informed in writing that if a mutually satisfactory agreement of sale cannot be reached, the department will not acquire the property. In such cases, any resulting displacement of a tenant is subject to this chapter; or
7. A person whom the department determines is not displaced as a direct result of a partial acquisition; or
8. A person who is determined to be in unlawful occupancy or a person who has been evicted for cause, under applicable law, prior to the initiation of negotiations for the property.

"Rent supplement" means the amount in addition to present rent which is necessary to enable a displaced person to lease or rent a comparable replacement dwelling.

"Salvage value" means the probable sale price of an item, if offered for sale on the condition that it will be removed from the property at the buyers expense, allowing a reasonable period of time to find a purchaser with knowledge of the uses and purposes for which the item is adaptable and capable of being used, including separate use of serviceable components and scrap when there is no reasonable prospect of sale except on that basis.

"Small business" means a business having ~~at least one but~~ not more than 500 employees working at the site being acquired or permanently displaced by a program or project, *which site is the location of economic activity. Sites operated solely by outdoor advertising signs, displays, or devices do not qualify as a business eligible for reestablishment expenses.*

~~"State agency" means any department, agency or instrumentality of the state or of a political subdivision of a state, any department, agency, or instrumentality of two or more states or of two or more political subdivisions of a state or states, and any person who has the authority to acquire property by eminent domain under state law Commonwealth; public authority, municipal corporation, local governmental unit or political subdivision of the Commonwealth or any department, agency or instrumentality thereof; person who has the authority to acquire property by eminent domain under state law; or two or more of the aforementioned, which carries out projects that cause people to be displaced.~~

"Tenant" means a person who has the lawful temporary use and occupancy of real property owned by another.

"Tenant occupant of less than 90 days" means an individual or family who has occupied the property being acquired less than 90 days prior to the department's initiation of negotiations.

"Uneconomic remnant" means a parcel of real property in which the owner is left with an interest after the partial acquisition of the owner's property, and which the department has determined has little or no value or utility to the owner.

"Unlawful occupancy" means a situation where a person has been ordered to move by a court of competent jurisdiction prior to the initiation of negotiations or is determined by the department to be a squatter who is occupying the real property without the permission of the owner and otherwise has no legal right to occupy the property under state law.

"Utility cost" means expenses for heat, lights, water and sewer.

24 VAC 30-40-580. Fixed payment in lieu of moving costs.

A. Any displaced business is eligible for a fixed payment, in lieu of a payment for actual moving and related expenses and re-establishment expense, in an amount equal to its average annual net earnings as computed in accordance with 24 VAC 30-40-580, but not less than \$1,000 nor more than ~~\$20,000~~ \$50,000.

B. For an owner of a displaced business to be entitled to a payment the district must determine that:

1. The business cannot be relocated without a substantial loss of its existing patronage (clientele or net earnings). A business is assumed to meet this test unless the department demonstrates that it will not suffer a substantial loss of its existing patronage; and
2. The business is not part of a commercial enterprise having more than three other entities which are not being acquired by the department, and which are under the same ownership and engaged in the same or similar business activities. (For purposes of this rule, any remaining business facility that did not contribute materially to the income of the displaced person during the two taxable years prior to displacement shall not be considered "other entity");

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3. The business owns or rents personal property which must be moved in connection with such displacement and for which an expense would be incurred in such move; and, the business vacates or relocates from its displacement site;

4. The business is not operated at displacement dwelling solely for the purpose of renting such dwelling to others;

5. The business is not operated at the displacement site solely for the purpose of renting the site to others; and

6. The business contributed materially to the income of the displaced person during the two taxable years prior to displacement. However, the department may waive this test for good cause. In determining whether two or more displaced legal entities constitute a single business which is entitled to only one fixed payment, all pertinent factors shall be considered, including the extent to which:

- a. The same premises and equipment are shared;
- b. Substantially identical or interrelated business functions are carried out and business and financial affairs are comingled;
- c. The entities are held out to the public, and to those customarily dealing with them, as one business;
- d. The same person, or closely related persons own, control, or manage the affairs of the entities;
- e. The type of business conducted by the displaced person;
- f. The nature of the clientele of the displaced person;
- g. The relative importance of the present and proposed location to the displaced business and the availability of a suitable replacement location for the displaced person. This is most evident in those instances where the displaced owner is either elderly, ill or handicapped. There are many situations, particularly in older neighborhoods, where the owner lives next door or within the same building as the business. A replacement location may not be suitable for these particular owners if they were required to travel any distance to work;
- h. A part-time individual or family occupation in the home which does not contribute materially to the income of the displaced owner is not eligible for this payment; and
- i. After consideration of all the above items, the district will then make its decision and so advise the displacee.

C. In determining payment, the term "average annual net earnings" means one-half of any net earnings of the business before federal, state and local income taxes, during the two taxable years immediately preceding the taxable year in which the business is relocated. If the two taxable years immediately preceding displacement are not representative, the department may use a period that would be more representative. It must be determined that the proposed construction has been the cause of the outflow of residents

thereby resulting in a decline in net income for the business prior to utilizing this alternate procedure. Average annual net earnings include any compensation paid by the business to the owner, spouse, or dependents during the two year period. In the case of a corporate owner of a business, earnings shall include any compensation paid to the spouse or dependents of the owner of a majority interest in the corporation. For the purpose of determining majority ownership, stock held by a husband, his wife and their children shall be treated as one unit.

D. If the business was not in operation for the full two taxable years prior to displacement, net earnings shall be based on the actual period of operation at the displacement site during the two taxable years prior to displacement, projected to an annual rate.

E. For the owner of a business to be entitled to this payment, the business must provide information to support its net earnings. State or federal tax returns for the tax years in question are the best source of this information or certified financial state statements can be accepted as evidence of earnings. The tax returns furnished must either be signed and dated or accompanied by a certification from the business owner that the returns being furnished reflect the actual income of the business as reported to the Internal Revenue Service or the State Department of Taxation for the periods in question. The owner's statement alone would not be sufficient if the amount claimed exceeded the minimum payment of \$1,000.

24 VAC 30-40-600. Fixed payment in lieu of actual moving expenses.

Any owner of a displaced farm operation is eligible for a fixed payment equal to the average annual net earnings of the farm operation, in lieu of a payment for actual moving and related expenses and re-establishment expenses, except that such payment may not be less than \$1,000 nor more than ~~\$20,000~~ \$50,000 and providing the following requirements are met:

1. For an owner of a displaced farm operation to be entitled to payment under the provisions of this paragraph, the district must determine that:
 - a. The taking caused the operator to be displaced from the farm operation on the remaining land; and
 - b. The taking caused such a substantial change in the principle operation or the nature of the existing farm operation as to constitute a displacement. After consideration of all the above items, the district will advise the displaced farm operator.

2. The term "average annual net earnings" means one-half of any net earnings of a farm operation before federal, state and local income taxes during the two taxable years immediately preceding the taxable year in which the farm operation is relocated. "Average annual net earnings" include any compensation paid by the farm operation to the owner, spouse, or dependents during the two year period. Such earnings and compensation are to be established by the federal or state income tax returns

filed by the farm operation and its owner, spouse and dependents during the two-year period.

3. If the farm was not in operation for the full two taxable years prior to displacement, net earnings shall be based on the actual period of operation at the displacement site during the two taxable years prior to displacement, projected to an annual rate.

4. For the owner of a farm operation to be entitled to this payment, the farm operation must provide information to support its net earnings. State or federal tax returns for the tax years in question are the best source of this information and can be accepted as evidence of earnings. The tax returns furnished must either be signed and dated or accompanied by a certification from the farm owner that the returns being furnished reflect the actual income of the farm operation as reported to the Internal Revenue Service or State Department of Taxation for the periods in question. The owner's statement alone would not be sufficient if the amount claimed exceeded the minimum payment of \$1,000.

24 VAC 30-40-610. General provisions.

A. A displaced nonprofit organization is eligible to receive payment for actual, reasonable moving expenses, direct losses of tangible personal property and actual, reasonable expenses in searching for a replacement site in accordance with 24 VAC 30-40-550 through 24 VAC 30-40-570.

B. In lieu of payments described in 24 VAC 30-40-550 through 24 VAC 30-40-570 the nonprofit organization may be paid a fixed payment of \$1,000 to ~~\$20,000~~ \$50,000 if the department determines that the nonprofit organization cannot be relocated without a substantial loss of its existing patronage (membership or clientele). A nonprofit organization is assumed to meet this test, unless the department demonstrates otherwise. Any payment in excess of \$1,000 must be supported with financial ~~state~~ statements for the two 12-month periods prior to the acquisition. The amount to be used for the payment is the average of two years annual gross revenues less administrative expenses.

24 VAC 30-40-620. General provisions.

In addition to the payments available in 24 VAC 30-40-540 through 24 VAC 30-40-570, a small business, farm or nonprofit organization may be eligible to receive a payment, not to exceed ~~\$40,000~~ \$25,000, for expenses actually incurred in relocating and reestablishing such small business, farm or nonprofit organization at a replacement site. A small business, farm or nonprofit organization who elects a fixed payment in lieu of actual moving expenses is not entitled to a reestablishment expense payment

24 VAC 30-40-630. Eligible expenses.

Reestablishment expenses must be reasonable and necessary. They may include, but are not limited to, the following:

1. Repairs or improvements to the replacement real property as required by federal, state or local law, code or ordinance;

2. Modifications to the replacement property to accommodate the business operation or make replacement structures suitable for conducting the business;

3. Construction and installation costs, ~~not to exceed \$1,500~~ for exterior signing to advertise the business;

4. Provision of utilities from right-of-way to improvements on the replacement site;

5. Redecoration or replacement of soiled or worn surfaces at the replacement site, such as paint, paneling, or carpeting;

6. Licenses, fees and permits when not paid as part of moving expenses;

7. Feasibility surveys, soil testing and marketing studies;

8. Advertisement of replacement location, ~~not to exceed \$1,500~~;

9. Professional services in connection with the purchase or lease of a replacement site;

10. Increased costs of operation during the first two years at the replacement site, ~~not to exceed \$5,000~~, for such items as:

- a. Lease or rental charges;
- b. Personal or real property taxes;
- c. Insurance premiums; and
- d. Utility charges, excluding impact fees;

11. Impact fees or one-time assessments for anticipated heavy utility usage; *and*

12. Other items that the department considers essential to the re-establishment of the business; *and*.

~~13. Expenses in excess of the regulatory maximums set forth in subdivisions (3), (8), and (10) of this section may be considered eligible if large and legitimate disparities exist between costs of operation at the displacement site and costs of operation at an otherwise similar replacement site. In such cases the regulatory limitation for reimbursement of such costs may, at the request of the department, be waived by the federal agency funding the program or project, but in no event shall total costs payable under this section exceed the \$10,000 statutory maximum.~~

24 VAC 30-40-640. Ineligible expenses.

The following is a non exclusive listing of re-establishment expenditures not considered to be reasonable, necessary, or otherwise eligible:

1. Purchase of capital assets, such as, office furniture, filing cabinets, machinery or trade fixtures;

2. Purchase of manufacturing materials, production supplies, product inventory or other items used in the normal course of the business operation;

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~~3. Interior or exterior refurbishments at the replacement site which are for aesthetic purposes, except as provided in 24 VAC 30-40-630;~~

~~4. 3. Interest on money borrowed to make the move or purchase the replacement property; and~~

~~5. 4. Payment to a part-time business in the home which does not contribute materially to the household income.~~

NOTICE: The forms used in administering 24 VAC 30-40-10 et seq., Rules and Regulations Governing Relocation Assistance, 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 Transportation, 1401 E. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

~~Rules and Regulations Governing the Prequalification of Prospective Bidders, Form C-46 (eff. 1/1/87).~~

~~Contractor's Financial Statement, Form C-37 (eff. 1/1/87).~~

~~Maximum Prequalification Application and Experience Questionnaire, Form C-38 (eff. 1/90).~~

~~Request for Exemption of Prequalification Materials from Disclosure under the Virginia Freedom of Information Act, Form C-47 (eff. 1/83).~~

~~Certificate of Qualification, Form C-44.~~

~~Bidder Certification of Prequalification Classification and Work Capacity, Form C-42 (eff. 1/87).~~

~~Contractor's Proposal to Sublet, Form C-43 (eff. 1/1/87).~~

~~Agreement Supplemental Signs, Form TE-355 (eff. 3/2/87).~~

~~Vegetation Control Application, Form TTB (eff. 2/1/91).~~

~~Application for Outdoor Advertising Permit, Form OA-105A (eff. 7/1/93).~~

~~Information for Determining Disadvantaged (Minority) and Women Business Enterprise Eligibility and Registration to Perform as a Subcontractor, Form C-109 (eff. 9/89).~~

~~Affidavit for DBE/WBE Recertification/Registration Renewal, Form C-109A.~~

~~Certification Procedures Disadvantaged and Women-Owned Business Program, Appendix C-1.~~

~~Minimum Prequalification Application and Experience Questionnaire, Form C-38A (eff. 1/90).~~

~~Virginia Alternative Fuels Revolving Fund (VAFRF) Part III: Project Application Form.~~

~~Virginia Alternative Fuels Revolving Fund Quarterly Project Status Report, Attachment D.~~

~~Virginia Alternative Fuels Revolving Fund Vehicle Weekly Log Sheet, Attachment E.~~

~~State Vehicle Accident Report, Supplemental Accident Report Form, Form HPS-902F (eff. 7/1/85) GP-5 (eff. 7/1/85).~~

~~Central Garage Fund, Application for License Plate for Use on State-Owned Vehicle, Form CP-16 (eff. 4/1/73).~~

~~Central Garage Pool, Monthly Mileage Report, Form CP-6 (eff. 6/1/75).~~

~~Division of Fleet Management, Travel Request, Form CP-2 (eff. 9/20/88).~~

~~Division of Fleet Management, Application for Assignment of State Pool Vehicle or Update of Previous Application, Form CP-3 (eff. 10/88).~~

~~Division of Fleet Management, Application to Purchase or Lease Passenger-Type Vehicle, Form CP-15 (eff. 10/88).~~

~~Department of General Services-Division of Risk Management, Automobile Loss Notice, Form DGS-50-041.~~

~~Requisition Form, Form AS-2B (eff. 6/89).~~

~~Supplemental Agreement, Figure 9a.~~

~~Qualifications Questionnaire, Figure 2e.~~

~~Acknowledge Receipt of Expression of Interest, Figure 2f.~~

~~Architect-Engineer and Related Services Questionnaire, Form 254 (eff. 10/83).~~

~~Architect-Engineer and Related Services Questionnaire for Specific Project, Form 255 (eff. 10/83).~~

~~Civil Rights Act of 1964, Title VI Evaluation Report, Figure 4a.~~

~~Land Use Permit Application, Form CE-7A (eff. 9/90).~~

~~Land Use Permit Surety Bond, Form MP-20 (eff. 9/90).~~

~~Irrevocable Letter of Credit Bank Agreement, Form MP-231 (eff. 9/90).~~

~~General Hauling Permit Application, Form MP-66 (eff. 10/5/93).~~

~~Entrance Permit Application, Form MP-253.~~

~~Agreement Between the City/Town of _____ and Virginia Department of Transportation.~~

~~Agreement for the Development and Administration of _____ by _____.~~

~~Request for Street Additions or Deletions for Municipal Assistance Payments, Form U-1 (eff. 1/1/87).~~

~~Request for Change in Functional Classification System, Form U-2 (eff. 1/1/87).~~

~~Accounting of Expenditures and Certification of Street Maintenance Funds Quarterly Report, Form U-3 (eff. 1/1/87).~~

~~Street Condition Report, Form U-5 (eff. 1/1/87).~~

~~Travel Services Signing on Controlled and Limited Access Primary By-Pass Routes, Form T.E.-243.~~

~~Agreement, Form TE-223 (eff. 10/21/88).~~

~~Invitation for Bids.~~

~~Proposal Bond, Form AS-66 (eff. 9/85).~~

~~Standard Performance Bond, G.S. Form E & B CO-10 (eff. 12/88).~~

~~Standard Labor and Material Payment Bond, G.S. Form E & B CO-10.1 (eff. 12/88).~~

~~Bidder's Mailing List Application, Form AS-7.~~

~~Rules and Regulations Governing the Registration of Subcontractors, Form C-46B.~~

~~Department of Transportation, Form C-109.~~

~~Agreement for Supplemental Signs, Form TE-355 (eff. 3/2/87).~~

~~Moving Cost Application Families & Individuals, Form RW-60A (eff. 8/92).~~

~~Businesses, Farms & Non-Profit Organizations Moving Cost Application, Form RW-60B (eff. 9/89).~~

~~Occupancy Affidavit, Form RW-62C (eff. 9/89).~~

~~Application for Replacement Housing Payment (Owner-Occupant for 180 Days or More), Form RW-65A (eff. 9/89).~~

~~Application for Replacement Housing Payment (Purchase) (Owner-Occupant for Less than 180 Days but not Less than 90 Days) (Tenant-Occupant of not Less than 90 days), Form RW-65B (eff. 9/89).~~

~~Application for Rental Replacement Housing Payment, Form RW-65C (eff. 8/92).~~

~~Moving Cost Payment Claim Families and Individuals, Form RW-67A (eff. 8/92).~~

~~Moving Cost Payment Claim Businesses, Farms and Non-Profit Organizations, Form RW-67B (eff. 8/92).~~

~~Moving Cost Bid Virginia Department of Transportation, Form RW-71 (eff. 9/89).~~

~~Commonwealth of Virginia Division of Fleet Management Travel Request, Form CP-2 (eff. 9/20/88).~~

~~Division of Fleet Management Application for Assignment of State Pool Vehicle or Update of Previous Application, Form CP-3 (eff. 10/88).~~

~~Division of Fleet Management Virginia Department of Transportation Application to Purchase or Lease Passenger Type Vehicle, Form CP-15 (eff. 10/88).~~

RW-59(1), Form letter for moving families with certification of citizenship/legal residence (rev. 11/98).

RW-59(2), Form letter for moving personal property with certification of citizenship/legal residence (rev. 11/98).

RW-59(3), Form letter for moving businesses, farms, and nonprofit organizations with certification of citizenship/legal residence (rev. 4/00).

Occupancy Agreement (rev. 4/00).

RW-60A, Moving Cost Application (Families and Individuals/Personal Property Only) (rev. 4/00).

RW-60B, Moving Cost Application, Businesses, Farms, & Non-Profit Organizations (rev. 4/00).

RW-62C, Occupancy Affidavit (Tenants) (rev. 4/00).

RW-65A(1), Application for Purchase Replacement Housing Payment (Owner-Occupant for 180 Days or More) (rev. 4/00).

RW-65B, Application for Purchase Replacement Housing Payment (Owner-Occupant for Less than 180 Days but not Less than 90 days/Tenant-Occupant of not Less than 90 Days) (rev. 11/98).

RW-65C(1), Application for Rental Replacement Housing Payment (rev. 11/98).

RW-67A, Moving Cost Payment Claim (Families and Individuals/Personal Property Only), (rev. 4/00).

RW-67B, Moving Cost Payment Claim (Businesses, Farms, and Non-profit Organizations) (rev. 4/00).

VA.R. Doc. No. R00-171; Filed May 2, 2000, 2:28 p.m.



EMERGENCY REGULATIONS

TITLE 4. CONSERVATION AND NATURAL RESOURCES

MARINE RESOURCES COMMISSION

Title of Regulation: 4 VAC 20-620-10 et seq. **Pertaining to Summer Flounder (amending 4 VAC 20-620-10, 4 VAC 20-620-20, 4 VAC 20-620-30, 4 VAC 20-620-40, 4 VAC 20-620-50 and 4 VAC 20-620-70).**

Statutory Authority: §§ 28.2-201, 28.2-204, and 28.2-210 of the Code of Virginia.

Effective Dates: April 26, 2000, through May 25, 2000.

Summary:

This emergency regulation (i) allows for the distinction to be made between area-specific season and size limits; (ii) describes a change to the landings amount for the April 1 through June 30 period; (iii) allows for better conservation of the summer flounder quota through improved enforcement authority; (iv) allows for a temporary (2000 only) by-catch of summer flounder summer according to a specific quota; and (v) allows for the establishment of a minimum size limit, a recreational fishing season, and a closed recreational fishing season specific to the Potomac River tributaries.

Agency Contact: Copies of the regulation may be obtained from Deborah R. Cawthon, Regulatory Coordinator, Marine Resources Commission, P.O. Box 756, Newport News, VA 23607, telephone (757) 247-2248.

4 VAC 20-620-10. Purpose.

The purpose of this *emergency* chapter is to reduce commercial and recreational fishing mortality in order to rebuild the severely depleted stocks of Summer Flounder.

4 VAC 20-620-20. Definition.

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

"Land" or "landing" means to enter port with finfish, shellfish, crustaceans or other marine seafood on board any boat or vessel, to begin offloading finfish, shellfish, crustaceans or other marine seafood, or to offload finfish, shellfish, crustaceans, or other marine seafood.

"Potomac River tributaries" means all the tributaries of the Potomac River that are within Virginia's jurisdiction beginning with, and including, Flag Pond, thence upstream to the District of Columbia boundary.

4 VAC 20-620-30. Commercial harvest quotas.

A. During each calendar year, commercial landings of Summer Flounder shall be limited to the total pounds calculated pursuant to the joint Mid-Atlantic Fishery Management Council/Atlantic States Marine Fisheries Commission Summer Flounder Fishery Management Plan, as approved by the National Marine Fisheries Service on August

6, 1992 (50 CFR Part 625); and shall be distributed as described in subsections B through H of this section:

B. The commercial harvest of Summer Flounder from Virginia tidal waters for each calendar year shall be limited to 300,000 pounds.

C. During the period of January 4 through March 31 of each calendar year, landings of Summer Flounder harvested outside of Virginia shall be limited to an amount of pounds equal to 64.3% of the total specified in subsection A of this section after deducting the amount specified in subsection B of this section.

D. During the period of April 1 through June 30 of each calendar year, landings of Summer Flounder harvested outside of Virginia shall be limited to an amount of pounds equal to 6.4% of the total specified in subsection A of this section after deducting the amount specified in subsection B, *except as modified by 4 VAC 20-620-40 C.*

E. During the period of November 1 through December 31 of each calendar year, landings of Summer Flounder harvested outside of Virginia shall be limited to an amount of pounds equal to 29.3% of the total specified in subsection A of this section after deducting the amount specified in subsection B of this section and as may be further modified by subsection F.

F. During the periods set forth in subsections C and D of this section, should landings exceed or fall short of the quota specified for that period any such excess shall be deducted from, and any such shortage shall be added to, the quota for the period set forth in subsection E of this section. During the period specified in subsection B of this section, should landings be projected to fall short of the quota specified for that period, any such shortage shall be added to the quota for the period set forth in subsection E of this section. A projection of harvest under this subsection will be made on or about November 1.

G. For each of the time periods and quotas set forth in subsections C, D, and E of this section, the Marine Resources Commission will give timely notice to the industry of the calculated poundages and any adjustments thereto. It shall be unlawful for any person to harvest or to land Summer Flounder for commercial purposes after the commercial harvest or landing quota as described in this section has been attained and announced as such. *If a person lands flounder after the harvest or landing quota has been attained and announced as such, the entire amount of summer flounder in that person's possession shall be confiscated.*

H. It shall be unlawful for any buyer of seafood to receive any Summer Flounder after any commercial harvest or landing quota as described in this section has been attained and announced as such.

4 VAC 20-620-40. Commercial vessel possession limitations.

A. During the period of January 4 through March 31 of each calendar year, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia's waters to possess aboard any vessel in Virginia any amount of Summer

Flounder in excess of 5,000 pounds except that when it is projected and announced that 85% of the quota for this period has been taken, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia's waters to possess aboard any vessel in Virginia any amount of Summer Flounder in excess of 10% by weight of all other landed species on board the vessel.

B. During the period of April 1 through June 30 of each calendar year, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia's waters to possess aboard any vessel in Virginia any amount of Summer Flounder in excess of 2,500 pounds, except that when it is projected and announced that 85% of the quota for this period has been taken, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia's waters to possess aboard any vessel in Virginia any amount of Summer Flounder in excess of 10% by weight of all other landed species on board the vessel.

C. *During the period of April 26, 2000, through June 30, 2000, a bycatch-only quota of 90,912 pounds shall be established from a transfer of quota allocated to the November 1, 2000, through December 31, 2000, period. During the April 26, 2000, through June 30, 2000, period, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia waters to possess aboard any vessel in Virginia any amount of Summer Flounder in excess of 10% by weight of all other species on board the vessel.*

G. D. During the period of July 1 through October 31 of each calendar year, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia's waters to possess aboard any vessel in Virginia any amount of Summer Flounder in excess of 10% by weight of all other landed species on board the vessel.

D. E. During the period November 1 through December 31 of each calendar year, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia's waters to possess aboard any vessel in Virginia any amount of Summer Flounder in excess of 5,000 pounds, except that when it is projected and announced that 85% of the quota for this period has been taken, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia's waters to possess aboard any vessel in Virginia any amount of Summer Flounder in excess of 10% by weight of all other landed species on board the vessel.

E. F. For each of the time periods set forth in subsections A, B, C and D E of this section, the Marine Resources Commission will give timely notice of any changes in possession limits.

F. G. Each possession limit described in subsections A, B, C and D E of this section shall be determined by the net weight of Summer Flounder as customarily packed, boxed and weighed by the seafood buyer or processor. The net weight of any Summer Flounder found in excess of this possession limit described in subsections A, B, C and D E of this section shall be prima facie evidence of violation of this chapter. Persons in possession of Summer Flounder, aboard any vessel, in excess of the possession limit shall be in violation of this *emergency* chapter. Any buyer or processor

offloading or accepting any quantity of Summer Flounder from any vessel in excess of the possession limit shall be in violation of this chapter.

G. H. If a person violates the possession limits described in this section, the entire amount of Summer Flounder in that person's possession shall be confiscated. Any confiscated Summer Flounder shall be considered as a removal from the appropriate commercial harvest or landings quota. Upon confiscation, the marine patrol officer shall inventory the confiscated Summer Flounder and, at a minimum, secure two bids for purchase of the confiscated Summer Flounder from approved and licensed seafood buyers. The confiscated fish will be sold to the highest bidder and all funds derived from such sale shall be deposited for the Commonwealth pending court resolution of the charge of violating the possession limits established by this *emergency* chapter. All of the collected funds will be returned to the accused upon a finding of innocence or forfeited to the Commonwealth upon a finding of guilty.

H. I. *It shall be unlawful for a licensed seafood buyer or federally permitted seafood buyer to fail to contact the Marine Resources Commission Operation Station prior to a vessel offloading flounder harvested outside of Virginia. The buyer shall provide to the commission the name of the vessel and its captain and the anticipated or approximate offloading time.* It shall be unlawful for any person to offload from a boat or vessel for commercial purposes any Summer Flounder during the period of 10 p.m. to 7 a.m.

I. J. Any boat or vessel possessing more than the lawful limit of Summer Flounder which has entered Virginia waters for safe harbor shall not offload any Summer Flounder.

J. K. After any commercial harvest or landing quota as described in 4 VAC 20-620-30 has been attained and announced as such, any boat or vessel possessing Summer Flounder on board may enter Virginia waters for safe harbor but shall contact the Marine Resources Commission Operation Center in advance of such entry into Virginia waters.

4 VAC 20-620-50. Minimum size limits.

A. The minimum size for Summer Flounder harvested by commercial fishing gear shall be 14 inches, total length.

B. The minimum size of Summer Flounder harvested by recreational fishing gear, including but not limited to hook and line, rod and reel, spear and gig, shall be 15-1/2 inches, total length, *except that the minimum size of Summer Flounder harvested in the Potomac River tributaries shall be 15 inches total length.*

C. Length shall be measured in a straight line from tip of nose to tip of tail.

D. It shall be unlawful for any person to possess any Summer Flounder smaller than the designated minimum size limit.

E. Nothing in this chapter shall prohibit the landing of Summer Flounder in Virginia which were legally harvested in the Potomac River.

Emergency Regulations

4 VAC 20-620-70. Recreational fishing season.

A. The recreational fishing season shall be closed from January 1 through March 28, 2000, and from July 24 through August 1, 2000, *except as described in subsection B of this section.* ~~It shall be unlawful for any person fishing recreationally to take, catch, or possess any Summer Flounder during the closed fishing season.~~

B. ~~Nothing in this chapter shall prohibit the landing of Summer Flounder in Virginia which were legally harvested in the Potomac River.~~ *The recreational fishing season for the Potomac River tributaries shall be closed from January 1 through May 14, 2000.*

C. *It shall be unlawful for any person fishing recreationally to take, catch, or possess any Summer Flounder during any closed recreational fishing season.*

D. *Nothing in this regulation shall prohibit the landing of Summer Flounder in Virginia which were legally harvested in the Potomac River.*

VA.R. Doc. No. R00-167; Filed April 26, 2000, 2:58 p.m.



FORMS

TITLE 22. SOCIAL SERVICES

DEPARTMENT OF SOCIAL SERVICES

EDITOR'S NOTICE: The forms used in administering the following regulation have been amended by the Department of Social Services to reflect technical changes. The forms were revised to omit the address to which the form is to be returned. The forms are available for public inspection at the Department of Social Services, 730 East Broad Street, Richmond, VA 23219, or at the office of the Registrar of Regulations. Copies of the forms may be obtained from L. Richard Martin, Jr., Division of Management and Customer Services, Department of Social Services, 730 East Broad Street, Richmond, VA 23219, telephone (804) 692-1825.

Title of Regulation: **22 VAC 40-110-10 et seq. Minimum Standards for Licensed Family Day Homes.**

FORMS

Staffing Recommendation for Children with Special Needs (eff. 9/93).

Information and Agreement, 032-05-011/5 (rev. 6/99).

New Application for a State License to Operate a Family Day Home, ~~032-05-335/5~~ 032-05-335/6 (rev. ~~7/98~~ 4/00).

Application for Renewal of a State License to Operate a Family Day Home, ~~032-05-336/4~~ 032-05-336/5 (rev. ~~6/99~~ 4/00).



GUIDANCE DOCUMENTS

Chapter 11 of the 1997 Acts of Assembly requires annual publication in the *Virginia Register* of guidance document lists from state agencies covered by the Administrative Process Act (§ 9-6.14:1 et seq.) and the Virginia Register Act (§ 9-6.15 et seq.). A guidance document is defined as "...any document developed by a state agency or staff that provides information or guidance of general applicability to the staff or public to interpret or implement statutes or the agency's rules or regulations..." Agencies are required to maintain a complete, current list of all guidance documents and make the full text of such documents available to the public.

Generally, the format for the guidance document list is: document number (if any), title of document, date issued or last revised, and citation of Virginia Administrative Code regulatory authority or Code of Virginia statutory authority. Questions concerning documents or requests for copies of documents should be directed to the contact person listed by the agency.

DEPARTMENT OF CONSERVATION AND RECREATION

Copies of the following documents may be viewed during regular work days from 8:30 a.m. until 4:30 p.m. in the office of the Director of the Department of Conservation and Recreation, 203 Governor Street, Suite 302, Richmond, VA 23219. The director's office serves as the central repository for the Department of Conservation and Recreation, the Board of Conservation and Recreation, the Board on Conservation and Development of Public Beaches, the Virginia Soil and Water Conservation Board, the Virginia Cave Board, all designated Scenic River Advisory Boards, the Chippokes Plantation Farm Foundation, the Virginia Land Conservation Foundation, the Virginia Outdoors Foundation, and the Virginia State Parks Foundation. Individual copies of listed publications may be obtained free of charge, unless a price is listed, by contacting Kathleen A. Carter at the above address, telephone (804) 786-6124 or FAX (804) 786-6141. Most manuals and reports listed without a price attached were produced in very limited quantities and are available for copying charges. For documents with a cost associated, please refer to the document listings. Individual copies of certain documents may also be viewed at the department's divisional headquarters and in some cases at regional or district offices or at Virginia State Parks.

For information purposes only, the Secretary of Natural Resources' Virginia Water Quality Improvement Fund Guidelines for Fiscal Year 1999-2000 issued August 17, 1998, are listed here. The guidelines have two parts with the nonpoint source portion administered for the Secretary by the Department of Conservation and Recreation and the point source portion administered by the Department of Environmental Quality for the Secretary. The guidelines are available from either department.

Questions regarding interpretation or implementation of these documents may be directed to Leon E. App, Acting Deputy Director and Conservation and Development Programs Supervisor, Department of Conservation and Recreation, 203 Governor Street, Suite 302, Richmond, VA 23219, telephone (804) 786-4570 or FAX (804) 786-6141. Other staff may be assigned by the director or Mr. App to answer specific questions regarding these documents.

Guidance Documents:

Division of Dam Safety

Rodent Control on Earthfilled Dams, revised April 1998, Dept. of Conservation and Recreation Fact Sheet No. 4, §§ 10.1-604 through 10.1-613

Virginia's Program for Safety of Dams, revised March 1998, Dept. of Conservation and Recreation Fact Sheet No. 1, §§ 10.1-604 through 10.1-613

Vegetation Control for Embankment Dams, revised March 1998, Dept. of Conservation and Recreation Fact Sheet No. 3, §§ 10.1-604 through 10.1-613

Dam Classification: What Does It Mean? Why Does It Change?, revised November 1998, Dept. of Conservation and Recreation Fact Sheet No. 2, §§ 10.1-604 through 10.1-613

Division of Natural Heritage

Managing Invasive Alien Plants in Natural Areas, Parks, and Small Woodlands (booklet), §§ 10.1-209 through 10.1-217

Native Plants for Conservation, Restoration, and Landscaping, Coastal Plain, 1997, §§ 10.1-209 through 10.1-217

Native Plants for Conservation, Restoration, and Landscaping, Piedmont Region, 1997, §§ 10.1-209 through 10.1-217

Native Plants for Conservation, Restoration, and Landscaping, Mountain Region, 1997, §§ 10.1-209 through 10.1-217

Natural Heritage Technical Document #95-9, North Landing River Natural Area Preserve Resource Management Plan, First Edition, February 15, 1995, §§ 10.1-209 through 10.1-217, cost: \$25 (spiral bound report, shipping and handling included)

Natural Heritage Technical Document #95-10, Bethel Beach Natural Area Preserve Resource Management Plan, First Edition, February 15, 1995, §§ 10.1-209 through 10.1-217, cost: \$25 (spiral bound report, shipping and handling included)

Natural Heritage Ranks - Definition of Abbreviations Used on Natural Heritage Resource Lists of the Virginia Department of

- Conservation and Recreation, May 1996, §§ 10.1-209 through 10.1-217
- Natural Heritage Resources of Virginia - Rare Vascular Plants, January 1998, §§ 10.1-209 through 10.1-217
- Natural Heritage Resources of Virginia - Rare Animals, April 1998, §§ 10.1-209 through 10.1-217
- Natural Heritage Program Fact Sheet - Natural Heritage Information Services, §§ 10.1-209 through 10.1-217
- Natural Heritage Program Fact Sheet - Natural Area Dedication, §§ 10.1-209 through 10.1-217
- Natural Heritage Program Fact Sheet - Natural Area Management Agreements, §§ 10.1-209 through 10.1-217
- Natural Heritage Program Fact Sheet - Natural Area Registry, §§ 10.1-209 through 10.1-217
- Natural Heritage Program Fact Sheet - Ecological Management, §§ 10.1-209 through 10.1-217
- Natural Heritage Program Fact Sheet - Fire and Natural Areas, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Conserving Endangered Species (brochure), §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Barrier Beaches, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Sea-level Fens, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Tidal Freshwater Marshes, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Pocosins, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Baldcypress - Water Tupelo Swamps, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Turkey Oak Sandhills, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Seasonal Ponds, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Groundwater Seepage Wetlands, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Conserving Natural Communities, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Rare Beach Nesting Birds, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Rare Marsh Nesting Birds, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Migratory Songbird Habitat, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Rare Odonates, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Sensitive Joint-vetch, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Spreading Pogonia, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Purple Pitcher Plant, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Swamp Pink, §§ 10.1-209 through 10.1-217
- Natural Heritage Resource Fact Sheet - Virginia Sneezeweed, §§ 10.1-209 through 10.1-217
- Native Plants for Conservation, Restoration and Landscaping - Master list, comb-bound booklet, §§ 10.1-209 through 10.1-217
- Native Plants for Conservation, Restoration and Landscaping - Riparian Forest Buffers (brochure), §§ 10.1-209 through 10.1-217
- Native Plants for Conservation, Restoration and Landscaping - Grasslands (brochure), §§ 10.1-209 through 10.1-217
- Virginia Natural Heritage Program Twelve Year Report, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - List of Invasive Plant Species, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Alligatorweed, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Aneilema, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Asiatic Sand Sedge, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Autumn Olive and Russian Olive, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Bush Honeysuckle, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Canada Thistle, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Chinese Lespedeza, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Chinese Privet, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Common Reed, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Crown Vetch, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Eurasian Water-milfoil, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Garlic Mustard, §§ 10.1-209 through 10.1-217
- Invasive Alien Plant Species of Virginia - Giant Reed, §§ 10.1-209 through 10.1-217

Guidance Documents

Invasive Alien Plant Species of Virginia - Hydrilla, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Japanese Honeysuckle, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Japanese Knotweed, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Japanese Stilt Grass, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Johnson Grass, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Kudzu, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Mile-a-Minute, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Multiflora Rose, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Oriental Bittersweet, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Parrot's Feather, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Porcelain Berry, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Purple Loosestrife, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Spotted Knapweed, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Tall Fescue, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Tree-of-Heaven, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Winged Burning Bush, §§ 10.1-209 through 10.1-217

Invasive Alien Plant Species of Virginia - Battling an Invasive Plant Species, §§ 10.1-209 through 10.1-217

Canoe Trail Guide - Alton's Creek, North Landing River Natural Area Preserve (brochure), §§ 10.1-209 through 10.1-217

Canoe Trail Guide - Pocaty Creek, North Landing River Natural Area Preserve (brochure), §§ 10.1-209 through 10.1-217

Division of Planning and Recreation Resources

1992 Virginia Outdoors Survey, 1992 (a survey of Virginians' use of and attitudes about the Commonwealth's natural and outdoor recreational resources), §§ 10.1-200 and 10.1-207 (To be revised in Spring of 2000)

1996 Virginia Outdoors Plan, 1996 (a plan for meeting Virginia's outdoor recreational needs and conserving the

environment (a 360 page document)), §§ 10.1-200 and 10.1-207, cost: \$20 plus \$4.00 for shipping and handling

Virginia Recreational Trails Fund Program, Volume V (project application for the grant program established for the purposes of providing and maintaining recreational trails and trails-related facilities), § 10.1-200

Virginia Outdoors Fund Grant Program, January 1993 (describes the Virginia Outdoors Fund Grant Program and provides appropriate application instructions and forms), § 10.1-200

Virginia Outdoors Fund Revolving Loan Program, December 1992 (to facilitate the availability of outdoor recreation areas and facilities for all political jurisdictions in the Commonwealth of Virginia), Item 406, Chapter 893, Acts of Assembly of 1992

Potential Park Site Criteria (Level 1), § 10.1-200

Two page briefing on the Scenic River program and a list of the current components of the Virginia Scenic Rivers System, §§ 10.1-400 and 10.1-402

The Goose Creek Scenic River Advisory Board (brochure describing board responsibilities to state and county governments), §§ 10.1-400, 10.1-402 and 10.1-411

Evaluation Criteria (evaluating and ranking of streams according to relative uniqueness or quality), § 10.1-401

Open Space Land Within the Shenandoah River Corridor and Use-Value Assessment, §§ 10.1-417 and 58.1-3230

Belle Isle State Park Master Plan, Reviewed by the Board of Conservation and Recreation on December 7, 1998, and adopted by David G. Brickley, December 29, 1998, §§ 10.1-107, 10.1-200 and 10.1-200.1

Caledon Natural Area Master Plan, Reviewed by the Board of Conservation and Recreation on December 7, 1998, and adopted by David G. Brickley, December 29, 1998, §§ 10.1-107, 10.1-200 and 10.1-200.1

Chippokes State Park Master Plan, Reviewed by the Board of Conservation and Recreation on December 2, 1999, §§ 10.1-107, 10.1-200 and 10.1-200.1

Douthat State Park Master Plan, Reviewed by the Board of Conservation and Recreation on December 7, 1998, and adopted by David G. Brickley, December 29, 1998, §§ 10.1-107, 10.1-200 and 10.1-200.1

False Cape State Park Master Plan, Reviewed by the Board of Conservation and Recreation on December 7, 1998, and adopted by David G. Brickley, December 29, 1998, §§ 10.1-107, 10.1-200 and 10.1-200.1

First Landing State Park Master Plan, Reviewed by the Board of Conservation and Recreation on September 27, 1999 and adopted by David G. Brickley, November 15, 1999, §§ 10.1-107, 10.1-200 and 10.1-200.1

James River State Park Master Plan, Reviewed by the Board of Conservation and Recreation on December 7, 1998, and adopted by David G. Brickley, December 29, 1998, §§ 10.1-107, 10.1-200 and 10.1-200.1

New River Trail State Park Master Plan, Reviewed by the Board of Conservation and Recreation on April 26, 1999 and adopted by David G. Brickley, November 15, 1999, §§ 10.1-107, 10.1-200 and 10.1-200.1

Natural Tunnel State Park Master Plan, Reviewed by the Board of Conservation and Recreation on December 2, 1999, §§ 10.1-107, 10.1-200 and 10.1-200.1

Pocahontas State Park Master Plan, Reviewed by the Board of Conservation and Recreation on December 7, 1998, and adopted by David G. Brickley, December 29, 1998, §§ 10.1-107, 10.1-200 and 10.1-200.1

Staunton River Battlefield State Park Master Plan, Reviewed by the Board of Conservation and Recreation on December 7, 1998, and adopted by David G. Brickley, December 29, 1998, §§ 10.1-107, 10.1-200 and 10.1-200.1

Wilderness Road State Park Master Plan (formerly Karlan State Park), Reviewed by the Board of Conservation and Recreation on June 30, 1998, and December 7, 1998, and adopted by David G. Brickley, on July 2, 1998, and December 14, 1998, §§ 10.1-107, 10.1-200 and 10.1-200.1

Division of Soil and Water Conservation

The Floodplain Management Plan for the Commonwealth of Virginia, April 29, 1991 (plan with 3-ring binder), 1991 plan out of print, revised plan pending, §§ 10.1-658 and 10.1-659, cost: per page copying

Virginia Erosion and Sediment Control Handbook, Third Edition, 1992, 4 VAC 5-30, §§ 10.1-560 through 10.1-571, cost: \$28 (handbook with 3-ring binder and shipping and handling included)

Virginia Erosion and Sediment Control Field Manual, Second Edition, 1995, 4 VAC 5-30, §§ 10.1-560 through 10.1-571, cost: \$13 (field manual, plastic cover, and shipping and handling included)

Virginia Erosion and Sediment Control Handbook AutoCad Drawings, 4 VAC 5-30, §§ 10.1-560 through 10.1-571, cost: \$23 (shipping and handling included)

Virginia Nutrient Management Guidelines for Continuing Education Meetings, May 1997, 4 VAC 5-15-40 A

Virginia Nutrient Management Certification Education and Experience Guidelines, June 1997, 4 VAC 5-15-40 A

Virginia Nutrient Management Application Instruction Packet, October 1997, 4 VAC 5-15-40 A 1

Virginia Nutrient Management Standards and Criteria, November 1995, 4 VAC 5-15

Nutrient Management Handbook, Second Edition, 1993, 4 VAC 5-15

DCR Staff Guidance for Biosolids Use Regulations Site Reviews, October 1996, 12 VAC 5-585

DCR Staff Guidance for VPA Permit Nutrient Management Plans, September 1997, 9 VAC 25-192

Improving Water Quality, a Virginia Priority... A Local Option, Tax Incentives To Protect Wetlands, Riparian Buffers & To Promote Erosion Control Structures (Local Government version), November 1998, §§ 58.1-3230, 58.1-3665 and 58.1-3666

Improving Water Quality, a Virginia Priority... A Local Option, Tax Incentives To Protect Wetlands, Riparian Buffers & To Promote Erosion Control Structures (Landowner version), November 1998, §§ 58.1-3230, 58.1-3665 and 58.1-3666

Division of State Parks

The 1999 Virginia State Parks' Guide to Virginia State Parks, §§ 10.1-200 and 10.1-201

The 1999 Virginia State Parks' Guide to Outdoors Adventures, §§ 10.1-200 and 10.1-201

Virginia State Parks, Bear Creek Lake State Park, Cumberland Multi-Use Trail Map and Guide, April 2000, §§ 10.1-200 and 10.1-201

Virginia State Parks, Bear Creek Lake State Park Fact Sheet, 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Bear Creek Lake State Park Guide and Map, revised March 2000, §§ 10.1-200 and 10.1-201

Virginia State Parks, Bear Creek Lake State Park Trail Guide and Map, March 2000, §§ 10.1-200 and 10.1-201

Virginia State Parks, Belle Isle State Park Guide, May 1995, §§ 10.1-200 and 10.1-201

Virginia State Parks, Breaks Interstate Park & Conference Center Brochure, November 1999, §§ 10.1-200 and 10.1-201

Virginia State Parks, Caledon Natural Area, Boyd's Hole Trail Guide, 1995, §§ 10.1-200 and 10.1-201

Virginia State Parks, Caledon Natural Area Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Caledon Natural Area Guide, 1995, §§ 10.1-200 and 10.1-201

Virginia State Parks, Caledon Natural Area Junior Ranger Application, 2000, §§ 10.1-200 and 10.1-201

Virginia State Parks, Caledon Natural Area Summer Program Brochure, 2000, §§ 10.1-200 and 10.1-201

Virginia State Parks, Caledon Natural Area, Deer Herd Management Brochure, 1995, §§ 10.1-200 and 10.1-201

Virginia State Parks, Chippokes Plantation State Park Guide, 1998, §§ 10.1-200 and 10.1-201

Virginia State Parks, Chippokes State Park Fact Sheet, December 1996, §§ 10.1-200 and 10.1-201

Virginia State Parks, Chippokes Farm and Forestry Museum, §§ 10.1-200 and 10.1-201

Virginia State Parks, Claytor Lake State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201

Guidance Documents

Virginia State Parks, Claytor Lake State Park Guide, May 1995, §§ 10.1-200 and 10.1-201

Virginia State Parks, Claytor Lake State Park, Shady Ridge Trail Interpretive Guide, 1988, §§ 10.1-200 and 10.1-201

Virginia State Parks, Claytor Lake State Park, William Christian Interpretive Brochure, 1992, §§ 10.1-200 and 10.1-201

Virginia State Parks, Douthat State Park Fact Sheet, December 1996, §§ 10.1-200 and 10.1-201

Virginia State Parks, Douthat State Park Guide, December 1999, §§ 10.1-200 and 10.1-201

Virginia State Parks, Douthat State Park Trail Guide, June 1999, §§ 10.1-200 and 10.1-201

Virginia State Parks, Fairy Stone State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Fairy Stone State Park Guide, December 1998, §§ 10.1-200 and 10.1-201

Virginia State Parks, Fairy Stone State Park Trail Guide, December 1998, §§ 10.1-200 and 10.1-201

Virginia State Parks, False Cape State Park Fact Sheet, January 1997, §§ 10.1-200, 10.1-201 and 10.1-205

Virginia State Parks, False Cape State Park Guide, April 1993, §§ 10.1-200, 10.1-201, and 10.1-205

Virginia State Parks, False Cape State Park Environmental Education Center Application, §§ 10.1-200 and 10.1-205

Virginia State Parks, First Landing/Seashore State Park and Natural Area Trail System Guide, May 1996, §§ 10.1-200 and 10.1-201

Virginia State Parks, First Landing/Seashore State Park and Natural Area Trail System Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Grayson Highlands State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Grayson Highlands State Park Guide, February 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Grayson Highlands State Park Hunting Guide, February 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Grayson Highlands State Park Horseback Riding Guide, February 1997, §§ 10.1-200 and 10.1-201.

Virginia State Parks, Grayson Highlands State Park Mountain Bike Guide, February 1997, §§ 10.1-200 and 10.1-201.

Virginia State Parks, Holliday Lake State Park Guide, November 1996, §§ 10.1-200 and 10.1-201

Virginia State Parks, Holliday Lake State Park, Sunfish Trail (Self-guided Boat Trail), §§ 10.1-200 and 10.1-201.

Virginia State Parks, Hungry Mother State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Hungry Mother State Park Guide, February 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, James River State Park Guide, February 2000, §§ 10.1-200 and 10.1-201

Virginia State Parks, Kiptopeke State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Kiptopeke State Park Guide, February 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Lake Anna State Park Fact Sheet, July 1999, §§ 10.1-200 and 10.1-201

Virginia State Parks, Lake Anna State Park Guide, February 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Lake Anna State Park Guide Fortune's Wheel, A history of the land surrounding Lake Anna State Park, §§ 10.1-200 and 10.1-201

Virginia State Parks, Lake Anna State Park Old Pond Trail, Self guided trail, §§ 10.1-200 and 10.1-201

Virginia State Parks, Lake Anna State Park Trail Guide, §§ 10.1-200 and 10.1-201

Virginia State Parks, Leesylvania State Park A Potomac Legacy, §§ 10.1-200 and 10.1-201

Virginia State Parks, Leesylvania State Park Fact Sheet, July 1998, §§ 10.1-200 and 10.1-201

Virginia State Parks, Leesylvania State Park History of Leesylvania, §§ 10.1-200 and 10.1-201

Virginia State Parks, Leesylvania State Park Lee's Woods Self Guided Trail, §§ 10.1-200 and 10.1-201

Virginia State Parks, Leesylvania State Park Map and Guide, May 1999, §§ 10.1-200 and 10.1-201

Virginia State Parks, Leesylvania State Park Powells Creek Self Guided Trail, §§ 10.1-200 and 10.1-201

Virginia State Parks, Mason Neck State Park Fact Sheet, July 1993, §§ 10.1-200 and 10.1-201

Virginia State Parks, Mason Neck State Park Guide, February 1998, §§ 10.1-200 and 10.1-201

Virginia State Parks, Natural Tunnel State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Natural Tunnel State Park Full color NT Brochure for racks/promotion, revised April 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, Natural Tunnel State Park Trail Guide, July 1996, §§ 10.1-200 and 10.1-201

Virginia State Parks, New River Trail State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201

Virginia State Parks, New River Trail State Park Guide, April 2000, §§ 10.1-200 and 10.1-201

Virginia State Parks, New River Trail State Park Trail User Guide, February 1998, §§ 10.1-200 and 10.1-201

- Virginia State Parks, Occoneechee State Park Guide, July 1996, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Occoneechee State Park Fact Sheet, November 1996, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Pocahontas State Park Bicycle Trails Guide, 1998, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Pocahontas State Park Fact Sheet, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Pocahontas State Park Guide, May 1996, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Sailor's Creek State Park Guide, 72 Hours Before the End, March 1996, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Shot Tower Historical State Park Guide, September 1998, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Raymond R. "Andy" Guest, Jr./Shenandoah River State Park/Brochure, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Sky Meadows State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Sky Meadows State Park Guide, May 1996, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Sky Meadows State Park, Sky Meadows Bird Checklist, 1992, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Sky Meadows State Park 10 Good Reasons to Leash Your Dog, 1997, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Sky Meadows State Park Sky Meadows Seasonal Interpretive Program Brochure, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Smith Mountain Lake State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Smith Mountain Lake State Park Guide, August 1998, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Smith Mountain Lake State Park, Tournament Building Reservation Guide, February 2000, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Staunton River Battlefield State Park Civil-War Self-guided Trail Brochure Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Staunton River Battlefield State Park Civil-War Trails (1999), §§ 10.1-200 and 10.1-201
- Virginia State Parks, Staunton River Battlefield State Park Edgewood Self-guided Interpretive Trail (1998), §§ 10.1-200 and 10.1-201
- Virginia State Parks, Staunton River Battlefield State Interpretive Programs Brochure (2000), §§ 10.1-200 and 10.1-201
- Virginia State Parks, Staunton River State Park, 2000 Interpretive Schedule, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Staunton River State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Staunton River State Park Trail Guide, April 1994, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Southwest Virginia Museum, A Story To Tell, Guide, September 1998, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Southwest Virginia Museum, A Walk on the Grounds, 1998, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Southwest Virginia Museum, Calendar of Events, 2000, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Southwest Virginia Museum, Victorian Parlor, 1999, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Twin Lakes State Park Fact Sheet, December 1996, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Twin Lakes State Park Guide, August 1995, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Twin Lakes State Park Gallion Boot, Bike, Bridle Trail Guide, April 1997, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Westmoreland State Park, Big Meadows Interpretive Brochure, 1996, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Westmoreland State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Westmoreland State Park Guide, 1999, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Westmoreland State Park Potomac River Retreat Publication, 1998, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Westmoreland State Park Summer Interpretive Brochure, May 2000, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Wilderness Road State Park Guide, November 1999, §§ 10.1-200 and 10.1-201
- Virginia State Parks, York River State Park Fact Sheet, January 1997, §§ 10.1-200 and 10.1-201
- Virginia State Parks, York River State Park Guide, June 1996, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Become a Volunteer, January 1995, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Camping and Cabins Fees Guide, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Calling One, Calling All Experienced Campers! Come Be a Virginia State Park Campground Host or Park Host, February 1996, §§ 10.1-200 and 10.1-201
- Virginia State Parks Facilities and Meeting Guide, August 1999, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Hunting and Fishing Guide, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Nature's Image, Photography Field Workshops, §§ 10.1-200 and 10.1-201
- Virginia State Parks, Trail Facts, §§ 10.1-200 and 10.1-201

Guidance Documents

Board of Conservation and Recreation

General Information for Board Members (3-ring notebook), December 1998, §§ 10.1-105 through 10.1-107, cost: per page copying

Board on Conservation and Development of Public Beaches

General Information for Board Members (3-ring notebook), May 1997, §§ 10.1-705 through 10.1-711, cost: per page copying

Virginia Soil and Water Conservation Board

General Information for Board Members (3-ring notebook), December 1998, §§ 10.1-502 through 10.1-505, cost: per page copying

Virginia Cave Board

General Information for Board Members (3-ring notebook), May 1997, §§ 10.1-1000 through 10.1-1008, cost: per page copying

Designated Scenic River Advisory Boards

Handouts to Scenic River Advisory Boards: these include a 2-page briefing on the Scenic Rivers Program, a copy of the Scenic River enabling legislation from the Code of Virginia, a list of the current components of the Virginia Scenic River System, a list of Virginia Register publication deadlines and schedules, Department of Conservation and Recreation guidance for meeting minutes, and a copy of the appropriate Scenic River Advisory Board Bylaws, §§ 10.1-400, 10.1-402 and 10.1-406

Chippokes Plantation Farm Foundation

Chippokes Farm and Forestry Museum pamphlet, 1992, §§ 3.1-22.6 through 3.1-22.12

Chippokes Calendar of Events, 1999, §§ 3.1-22.6 through 3.1-22.12

General Information for Board Members (3-ring notebook), May 1997, §§ 3.1-22.6 through 3.1-22.12, cost: per page copying

Virginia Land Conservation Foundation

General Information for Board Members (3-ring notebook), July 1997, §§ 10.1-1017 through 10.1-1025, cost: per page copying

Virginia Land Conservation Foundation, Virginia Land Conservation Fund Grant Program, September 21, 1999, § 10.1-1021.

Virginia Outdoors Foundation

General Information for Board Members (3-ring notebook), May 1997, §§ 10.1-1800 through 10.1-1804, cost: per page copying

The Open-Space Lands Preservation Trust Fund (brochure), 1997, §§ 10.1-1800 through 10.1-1804

Open-Space Lands Preservation Trust Fund Application (to be completed by the landowner) (interim form), 1997, §§ 10.1-1800 through 10.1-1804

Regional Advisory Board Open Space Preservation Trust Fund Summary Ranking Sheet, to be compiled by the applicable Regional Advisory Board (interim form), 1997, §§ 10.1-1800 through 10.1-1804

Virginia State Parks Foundation

General Information for Board Members (3-ring notebook), revised December 1998, §§ 10.1-218 through 10.1-225, cost: per page copying

Secretary of Natural Resources

Virginia Water Quality Improvement Fund Guidelines for Fiscal Year 1999-2000 issued by The Secretary of Natural Resources, Richmond, VA, August 17, 1998, Final, § 10.1-2128

GENERAL NOTICES/ERRATA

STATE CORPORATION COMMISSION

Bureau of Insurance

April 20, 2000

Administrative Letter 2000 - 4

TO: All Companies Licensed under Chapter 10, 11, 12, 25, 26, 38, 39, 40, 41, 42, 43, 44, 45 or 46 of Title 38.2 of the Code of Virginia

**RE: Seven Year Rotation of Certified Public Accountants
Rules Governing Annual Audited Financial Reports
(14 VAC 5-270-10 et seq.)**

The purpose of this letter is to remind insurers and other affected parties that, pursuant to 14 VAC 5-270-80 C, no partner or other person responsible for rendering an annual audited financial report may act in that capacity for more than seven consecutive years.

The "Rules Governing Annual Audited Financial Reports" (14 VAC 5-270-10 et seq.) became effective in 1991. However, the seven year rotation requirement found in subsection 14 VAC 5-270-80 C did not become effective until 1993. Insurers and other affected parties are reminded that any partner or other person who has been responsible for rendering the annual audited financial report for the period ending December 31, 1993, and all subsequent years to date shall be disqualified from acting in that or a similar capacity for the insurer, or its insurance subsidiaries or affiliates, with respect to the audited financial reports filed for the period ending December 31, 2000, and December 31, 2001. An insurer may request relief from this rotation requirement based on the existence of unusual circumstances. The Bureau may consider the following factors in determining if relief should be granted:

1. The number of partners, expertise of the partners, or the number of insurance clients in the currently registered firm;
2. The premium volume of the insurer; or
3. The number of jurisdictions in which the insurer transacts business.

Written requests for relief from this rotation requirement should address the factors listed above, and identify also the person and, if applicable, the title of the person or persons responsible for rendering the annual audited financial reports for each of the last seven years. A foreign or alien company seeking relief shall include with its request a letter from its domiciliary regulator specifying the reason relief was granted in the domiciliary jurisdiction and, if applicable, explaining the conditions of the relief granted. Written requests for relief in connection with the December 31, 2000, audited financial report should be received by the Bureau no later than July 31, 2000. Written requests for relief in connection with audited financial reports for years ending December 31, 2001, and beyond should be received by the Bureau no later than July 31 of the reporting year.

All companies which are required to file an annual audited financial report pursuant to 14 VAC 5-270-30, including foreign and alien insurers, must comply with the requirements as set forth in 14 VAC 5-270-80 C and as restated in this letter.

Insurers and other affected parties are reminded also that the letter required by 14 VAC 5-270-130 should indicate compliance with 14 VAC 5-270-80 by disclosing the number of years the engagement partner (partner responsible for rendering an annual audited financial report) has served in that capacity with respect to the company.

Questions regarding the implementation of the contents of this letter should be sent to the attention of Edward J. Buyalos, Jr. for domestic insurers, Andy R. Delbridge for health maintenance organizations and Gregory D. Walker for foreign and alien insurers c/o:

State Corporation Commission, Bureau of Insurance
Financial Regulation Division
P.O. Box 1157
Richmond, VA 23218

/s/ Alfred W. Gross
Commissioner of Insurance

April 25, 2000

Administrative Letter 2000 - 5

TO: All domestic companies licensed in accordance with Chapter 10, 40, 41, 42, 43, 44 or 45 of Title 38.2 of the Code of Virginia or otherwise authorized to write insurance or reinsurance risks pursuant to Chapter 26, 27, 28, 29 or 51 of Title 38.2 of the Code of Virginia or § 65.2-802 of the Code of Virginia, and all reinsurance intermediaries that are residents of Virginia and licensed in accordance with Article 5 of Chapter 18 of Title 38.2 of the Code of Virginia.

RE: 18 U.S.C. §§ 1033, 1034 -- Violent Crime Control and Law Enforcement Act of 1994

The purpose of this administrative letter is to remind domestic insurers and others domiciled or residing in Virginia of the requirement and means of complying with 18 U.S.C. § 1033 (attached) pertaining to the federal Violent Crime Control and Law Enforcement Act of 1994 (Act). This Act prohibits any individual, who is engaged in the "business of insurance" as defined in 18 U.S.C. § 1033(f)(1) and whose activities affect "interstate commerce" as defined in 18 U.S.C. § 1033 (f)(3), from willfully permitting any individual who has been convicted of a criminal felony involving dishonesty or breach of trust, or who has been convicted of an offense under 18 U.S.C. § 1033, to be engaged in the business of insurance unless written consent is given pursuant to 18 U.S.C. § 1033(e)(2) by an insurance regulatory official authorized to regulate the insurer.

General Notices/Errata

The Act requires a written consent from an insurance regulatory official authorized to regulate the insurer before an insurer may permit an individual, who has been convicted of a criminal felony involving breach of trust or dishonesty or any offense referenced in 18 U.S.C. § 1033 (prohibited individual), to engage in the business of insurance as the insurer's director, officer, agent or employee.

The attached *Notice and Request for Waiver Evidencing Written Consent to Engage in the Business of Insurance Pursuant to 18 U.S.C. § 1033 (e)(2)* (application) should be reproduced, completed and filed with the State Corporation Commission Bureau of Insurance (Commission), by licensed companies domiciled in Virginia, before any prohibited individual is permitted to engage in the business of insurance as a director, officer or employee of such company. **THIS REQUIREMENT APPLIES TO CURRENT, AS WELL AS FUTURE, EMPLOYEES, DIRECTORS AND OFFICERS.** A letter from the company expressly stating that the company wants to employ or otherwise retain the services of the individual in question must be filed with the application.

The filing of the application does not constitute written consent to engage in the business of insurance within Virginia. Any consent or waiver given by the Commission will be in writing and expressly given. Criminal sanctions are authorized for those who willfully permit a prohibited individual to engage in the business of insurance without written consent.

A company licensed in Virginia but domiciled in another state should contact the Commissioner, Director or Superintendent of Insurance of its domiciliary state for information regarding procedures for complying with the Act. Similarly, non-resident agents and intermediaries should contact the Commissioner, Director or Superintendent of Insurance in its domiciliary state for information regarding procedures for complying with the Act.

Questions concerning persons licensed as agents, insurance consultants, managing general agents, surplus lines brokers or viatical settlement brokers should be directed to:

Warren E. Spruill
Supervisor, Agents Licensing
Life and Health Division
SCC, Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
(804) 786-9522

Completed applications and questions concerning this administrative letter should be directed to:

Victoria I. Savoy, CPA
Chief Financial Auditor, Financial Regulation Division
SCC, Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
(804) 371-9869

/s/ Alfred W. Gross
Commissioner of Insurance

Attachments

**ATTACHMENT A:
18 UNITED STATES CODE, SECTIONS 1033 AND 1034**

Sec. 1033. Crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce.

(a)(1) Whoever is engaged in the business of insurance whose activities affect interstate commerce and knowingly, with the intent to deceive, makes any false material statement or report or willfully and materially overvalues any land, property or security—

(A) in connection with any financial reports or documents presented to any insurance regulatory official or agency or an agent or examiner appointed by such official or agency to examine the affairs of such person, and

(B) for the purpose of influencing the actions of such official or agency or such an appointed agent or examiner,

shall be punished as provided in paragraph (2):

(2) The punishment for an offense under paragraph (1) is a fine as established under this title or imprisonment for not more than 10 years, or both, except that the term of imprisonment shall be not more than 15 years if the statement or report or overvaluing of land, property, or security jeopardized the safety and soundness of an insurer and was a significant cause of such insurer being placed in conservation, rehabilitation, or liquidation by an appropriate court.

(b)(1) Whoever—

(A) acting as, or being an officer, director, agent, or employee of, any person engaged in the business of insurance whose activities affect interstate commerce, or

(B) is engaged in the business of insurance whose activities affect interstate commerce or is involved (other than as an insured or beneficiary under a policy of insurance) in a transaction relating to the conduct of affairs of such a business, willfully embezzles, abstracts, purloins, or misappropriates any of the moneys, funds, premiums, credits, or other property of such person so engaged shall be punished as provided in paragraph (2).

(2) The punishment for an offense under paragraph (1) is a fine as provided under this title or imprisonment for not more than 10 years, or both, except that if such embezzlement, abstraction, purloining, or misappropriation described in paragraph (1) jeopardized the safety and soundness of an insurer and was a significant cause of such insurer being placed in conservation, rehabilitation, or liquidation by an appropriate court, such imprisonment shall be not more than 15 years. If the amount or value so embezzled, abstracted, purloined, or misappropriated does not exceed \$5,000, whoever violates paragraph (1) shall be fined as provided in this title or imprisoned not more than one year, or both.

(c)(1) Whoever is engaged in the business of insurance and whose activities affect interstate commerce or is involved (other than as an insured or beneficiary under a policy of insurance) in a transaction relating to the conduct of affairs of such a business, knowingly makes any false entry of material fact in any book, report, or statement of such person engaged in the business of insurance with intent to deceive any person, including any officer, employee, or agent of such person engaged in the

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General Notices/Errata

business of insurance , any insurance regulatory official or agency, or any agent or examiner appointed by such official or agency to examine the affairs of such person, about the financial condition or solvency of such business shall be punished as provided in paragraph (2).

(2) The punishment for an offense under paragraph (1) is a fine as provided under this title or imprisonment for not more than 10 years, or both, except that if the false entry in any book, report, or statement of such person jeopardized the safety and soundness of an insurer and was a significant cause of such insurer being placed in conservation, rehabilitation, or liquidation by an appropriate court, such imprisonment shall be not more than 15 years.

(d) Whoever, by threats or force or by any threatening letter or communication, corruptly influences, obstructs, or impedes or endeavors corruptly to influence, obstruct, or impede the due and proper administration of the law under which any proceeding involving the business of insurance whose activities affect interstate commerce is pending before any insurance regulatory official or agency or any agent or examiner appointed by such official or agency to examine the affairs of a person engaged in the business of insurance whose activities affect interstate commerce, shall be fined as provided in this title or imprisoned not more than 10 years, or both.

(e)(1)(A) Any individual who has been convicted of any criminal felony involving dishonesty or a breach of trust, or who has been convicted of an offense under this section, and who willfully engages in the business of insurance whose activities affect interstate commerce or participates in such business , shall be fined as provided in this title or imprisoned not more than 5 years, or both.

(B) Any individual who is engaged in the business of insurance whose activities affect interstate commerce and who willfully permits the participation described in subparagraph (A) shall be fined as provided in this title or imprisoned not more than 5 years, or both.

(2) A person described in paragraph (1)(A) may engage in the business of insurance or participate in such business if such person has the written consent of any insurance regulatory official authorized to regulate the insurer , which consent specifically refers to this subsection.

(f) As used in this section—

(1) the term “business of insurance” means—

- (A) the writing of insurance, or
- (B) the reinsuring of risks,

by an insurer , including all acts necessary or incidental to such writing or reinsuring and the activities of persons who act as, or are, officers, directors, agents, or employees of insurers or who are other persons authorized to act on behalf of such persons; ;

(2) the term “insurer” means any entity the business activity of which is the writing of insurance or the reinsuring of risks, and includes any person who acts as, or is, an officer, director, agent, or employee of that business ;

(3) the term “interstate commerce” means—

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- (A) commerce within the District of Columbia, or any territory or possession of the United States;
- (B) all commerce between any point in the State, territory, possession, or the District of Columbia and any point outside thereof;
- (C) all commerce between points within the same State through any place outside such State; or
- (D) all other commerce over which the United States has jurisdiction; and

(4) the term "State" includes any State, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands.

Sec. 1034. Civil penalties and injunctions for violations of section 1033.

(a) The Attorney General may bring a civil action in the appropriate United States district court against any person who engages in conduct constituting an offense under section 1033 and, upon proof of such conduct by a preponderance of the evidence, such person shall be subject to a civil penalty of not more than \$50,000 for each violation or the amount of compensation which the person received or offered for the prohibited conduct, whichever amount is greater. If the offense has contributed to the decision of a court of appropriate jurisdiction to issue an order directing the conservation, rehabilitation, or liquidation of an insurer, such penalty shall be remitted to the appropriate regulatory official for the benefit of the policyholders, claimants, and creditors of such insurer. The imposition of a civil penalty under this subsection does not preclude any other criminal or civil statutory, common law, or administrative remedy, which is available by law to the United States or any other person.

(b) If the Attorney General has reason to believe that a person is engaged in conduct constituting an offense under section 1033, the Attorney General may petition an appropriate United States district court for an order prohibiting that person from engaging in such conduct. The court may issue an order prohibiting that person from engaging in such conduct if the court finds that the conduct constitutes such an offense. The filing of a petition under this section does not preclude any other remedy which is available by law to the United States or any other person.

**NOTICE AND REQUEST FOR WAIVER EVIDENCING WRITTEN CONSENT
TO ENGAGE IN THE BUSINESS OF INSURANCE PURSUANT TO
18 U.S.C. § 1033(e)(2)
TO BE FILED WITH THE STATE CORPORATION COMMISSION BUREAU OF INSURANCE
(COMMISSION)**

Please fill in the blanks below, also number and attach requested descriptions, comments, and attachments.

SECTION I – APPLICANT INFORMATION

This Application is filed by _____ (the Licensee), a company now or in the future to be domiciled in Virginia and licensed under Title 38.2 of the Code of Virginia and _____ (the § 1033 (e)(1)(A) Individual).

1. License name: _____ NAIC #: _____
2. Contact person: _____ Title: _____
3. Telephone #: _____ FAX #: _____
4. § 1033 (e)(1)(A) Individual (director, officer or employee): _____
5. Social Security Number: _____
6. Home Address: _____
7. Telephone #: _____
8. Alias or other names used, if any: _____

SECTION II – PRESENT/PROPOSED INSURANCE EMPLOYMENT

9. The § 1033(e)(1)(A) Individual currently holds a position with the Licensee: Yes _____ No _____
 - Describe the current position. _____
10. The § 1033(e)(1)(A) Individual is contemplating a new position with the Licensee: Yes _____ No _____
 - Describe the new position. _____

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11. The position involves activities of a director _____, officer _____, employee _____ (check all that apply).
 - Describe the nature, duties and activities of the office, position, occupation, trade, vocation or profession for which the issuance of written consent is sought. Attach all written agreements or contracts to be entered into between the Licensee and the § 1033(e)(1)(A) Individual.

12. Actual or prospective dates of employment or association with the Licensee: _____

SECTION III – CRIMINAL HISTORY

13. Type and date(s) of conviction(s): _____

- Provide the details regarding each felony conviction that appears to prohibit the § 1033(e)(1)(A) Individual from engaging in the business of insurance as defined in 18 U.S.C. § 1033. Include (i) the type, (ii) date of the offense, (iii) the court (with city/county and state), (iv) docket number, (v) age of the § 1033(e)(1)(A) Individual on such date, (vi) time that has since elapsed, (vii) whether the § 1033(e)(1)(A) Individual has made full payment of outstanding court costs, supervision, fees/fines and restitution concerning the offense, and (viii) whether the § 1033(e)(1)(A) Individual has received a full pardon or other type of pardon for the offense. Attach additional pages if needed.

14. Was the offense insurance related? Yes _____ No _____
 - Comment on the bearing, if any, the criminal offense will have on the § 1033(e)(1)(A) Individual's fitness or ability to perform the duties, activities, or responsibilities presented in this Application. Attach additional pages if needed.

15. Are there special circumstances or additional information which should be considered with this Application? Yes _____ No _____
 - Describe any mitigating circumstances and attach evidence of rehabilitation (such as a letter from the state parole or probation office outlining performance or satisfactory completion of parole) or evidence of current qualifications, including current employment history and records of professional certifications presently held. Attach additional pages if needed.

16. Has disclosure of the conviction(s) been made to any regulators? Yes _____ No _____
 - Attach copies of any such notice or disclosure.
17. Has regulatory consent been requested or received by or on behalf of the § 1033(e)(1)(A) Individual from any insurance regulatory official or agency? Yes _____ No _____
 - Attach a copy of the request and the regulatory response(s).

SCCB0126(0425/00)

For the Licensee: Under penalty of perjury, I do hereby swear and/or affirm that I have reviewed the information contained in this Application, including all attachments, and to the best of my knowledge and belief, the information contained herein and all attachments is true, correct, and complete, and I further swear and/or affirm that the named § 1033(e)(1)(A) Individual will not be placed into a position by which the § 1033 (e)(1)(A) Individual's activities will constitute a risk or threat to this company or its insureds and policyholders.

Licensee _____
By: _____
Name and Title of Officer _____
Notary Public _____

Sworn before me this _____ day of _____

City/County of _____ in the State of _____
My commission expires: _____

SECTION IV - ATTACHMENTS

Attach the following documents to this Application. Applications without attachments, or Applications with incomplete attachments, will be returned to the Licensee.

1. A current copy (no more than 90 days old) of the § 1033(e)(1)(A) Individual's criminal history record report (CCRE). The § 1033(e)(1)(A) Individual can obtain a CCRE by contacting the state law enforcement agency in each state or other jurisdiction in which he or she has resided, and requesting the information. In Virginia that would be the Virginia State Police.
2. Certified copy of the indictment, criminal complaint, or docket sheet or other initiating documents for the charge(s) which is the subject of this Application.
3. A certified copy of the order of judgement and sentence of the court for the conviction that is the subject of this Application, including certification of completion and performance of all conditions imposed by the court.
4. A letter from the Licensee expressly stating that the Licensee wants to employ or otherwise retain the services of the § 1033(e)(1)(A) Individual.

For the § 1033(e)(1)(A) Individual:

I, _____ (name of the § 1033(e)(1)(A) Individual), swear under penalty of law that the statements in the attached Application, including the documents appended thereto, are true and correct and complete. I understand that the statements in the Application and the attachments to this Application are being filed with the Virginia State Corporation Commission Bureau of Insurance (Commission); and that they will be relied upon by the Commission in the execution of its duties under Title 38.2 of the Code of Virginia, and 18 U.S.C. § 1033, in making a decision on this Application. I understand that if there are any false statements in this Application, or if there are any false statements included in the attachments to this Application, I may be criminally prosecuted under any state criminal or administrative remedies available and that any insurance license(s) that I currently hold, or for which I have applied, will be subject to suspension or revocation. I further understand that a false statement would also constitute a violation of 18 U.S.C. § 1033. For the purposes of this Application, I do not contest the validity of any felony conviction upon which this request would be granted. *By signing this Application, I acknowledge that the Commission may make or direct to be made an independent investigation to confirm the information in this Application and I expressly consent and authorize any person, business or agency to release any information the Commission may request as part of the investigation, including but not limited to, records of my former employment, state and federal tax returns, business records, and banking records.*

_____ § 1033(e)(1)(A) Individual (signature)
_____ day of _____, _____
Print Name

Notary Public _____
City/County of _____ in the State of _____

My commission expires: _____

General Notices/Errata

DEPARTMENT OF ENVIRONMENTAL QUALITY

Notice of Public Comment

The Department Of Environmental Quality (DEQ) is seeking written comments from interested persons on the Water Quality Assessment Guidance Manual that contains the assessment procedures used for the development of Virginia's Total Maximum Load (TMDL) Priority List and § 305(b) Water Quality Report.

Section 62.1-44.19:7 C of the Code of Virginia requires DEQ to develop and publish the procedures used for defining and determining impaired waters and provide for public comment on the procedures.

DEQ is making a significant change in the procedure to be used for developing Virginia's § 305(b) Water Quality Report for year 2000. The agency is using a statistical method, based on a binomial distribution, for making the assessment for the development of the § 305(b) Water Quality Report. This statistical method is being used in this assessment rather than the simple percentage method presented in the Water Quality Assessment Guidance Manual public noticed in the Virginia Register on October 25, 1999.

The public comment period will end on Friday, June 23, 2000. Copies of the draft Water Quality Assessment Guidance Manual can be requested from Harry Augustine. Also, comments, questions, or information requests should be addressed to Mr. Augustine. Written comments should include the name, address, and telephone number of the person submitting the comments.

Contact: Harry Augustine, Department Of Environmental Quality, P.O. Box 10009, Richmond, Virginia 23240-0009, telephone (804) 698-4037, FAX (804) 698-4136, or e-mail hhaugustin@deq.state.va.us.

Request for Nominations for Membership on a Technical Advisory Committee to Assist in the Development of Amendments to the Virginia Water Protection Permit Regulation and General VWP Permits for Activities Impacting Wetlands

The Department of Environmental Quality is seeking nominations for membership on a Technical Advisory Committee (TAC) to assist in the development of amendments to the Virginia Water Protection Permit Regulation and General VWP Permits for Activities Impacting Wetlands.

The State Water Control Board will issue a Notice of Intended Regulatory Action for the amendments to this regulation at a later date. These amendments will incorporate changes mandated by the 2000 General Assembly in Senate Bill 648 and House Bill 1170 as well as other changes identified through the agency's periodic review of the regulation.

The TAC will meet at 9 a.m. on June 28, July 10, August 10, September 7, September 20, October 4, October 18, and October 31, 2000. (Note: See the Calendar of Events section for meeting locations.)

Interested persons should send nominations to Ellen Gilinsky, Ph.D., Virginia Water Protection Permit Program Manager, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240-0009, telephone (804) 698-4375 or FAX (804) 698-4032. Nominations must be received no later than 5 p.m. on June 5, 2000.

DEPARTMENT OF HEALTH PROFESSIONS

Notice of Periodic Review of Regulations Request for Comment

The following boards within the Department of Health Professions are conducting reviews of their regulations:

Board of Audiology and Speech-Language Pathology

18 VAC 30-20-10 et seq. Regulations Governing the Practice of Audiology and Speech-Language Pathology.

Goals of the Regulations: (i) establish continuing competency requirements and (ii) achieve positive ratings on Customer Service Satisfaction Survey for application process and renewal of licenses.

Board of Nursing

18 VAC 90-40-10 et seq. Regulations Governing Prescriptive Authority for Nurse Practitioners.

Goals of the Regulations: (i) achieve high ratings on Customer Service Satisfaction Survey for application process and renewal of licenses, (ii) review the requirements for prescriptive authority and remove unnecessary barriers to practice, and (iii) ensure submission of required documentation for prescriptive authority by physicians and licensees.

18 VAC 90-50-10 et seq. Regulations Governing the Certification of Massage Therapists.

Goals of the Regulations: (i) achieve high ratings on Customer Service Satisfaction Survey for application process and renewal of licenses, (ii) increase the number of applicants for certification to increase availability of services, and (iii) achieve a reduction in the burden of local ordinances for certified therapists.

Board of Psychology

18 VAC 125-30-10 et seq. Regulations Governing the Certification of Sex Offender Treatment Providers.

Goal of the Regulations: Ensure that persons who are certified to work in the public sector are sufficiently trained to provide services which will protect the public.

If any member of the public would like to comment on any of these regulations, please send comments by July 1, 2000, to:

Elaine J. Yeatts

Regulatory Boards Administrator
Department of Health Professions
6606 West Broad Street
Richmond, VA 23230

Comments may also be e-mailed to eyeatts@dhp.state.va.us or faxed to (804) 662-9114.

Regulations may be viewed on-line at <http://leg1.state.va.us/000/reg/TOC.HTM#T0018> or www.townhall.state.va.us or copies will be sent upon request.

STATE WATER CONTROL BOARD

Proposed Special Order Home Builders of America Corporation Greenbriar Estates Lagoon

The State Water Control Board proposes to take an enforcement action against the above listed facility. Under the terms of the proposed special order, the owner of this facility has agreed to be bound by the terms and conditions of a schedule of compliance contained in the appendix of the order. The requirements contained in the order bring the facility into compliance with state law and protect water quality.

On behalf of the State Water Control Board, the Department of Environmental Quality will receive comments relating to the special order until June 20, 2000. Comments should be addressed to Dallas Sizemore, Department of Environmental Quality, Southwest Regional office, P.O. Box 1688, Abingdon, Virginia 24212 and should refer to the consent special order.

The proposed order may be examined at the Department of Environmental Quality, 355 Deadmore Street, Abingdon, Virginia.

A copy of the order may be obtained in person or by mail from the above office.

Proposed Consent Special Order Sean Stanley d/b/a Lakewood Trailer Park

The State Water Control Board proposes to issue a consent special order to Sean Stanley, d/b/a Lakewood Trailer Park to resolve certain alleged violations of environmental laws and regulations occurring at the Lakewood Trailer Park in Halifax County, Virginia. The proposed order transfers the requirements in the November 25, 1997, order issued to the previous owner, Mr. John W. Scott to the new owner, Mr. Sean Stanley.

On behalf of the State Water Control Board, the Department of Environmental Quality will receive for 30 days from the date of publication of this notice written comments relating to the proposed consent special order. Comments should be addressed to Vernon Williams, Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Glen Allen, Virginia 23060-6295. A copy of the order may be obtained in person or by mail from the above office.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Mailing Address: 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 FAX two copies and do not follow up with a mailed copy. Our FAX number is: (804) 692-0625.

Forms for Filing Material for Publication in *The Virginia Register of Regulations*

All agencies are required to use the appropriate forms when furnishing material for publication in *The Virginia Register of Regulations*. The forms may be obtained from: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

Internet: Forms and other *Virginia Register* resources may be printed or downloaded from the *Virginia Register* web page:

<http://legis.state.va.us/codecomm/register/regindex.htm>

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 OBJECTIONS

- RR08


CALENDAR OF EVENTS

Symbol Key

-  Location accessible to persons with disabilities
 Teletype (TTY)/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) 698-1500 or Senate Information and Constituent Services at (804) 698-7410 or (804) 698-7419/TTY, or visit the General Assembly web site's Legislative Information System (<http://leg1.state.va.us/lis.htm>) and select "Meetings."

VIRGINIA CODE COMMISSION


EXECUTIVE

COMMONWEALTH COUNCIL ON AGING

May 30, 2000 - 7 p.m. -- Open Meeting
Martha Washington Inn, 150 West Main Street, Abingdon, Virginia (Interpreter for the deaf provided upon request)

A "brainstorming meeting" of the council.

Contact: Marsha Mucha, Administrative Staff Assistant, Commonwealth Council on Aging, 1600 Forest Ave., Suite 102, Richmond, VA 23229, telephone (804) 662-9312.


May 31, 2000 - 10 a.m. -- Open Meeting
Oxbow Center, 16620 East Riverside Drive, St. Paul, Virginia (Interpreter for the deaf provided upon request)

A regular business meeting.

Contact: Marsha Mucha, Administrative Staff Assistant, Commonwealth Council on Aging, 1600 Forest Ave., Suite 102, Richmond, VA 23229, telephone (804) 662-9312.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES


Virginia Aquaculture Advisory Board

† June 9, 2000 - 9 a.m. -- Open Meeting
Virginia Institute of Marine Science, Eastern Shore Lab, Conference Room (new building), Atlantic Avenue, Wachapreague, Virginia

The board will meet in its regular session to discuss issues related to Virginia aquaculture. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least five days before the meeting date so that suitable arrangements can be made.

Contact: T. Robins Buck, Secretary, Virginia Aquaculture Board, 1100 Bank St., Room 211, Richmond, VA 23219, telephone (804) 371-6094, FAX (804) 371-2945.


Virginia Cattle Industry Board

† May 22, 2000 - 10:30 a.m. -- Open Meeting
Holiday Inn, Woodrow Wilson Parkway, Staunton, Virginia

A regular meeting in which the board will approve minutes from the February 2000 meeting and review the financial statement for the period February 1 through April 30. Staff will give program updates for the state and national level. Priorities will be discussed and set for preliminary planning of the FY 00-01 marketing plan. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least five days before the meeting date so that suitable arrangements can be made.

Contact: Reginald B. Reynolds, Executive Director, Virginia Cattle Industry Board, P.O. Box 9, Daleville, VA 24083, telephone (540) 992-1992, FAX (540) 992-4632.

Virginia Charity Food Assistance Advisory Board

June 8, 2000 - 10:30 a.m. -- Open Meeting
Washington Building, 1100 Bank Street, Second Floor Board Room, Richmond, Virginia

A routine meeting to discuss issues related to food insecurity. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact Steven W. Thomas at least five days before the meeting date so that suitable arrangements can be made.

Contact: Steven W. Thomas, Executive Director, Virginia Charity Food Assistance Advisory Board, 1100 Bank St.,

Room 809, Richmond, VA 23219, telephone (804) 786-3936, FAX (804) 371-7788.

Virginia Marine Products Board

June 14, 2000 - 6 p.m. -- Open Meeting

Chesapeake Bay Prime Rib and Seafood Company, 4329 George Washington Memorial Highway, Gloucester, Virginia. ♿

A meeting to receive reports from the Executive Director on finance, marketing, past and future program planning, publicity, public relations and old and new business. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least five days before the meeting date so that suitable arrangements can be made.

Contact: Shirley Estes, Executive Director, Virginia Marine Products Board, 554 Denbigh Blvd., Suite B, Newport News, VA 23608, telephone (757) 874-3474, FAX (757) 886-0671.

Virginia Small Grains Board

† **July 27, 2000 - 8 a.m.** -- Open Meeting

Richmond Airport Hilton, 5501 Eubank Road, Sandston, Virginia ♿

The board will review FY 1999-2000 project reports and will receive 2000-2001 project proposals. Minutes from the last board meeting and a current financial statement will be heard and approved. Additionally, action will be taken on any other new business that comes before the group. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least five days before the meeting date so that suitable arrangements can be made.

Contact: Philip T. Hickman, Program Director, Virginia Small Grains Board, 1100 Bank St., Room 1005, Richmond, VA 23219, telephone (804) 371-6157, FAX (804) 371-7786.

STATE AIR POLLUTION CONTROL BOARD

June 14, 2000 - 9 a.m. -- Public Hearing

Main Street Centre, 600 East Main Street, Lower Level Conference Room, Richmond, Virginia.

July 7, 2000 - Public 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 Air Pollution Control Board intends to amend regulations entitled: **9 VAC 5-60-10 et seq. Hazardous Air Pollutant Sources**, and **9 VAC 5-80-10 et seq. Permits for Stationary Sources**. The regulation amendments concern provisions covering federal operating

permits and can be summarized as falling primarily into seven categories. The proposed amendments (i) remove deficiencies that prevent full federal approval for Virginia's Title V program; (ii) support commitments made in a letter of February 27, 1997, from the DEQ director to EPA's Region III administrator amending previous program submittals; (iii) incorporate guidance from EPA's White Papers of July 1995 and March 1996; (iv) clarify applicable state requirements; (v) bring the acid rain program into conformity with federal regulations; (vi) incorporate provisions relating to the new federal Compliance Assurance Monitoring (CAM) rule; and (vii) incorporate provisions relating to § 112(j) of the federal Clean Air Act.

Request for Comments: The purpose of this notice is to provide the public with the opportunity to comment on the proposed regulation and the costs and benefits of the proposal.

Localities Affected: There is no locality which will bear any identified disproportionate material air quality impact due to the proposed regulation which would not be experienced by other localities.

Location of Proposal: The proposal, an analysis conducted by the department (including a statement of purpose, a statement of estimated impact and benefits of the proposed regulation, an explanation of need for the proposed regulation, an estimate of the impact of the proposed regulation upon small businesses, identification of and comparison with federal requirements, and a discussion of alternative approaches) and any other supporting documents may be examined by the public at the department's Office of Air Regulatory Development (Eighth Floor), 629 East Main Street, Richmond, Virginia, and the department's regional offices (listed below) between 8:30 a.m. and 4:30 p.m. of each business day until the close of the public comment period.

Abingdon Regional Office
Department of Environmental Quality
355 Deadmore Street
Abingdon, Virginia
Ph: (540) 676-4800

Roanoke Regional Office
Department of Environmental Quality
3019 Peters Creek Road, Suite D
Roanoke, Virginia
Ph: (540) 562-6700

Lynchburg Satellite Office
Department of Environmental Quality
7705 Timberlake Road
Lynchburg, Virginia
Ph: (804) 582-5120

Harrisonburg Regional Office
Department of Environmental Quality
116 North Main Street
Bridgewater, Virginia 22812
Ph: (540) 828-2595

Calendar of Events

Fredericksburg Satellite Office
Department of Environmental Quality
806 Westwood Office Park
Fredericksburg, Virginia
Ph: (540) 899-4600

Woodbridge Regional Office
Department of Environmental Quality
1549 Old Bridge Road, Suite 108
Woodbridge, Virginia
Ph: (703) 490-8922

Piedmont Regional Office
Department of Environmental Quality
4949-A Cox Road
Glen Allen, Virginia
Ph: (804) 527-5020

Tidewater Regional Office
Department of Environmental Quality
5636 Southern Boulevard
Virginia Beach, Virginia
Ph: (757) 518-2000
Statutory Authority: § 10.1-1308 of the Code of Virginia.

Public comments may be submitted until 4:30 p.m., July 7, 2000, to the Director, Office of Air Regulatory Development, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240.

Contact: Kathleen Sands, Ph.D., Policy Analyst, Office of Air Regulatory Development, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4413, FAX (804) 698-4510, toll-free 1-800-592-5482, or (804) 698-4021/TTY ☎

ALCOHOLIC BEVERAGE CONTROL BOARD

May 22, 2000 - 9:30 a.m. -- Open Meeting
Department of Alcoholic Beverage Control, 2901 Hermitage Road, Richmond, Virginia. ♿

A meeting to receive reports from staff members, discuss activities, and discuss other matters not yet determined.

Contact: W. Curtis Coleburn, Secretary to the Board, Department of Alcoholic Beverage Control, 2901 Hermitage Rd., P.O. Box 27491, Richmond, VA 23261, telephone (804) 213-4409 or FAX (804) 213-4442.

COMPREHENSIVE SERVICES FOR AT-RISK YOUTH AND THEIR FAMILIES

State Executive Council

May 31, 2000 - 9 a.m. -- Open Meeting
June 28, 2000 - 9 a.m. -- Open Meeting
Department of Social Services, 730 East Broad Street, Richmond, Virginia.

A monthly meeting to discuss interagency programmatic and fiscal policies, oversee the administration of funds appropriated under the Act, and advise the Governor.

Contact: Alan G. Saunders, Director, Office of Comprehensive Services, Department of Social Services, Wythe Building, 1604 Santa Rosa Road, Suite 137, Richmond, VA 23229, telephone (804) 662-9815, FAX (804) 662-9831, e-mail ags992@central.dss.state.va.us.

BOARD FOR BARBERS

June 19, 2000 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 5th Floor, Richmond, Virginia ♿ (Interpreter for the deaf provided upon request)

A meeting to discuss regulatory review and other matters requiring board action, including disciplinary cases. A public comment period will be held at the beginning of the meeting. All meetings are subject to cancellation. The time of the meeting is subject to change. Any person desiring to attend the meeting and requiring special accommodations or interpreter services should contact the department at 804-367-8590 or 804-367-9753/TTY at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Nancy Taylor Feldman, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8590, FAX (804) 367-6295, (804) 367-9753/TTY ☎, e-mail barbers@dpor.state.va.us.

COMPENSATION BOARD

May 23, 2000 - 11 a.m. -- Open Meeting
Compensation Board, 202 North 9th Street, 10th Floor, Richmond, Virginia. ♿

A monthly board meeting.

Contact: Cindy P. Waddell, Administrative Staff Assistant, Compensation Board, P.O. Box 710, Richmond, VA 23218, telephone (804) 786-0786, FAX (804) 371-0235, e-mail cwaddell@scb.state.va.us.

DEPARTMENT OF CONSERVATION AND RECREATION


Virginia Agricultural BMP Implementation Advisory Committee

July 6, 2000 - 9:30 a.m. -- Open Meeting
Department of Forestry, 900 Natural Resources Drive, Charlottesville, Virginia. ♿ (Interpreter for the deaf provided upon request)

A quarterly meeting. Request for interpreter for the deaf should be filed with the department two weeks prior to the meeting.

Contact: Dana R. Bayless, Agricultural Incentives Program Manager, Department of Conservation and Recreation, 203 Governor St., Richmond, VA 23219, telephone (804) 371-7330, e-mail drbayless@dcr.state.va.us.


Chippokes Plantation Farm Foundation

† **May 31, 2000 - 1:30 p.m.** -- Open Meeting
Chippokes Plantation State Park, Mansion, Conference Room 695, Chippokes Park Road, Surry, Virginia.  (Interpreter for the deaf provided upon request)

The Fund Raising Committee will discuss the job description for a new position. Requests for an interpreter for the deaf must be filed with the state park at least two weeks prior to the meeting.

Contact: Katherine Wright, Executive Secretary, Department of Conservation and Recreation, 203 Governor St., Richmond, VA 23219, telephone (804) 786-7930, FAX (804) 371-8500, e-mail krwright@dcr.state.va.us.


Board on the Conservation and Development of Public Beaches

May 22, 2000 - 10 a.m. -- Open Meeting
Virginia Institute of Marine Science, Watermans Hall, Director's Conference Room, Gloucester Point, Virginia.  (Interpreter for the deaf provided upon request)

The board will review requests from localities for matching grant funds, accept public comments about the management and conservation of public beaches, and on May 4, tour the Norfolk public beaches. Requests for an interpreter for the deaf should be filed at least two weeks prior to the meeting.


Contact: Lee Hill, Environmental Engineer, Department of Conservation and Recreation, 203 Governor St., Richmond, VA 23219, telephone (804) 786-3998, e-mail leehill@dcr.state.va.us.

BOARD FOR CONTRACTORS


† **June 7, 2000 - 9 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regularly scheduled meeting of the board to address policy and procedural issues, review and render case decisions on matured complaints against licensees, and discuss other matters which may require board action. The meeting is open to the public, however, a portion of the board's business may be discussed in a closed meeting. The department fully complies with the Americans with Disabilities Act. Persons desiring to participate in the meeting and who require special

accommodations or interpreter services should contact Kelley L. Hellams.

Contact: Mrs. Kelley L. Hellams, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail contractors@dpor.state.va.us.


Tradesman Committee

† **May 23, 2000 - 10 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Conference Room 4W, Richmond, Virginia.  (Interpreter for the deaf provided upon request)


A regular meeting of the committee to consider items of interest relating to tradesmen/backflow workers/natural gas fitters and other appropriate matters relating to the tradesman section of the Board for Contractors.

Contact: Robert F. Tortolani, Administrator, Department of Professional and Occupational Regulation, 3600 W. Broad St., Department of Professional and Occupational Regulation, Richmond, VA 23230, telephone (804) 367-2607, FAX (804) 367-2474.

BOARD FOR COSMETOLOGY

June 19, 2000 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 5th Floor, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting to discuss regulatory review and other matters requiring board action, including disciplinary cases. A public comment period will be held at the beginning of the meeting. All meetings are subject to cancellation. The time of the meeting is subject to change. Any person desiring to attend the meeting and requiring special accommodations or interpreter services should contact the department at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Nancy Taylor Feldman, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8590, FAX (804) 367-6295, (804) 367-9753/TTY , e-mail cosmo@dpor.state.va.us.

BOARD OF DENTISTRY

May 26, 2000 - 9:30 a.m. -- Open Meeting
June 13, 2000 - 1:30 p.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, Virginia. 

Calendar of Events

An informal conference committee will convene to hear possible violations of the regulations governing the practice of dentistry. No public comment will be heard.

Contact: Marcia J. Miller, Executive Director, Board of Dentistry, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9906, FAX (804) 662-9943, (804) 662-7197/TTY ☎, e-mail mmiller@dhp.state.va.us.

VIRGINIA ECONOMIC DEVELOPMENT PARTNERSHIP

† **May 23, 2000 - 9:30 a.m.** -- Open Meeting
Virginia Economic Development Partnership, 901 East Byrd Street, Riverfront Plaza, West Tower, 19th Floor, Presentation Center, Richmond, Virginia. ♿

A meeting of the Personnel Committee to review personnel policies and compensation for the Virginia Economic Development Partnership.

Contact: Kimberly M. Ellett, Administrative Assistant, Virginia Economic Development Partnership, P.O. Box 798, Richmond, VA 23218-0798, telephone (804) 371-8108 or FAX (804) 371-8112.

† **May 23, 2000 - 11 a.m.** -- Open Meeting
Virginia Economic Development Partnership, 901 East Byrd Street, Riverfront Plaza, West Tower, 19th Floor, Presentation Center, Richmond, Virginia. ♿

A meeting of the Board of Directors to discuss issues pertaining to the Virginia Economic Development Partnership.

Contact: Kimberly M. Ellett, Administrative Assistant, Virginia Economic Development Partnership, P.O. Box 798, Richmond, VA 23218-0798, telephone (804) 371-8108 or FAX (804) 371-8112.

BOARD OF EDUCATION

May 25, 2000 - 9 a.m. -- Open Meeting
Cultural Arts Center, 2880 Mountain Road, Glen Allen, Virginia. ♿ (Interpreter for the deaf provided upon request)

A summit for the fine arts. Persons requesting interpreter services are requested to do so in advance.

Contact: Dr. Margaret N. Roberts, Office of Policy, Department of Education, Monroe Building, 101 North 14th Street, 25th Floor, P.O. Box 2120, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524 or toll-free (800) 292-3829, e-mail mroberts@mail.vak12ed.edu.

May 26, 2000 - 9 a.m. -- Open Meeting
Cultural Arts Center, 2880 Mountain Road, Glen Allen, Virginia. ♿ (Interpreter for the deaf provided upon request)

A regular business meeting. Persons requesting interpreter services are requested to do so in advance.

The Board of Education seeks public comment on the proposed Standards of Learning for computer/technology

to be completed by grade 12. The purpose of the standards is to ensure mastery of skills that will result in students who are both computer literate and competent in application of skills. Proposal may be viewed at www.pen.k12.va.us. Written comments were received until May 12, 2000.

Contact: Dr. Margaret N. Roberts, Office of Policy, Department of Education, Monroe Building, 101 North 14th Street, 25th Floor, P.O. Box 2120, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524 or toll-free (800) 292-3829, e-mail mroberts@mail.vak12ed.edu.

LOCAL EMERGENCY PLANNING COMMITTEE - ALEXANDRIA

† **June 7, 2000 - 4 p.m.** -- Open Meeting
Lee Center Training Academy, 1108 Jefferson Street, Alexandria, Virginia. ♿ (Interpreter for the deaf provided upon request)

A meeting with committee members and facility emergency coordinators to conduct business in accordance with SARA Title III, Emergency Planning and Community Right-To-Know Act of 1986.

Contact: Charles McRorie, Coordinator, Local Emergency Planning Committee, P.O. Box 178, Alexandria, VA 22313, telephone (703) 838-3825 or (703) 838-5056/TTY ☎

LOCAL EMERGENCY PLANNING COMMITTEE - GLOUCESTER

May 24, 2000 - 6:30 p.m. -- Open Meeting
Gloucester Courthouse Office Building, 6467 Main Street, Gloucester, Virginia. ♿

A meeting to discuss training opportunities, review the public information campaign, and appoint a nominating committee.

Contact: Georgette N. Hurley, Assistant County Administrator, Gloucester County Administrator's Office, P.O. Box 329, Gloucester, VA 23061, telephone (804) 693-4042 or (804) 693-1476/TTY ☎


LOCAL EMERGENCY PLANNING COMMITTEE - WINCHESTER

† **June 7, 2000 - 3 p.m.** -- Open Meeting
Shawnee Fire Department, 2333 Roosevelt Boulevard, Winchester, Virginia. ♿

A regular quarterly business meeting.


Contact: L. A. Miller, Fire and Rescue Chief, Winchester Fire and Rescue Department, 126 N. Cameron St., Winchester, VA 22601, telephone (540) 662-2298 or (540) 662-4131/TTY ☎

DEPARTMENT OF ENVIRONMENTAL QUALITY

May 23, 2000 - 10:30 a.m. -- Open Meeting
Department of Transportation, 86 Deacon Road,
Fredericksburg, Virginia. 


The Department of Environmental Quality, in cooperation with the Department of Conservation and Recreation and other state agencies, is developing a water quality management plan (WQMP) for the Rappahannock River Basin. WQMPs are required by §§ 208 and 303(e) of the federal Clean Water Act. This will be the first meeting of the Rappahannock River Basin Advisory Committee. The state's planning process will be explained and an outline of the plan will be discussed.

Contact: Dr. Kultar Singh, Environmental Engineer Senior, Department of Environmental Quality, 13901 Crown Court, Woodbridge, VA 22193, telephone (703) 583-3848, FAX (703) 583-3841, e-mail ksingh@deq.state.va.us.

† May 23, 2000 - 7 p.m. -- Open Meeting
Bedford Elementary School Gym, 806 Burkshill Road,
Bedford, Virginia. 

The second public meeting to receive comments on the development of a Total Maximum Daily Load for fecal coliform bacteria on five segments of the Otters located in Bedford and Campbell Counties.


Contact: Clint Boschen, Department of Environmental Quality, 3019 Peters Creek Rd., Roanoke, VA 24019, telephone (540) 562-6724, FAX (540) 562-6729, e-mail cjboschen@deq.state.va.us.

† May 24, 2000 - 7 p.m. -- Public Hearing
Radford City Council Chambers, 619 Second Street, Radford,
Virginia. 

A public hearing to receive comments on the issuance of a state operating permit under the State Air Pollution Control Law for emissions at the facility.

Contact: Steven Dietrich, Department of Environmental Quality, 3019 Peter's Creek Rd., Roanoke, VA 24019, telephone (540) 562-6762, e-mail sadietrich@deq.state.va.us.


Virginia Pollution Prevention Advisory Committee

May 25, 2000 - 10 a.m. -- Open Meeting
Department of Environmental Quality, Piedmont Regional
Office, 4949-A Cox Road, Glen Allen, Virginia. 


A meeting to discuss the voluntary pollution prevention program.

Contact: Sharon K. Baxter, Pollution Prevention Manager, Department of Environmental Quality, 629 East Main Street, Richmond, VA 23221, telephone (804) 698-4344 or toll-free 1-800-592-5482.


Technical Advisory Committee

June 6, 2000 - 10 a.m. -- Open Meeting
Department of Environmental Quality, Piedmont Regional
Office, 4949-A Cox Road, Training Room, Richmond,
Virginia.  (Interpreter for the deaf provided upon request)

A meeting to discuss possible amendments to the Regulations for the Development of Solid Waste Management Plans (9 VAC 20-130-10 et seq.).

Contact: Robert G. Wickline, Waste Operations Division, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240-0009, telephone (804) 698-4213, toll-free 1-800-592-5482 or (804) 698-4021/TTY 


Water Resources Committee

† June 5, 2000 - 2 p.m. -- Open Meeting
Department of Environmental Quality, 629 East Main Street,
Richmond, Virginia. 


A meeting of the Water Resources Committee which assists the department in meeting its mandates under the State Water Control Law, the federal Clean Water Act, and applicable state and federal regulations by reviewing and commenting on issues which could be incorporated into staff guidance documents or operating procedures.

Contact: Alan E. Pollock, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4002, FAX (804) 698-4319, e-mail aeapollock@deq.state.va.us.


BOARD OF FORESTRY

May 23, 2000 - 8:30 a.m. -- Open Meeting
Virginia Tech, School of Natural Resources, Blacksburg,
Virginia.  (Interpreter for the deaf provided upon request)

A general business meeting. Those requiring special accommodations to participate in this meeting or an interpreter for the deaf should notify the Department of Forestry five working days prior to the meeting.

Contact: Donna S. Hoy, Administrative Staff Specialist, Board of Forestry, 900 Natural Resources Dr., Suite 800, Charlottesville, VA 22903, telephone (804) 977-6555, FAX (804) 977-7749, (804) 977-6555/TTY , e-mail hoyd@dof.state.va.us.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

May 30, 2000 - 9 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street,
5th Floor, Conference Room 2, Richmond, Virginia. 

A meeting to consider legislative and regulatory agenda items and other matters as may come before it.

Contact: Elizabeth Young Tisdale, Executive Director, Board of Funeral Directors and Embalmers, 6606 W. Broad St., 4th

Calendar of Events

Floor, Richmond, VA 23230, telephone (804) 662-9907, FAX (804) 662-9523, (804) 662-7197/TTY ☎, e-mail etisdale@dhp.state.va.us.

† **June 21, 2000 - 2 p.m.** -- Public Hearing
Richmond Marriott, 500 East Broad Street, Richmond, Virginia ♿

The board will conduct a public hearing on legislative proposals to be adopted at the meeting on May 30, 2000. To receive a copy of the legislative proposals, contact the board after June 1.

Contact: Elizabeth Young Tisdale, Executive Director, Board of Funeral Directors and Embalmers, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9907, FAX (804) 662-9523, (804) 662-7197/TTY ☎, e-mail etisdale@dhp.state.va.us.

BOARD OF GAME AND INLAND FISHERIES

June 1, 2000 - 9 a.m. -- Open Meeting
Department of Game and Inland Fisheries, 4000 West Broad Street, Richmond, Virginia ♿ (Interpreter for the deaf provided upon request)

A meeting to address the Department of Game and Inland Fisheries' Fiscal Year 2000-2001 operating and capital budgets and discuss general and administrative issues. The board may elect to hold a dinner Wednesday evening, May 31, at a location and time to be determined.

Contact: Phil Smith, Policy Analyst and Regulatory Coordinator, Board of Game and Inland Fisheries, 4010 W. Broad St., Richmond, VA 23230, telephone (804) 367-1000, FAX (804) 367-0488, e-mail dgifweb@dgif.state.va.us.

DEPARTMENT OF HEALTH PROFESSIONS

June 9, 2000 - 9 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Room 1, Richmond, Virginia ♿ (Interpreter for the deaf provided upon request)

The committee will meet with its contractor and representatives to review reports, policies, and procedures for the Health Practitioner's Intervention Program. The committee will meet in open session for general discussion of the program. The committee may meet in executive session to consider specific requests from applicants or participants in the program.

Contact: John W. Hasty, Director, Health Practitioner's Intervention Program, Department of Health Professions, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9424, FAX (804) 662-9114 or (804) 662-7197/TTY ☎

HISTORIC RESOURCES BOARD AND STATE REVIEW BOARD

† **June 14, 2000 - 10 a.m.** -- Open Meeting
Appomattox Regional Governor's School, 512 West Washington Street, Petersburg, Virginia ♿

A quarterly meeting to consider completed and proposed reports for the National Register of Historic Places and the Virginia Landmarks Register, easements and highway markers.

Contact: Marc C. Wagner, National Register Manager, Department of Historic Resources, 2801 Kensington Ave., Richmond, VA 23221, telephone (804) 367-2323 ext. 115, FAX (804) 367-2391 or (804) 367-2386/TTY ☎

HOPEWELL INDUSTRIAL SAFETY COUNCIL

June 6, 2000 - 9 a.m. -- Open Meeting
† **July 11, 2000 - 9 a.m.** -- Open Meeting
† **August 1, 2000 - 9 a.m.** -- Open Meeting
† **September 5, 2000 - 9 a.m.** -- Open Meeting
Hopewell Community Center, 100 West City Point Road, Hopewell, Virginia ♿ (Interpreter for the deaf provided upon request)

Local Emergency Preparedness Committee meeting as required by SARA Title III.

Contact: Robert Brown, Emergency Services Coordinator, 300 N. Main St., Hopewell, VA 23860, telephone (804) 541-2298.

INNOVATIVE TECHNOLOGY AUTHORITY

May 24, 2000 - 10 a.m. -- Open Meeting
University of Virginia Medical Center, Jordan Hall, Meeting Room 1, Charlottesville, Virginia ♿

A Board of Director's meeting to vote on the assignment of the floor area ration (FAR) to the authority's land donor.

Contact: Linda E. Gentry, Secretary, Innovative Technology Authority, 2214 Rock Hill Rd., Suite 600, Herndon, VA 20170, telephone (703) 689-3035 or FAX (703) 464-1706.

VIRGINIA INTERAGENCY COORDINATING COUNCIL


June 14, 2000 - 9:30 a.m. -- Open Meeting
Henrico Area Community Services Board, 10299 Woodman Road, Building B, Conference Room C, Glen Allen, Virginia ♿ (Interpreter for the deaf provided upon request)

The council meets quarterly to advise and assist the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services as lead agency for Part C (of IDEA), early intervention for infants and toddlers with disabilities and their families. Discussion will focus on issues related to Virginia's implementation of the Part C program.


Contact: LaKeishia L. White, Part C Office Services Specialist, Department of Mental Health, Mental Retardation and Substance Abuse Services, Early Intervention, 9th Floor, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 786-3710 or FAX (804) 371-7959.

DEPARTMENT OF LABOR AND INDUSTRY


Virginia Apprenticeship Council

June 15, 2000 - 10 a.m. -- Open Meeting
University of Virginia, Emmet Street, Newcomb Hall, South Meeting Room, 3rd Floor, Charlottesville, Virginia. 
(Interpreter for the deaf provided upon request)


A regular quarterly meeting.


Contact: Beverley Donati, Assistant Program Manager, Department of Labor and Industry, Powers-Taylor Bldg., 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-2382, FAX (804) 786-8418, (804) 786-2376/TTY , e-mail bgd@doli.state.va.us.

COMMISSION ON LOCAL GOVERNMENT


† May 30, 2000 - 10:30 a.m. -- Open Meeting
Clifton Forge Fire Department, 701 Church Street, Clifton Forge, Virginia  (Interpreter for the deaf provided upon request)

Oral presentations regarding the City of Clifton Forge - County of Alleghany Proposed Voluntary Settlement of Town Status Issues.

Contact: Barbara W. Bingham, Administrative Assistant, Commission on Local Government, 900 E. Main St., Suite 103, Richmond, VA 23219-3513, telephone (804) 786-6508, FAX (804) 371-7999, (800) 828-1120/TTY , e-mail bbingham@clg.state.va.us.


† May 30, 2000 - 7 p.m. -- Public Hearing
Clifton Middle School, 724 Commercial Avenue, Auditorium, Clifton Forge, Virginia.  (Interpreter for the deaf provided upon request)

A public hearing to consider the City of Clifton Forge's proposed reversion to a town in Alleghany County. Persons desiring to participate in the commission's proceedings and requiring special accommodations or interpreter services should contact the commission's offices at (804) 786-6508 or the Virginia Relay Center at (800) 828-1120.


Contact: Barbara W. Bingham, Administrative Assistant, Commission on Local Government, 900 E. Main St., Suite 103, Richmond, VA 23219-3513, telephone (804) 786-6508, FAX (804) 371-7999, (800) 828-1120/TTY , e-mail bbingham@clg.state.va.us.

† May 31, 2000 - 9 a.m. -- Open Meeting
Clifton Forge, Virginia, site to be determined.

A regular meeting of the commission to consider such matters as may be presented. Persons desiring to participate in the commission's proceedings and requiring special accommodations or interpreter services should contact the commission's offices at (804) 786-6508 or the Virginia Relay Center at (800) 828-1120.

Contact: Barbara W. Bingham, Administrative Assistant, Commission on Local Government, Pocahontas Building, 900 E. Main St., Suite 103, Richmond, VA 23219-3513, telephone (804) 786-6508, FAX (804) 371-7999, (800) 828-1120/TTY , e-mail bbingham@clg.state.va.us.

MARINE RESOURCES COMMISSION

May 23, 2000 - 9:30 a.m. -- Open Meeting
June 27, 2000 - 9:30 a.m. -- Open Meeting
Marine Resources Commission, 2600 Washington Avenue, Room 403, Newport News, Virginia.  (Interpreter for the deaf provided upon request)

The commission will hear and decide the following marine environmental matters beginning 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; and policy and regulatory issues. The commission will hear and decide the following fishery management items beginning at approximately noon: regulatory proposals, fishery management plans, fishery conservation issues, licensing, and shellfish leasing. Meetings are open to the public. Testimony will be taken under oath from parties addressing agenda items on permits and licensing. Public comments will be taken on resource matters, regulatory issues and items scheduled for public hearing.

Contact: LaVerne Lewis, Secretary to the Commission, Marine Resources Commission, P.O. Box 756, Newport News, VA 23607-0756, telephone (757) 247-2261, toll-free 1-800-541-4646 or (757) 247-2292/TTY 

BOARD OF MEDICAL ASSISTANCE SERVICES

June 13, 2000 - 10 a.m. -- Open Meeting
Department of Medical Assistance Services, 600 E. Broad Street, Richmond, Virginia. 


A regular meeting.

Contact: Leah D. Hamaker, Board Liaison, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-4626 or FAX (804) 371-4981.

Calendar of Events

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES


Pharmacy Liaison Committee

June 26, 2000 - 1 p.m. -- Open Meeting
Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Board Room, Richmond, Virginia. 


A meeting to conduct regular business.

Contact: Marianne Rollings, R.Ph., Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 225-4268, FAX (804) 786-1680, (800) 343-0634/TTY , e-mail mrollings@dmas.state.va.us.

BOARD OF MEDICINE

June 8, 2000 - 8 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, Conference Room 2, 5th Floor, Richmond, Virginia. 


A meeting to review public participation guidelines regulations and to consider other items as may come before it. Public comment will be received at the beginning of the meeting.

Contact: William L. Harp, M.D., Executive Director, Board of Medicine, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9908, FAX (804) 662-9943, (804) 662-7197/TTY , e-mail wharp@dhp.state.va.us.

Informal Conference Committee

July 13, 2000 - 9 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, Richmond, Virginia.

A meeting to inquire into allegations that certain practitioners may have violated laws and regulations governing the practice of medicine and other healing arts in Virginia. The committee will meet in open and closed sessions pursuant to § 2.1-344 of the Code of Virginia. Public comment will not be received.


Contact: Peggy Sadler or Renee Dixon, Board of Medicine, 6606 West Broad Street, 4th Floor, Richmond, VA 23230, telephone (804) 662-7332, FAX (804) 662-9517, (804) 662-7197/TTY 

Legislative Committee

May 26, 2000 - 1 p.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Richmond, Virginia.  (Interpreter for the deaf provided upon request)


A meeting to discuss legislative issues related to board activities and regulations, to review any pending regulations pursuant to regulatory review or legislative

action, and to consider any other information that may come before the committee. The committee will entertain public comments during the first 15 minutes on agenda items.

Contact: William L. Harp, M.D., Executive Director, Board of Medicine, Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9960, FAX (804) 662-9517 or (804) 662-7197/TTY 

DEPARTMENT OF MINES, MINERALS AND ENERGY


Coal Mine Safety Board

† May 25, 2000 - 9 a.m. -- Open Meeting
Department of Mines, Minerals and Energy, U.S. Route 23 South, Buchanan-Smith Building, Room 219 (next to Mountain Empire Community College), Big Stone Gap, Virginia.  (Interpreter for the deaf provided upon request)


A meeting to address general board business and to discuss proposed changes to 4 VAC 25-90-10 et seq., Rules and Regulations Governing the Use of Diesel Powered Equipment in Underground Coal Mines.


Contact: Frank Linkous, Mine Chief, Department of Mines, Minerals and Energy, US Route 23 South, Big Stone Gap, VA 24219, telephone (540) 523-8100, FAX (540) 523-8239, (800) 828-1120/TTY , e-mail fal@mme.state.va.us.

BOARD OF NURSING

May 25, 2000 - 10 a.m. -- Open Meeting
Arlington Circuit Court, 1425 North Courthouse Road, 11th Floor, Courtroom B, Arlington, Virginia. 

A panel of the board will conduct formal hearings with licensees and certificate holders. Public comment will not be received.

Contact: Nancy K. Durrett, R.N., Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY , e-mail nursebd@dhp.state.va.us.

† June 5, 2000 - 8:30 a.m. -- Open Meeting
† June 6, 2000 - 8:30 a.m. -- Open Meeting
† June 8, 2000 - 8:30 a.m. -- Open Meeting
† June 14, 2000 - 8:30 a.m. -- Open Meeting
† June 15, 2000 - 8:30 a.m. -- Open Meeting
† June 19, 2000 - 8:30 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 3, Richmond, Virginia. 

A Special Conference Committee, comprised of two or three members of the Virginia Board of Nursing, will conduct informal conferences with licensees or certificate holders. Public comment will not be received.

Contact: Nancy K. Durrett, R.N., Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY ☎, e-mail nursebd@dhp.state.va.us.

BOARD OF NURSING HOME ADMINISTRATORS

† **June 7, 2000 - 10 a.m.** -- Open Meeting
Department of Health Professions, 6606 W. Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia ♿

An informal hearing will be held in accordance with § 9-6.14:11 of the Code of Virginia. No public comments will be heard.

Contact: Senita Booker, Administrative Staff Assistant, Board of Nursing Home Administrators, 6606 W. Broad St., Suite 403, Richmond, VA 23230-1717, telephone (804) 662-9111, FAX (804) 662-9523, (804) 662-7197/TTY ☎, e-mail sbooker@dhp.state.va.us.

BOARD FOR OPTICIANS

June 9, 2000 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 5th Floor, Richmond, Virginia ♿
(Interpreter for the deaf provided upon request)

An open meeting to discuss regulatory review and other matters requiring board action, including disciplinary cases. A public comment period will be held at the beginning of the meeting. All meetings are subject to cancellation. The time of the meeting is subject to change. Any persons desiring to attend the meeting and requiring special accommodations or interpretative services should contact the department at 804-367-8590 or 804-367-9753/TTY at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Nancy Taylor Feldman, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., 4th Floor, Richmond, VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-6295, (804) 367-9753/TTY ☎, e-mail opticians@dpor.state.va.us.

VIRGINIA OUTDOORS FOUNDATION

Open Space Land Preservation Trust Fund Region II

May 22, 2000 - 10:30 a.m. -- Open Meeting
Woodstock Town Hall, Conference Room, Woodstock, Virginia ♿

A quarterly meeting of the Region II Advisory Board of the Open Space Land Preservation Trust Fund to review project proposals.

Contact: Faye Cooper, Conservation Easement Specialist, Virginia Outdoors Foundation, 11 East Beverley St., Staunton, VA 24401, telephone (540) 886-2460, FAX (540) 886-2464.

Preservation Trust Fund Advisory Board - Region II

May 24, 2000 - 10 a.m. -- Open Meeting
Culpeper County Office Building, Board of Supervisor's Meeting Room, Culpeper, Virginia.

The Region II Advisory Board will meet to conduct the business of the board, review applications received for funding under the Open Space Lands Preservation Trust Fund, and make recommendations. Public comment will be received after the conclusion of the regular business meeting.

Contact: Sherry Buttrick, Director, Charlottesville Office, Virginia Outdoors Foundation, 1010 Harris St., Room 4, Charlottesville, VA 22903, telephone (804) 293-3423, FAX (804) 293-3859, e-mail vofsherryb@aol.com.

Preservation Trust Fund Advisory Board - Region V

May 31, 2000 - 10:30 a.m. -- Open Meeting
Lynchburg Chamber of Commerce, Conference Room, Lynchburg, Virginia.

A meeting to review requests for Region V applications.

Contact: Sherry Buttrick, Virginia Outdoors Foundation, 1010 Harris St., Room 4, Charlottesville, VA 22903, telephone (804) 293-3423, FAX (804) 293-3859, e-mail vofsherryb@aol.com.

VIRGINIA BOARD FOR PEOPLE WITH DISABILITIES

May 31, 2000 - 9 a.m. -- Open Meeting
Library of Virginia, 800 East Broad Street, Lobby Level, Richmond, Virginia ♿ (Interpreter for the deaf provided upon request)

A meeting of the Executive Committee.

Contact: Tom Ariail, Jr., Assistant Director of Board Operations, Virginia Board for People with Disabilities, Ninth Street Office Building, 202 N. 9th St., 9th Floor, Richmond, VA 23219, telephone (804) 786-0016, FAX (804) 786-1118, toll-free 1-800-846-4464 or (804) 786-0016/TTY ☎


June 1, 2000 - 9 a.m. -- Open Meeting
Library of Virginia, 800 East Broad Street, Lobby Level, Richmond, Virginia ♿ (Interpreter for the deaf provided upon request)

A quarterly meeting.


Contact: Tom Ariail, Jr., Assistant Director of Board Operations, Virginia Board for People with Disabilities, Ninth Street Office Building, 202 N. 9th St., 9th Floor, Richmond, VA 23219, telephone (804) 786-0016, FAX (804) 786-1118, toll-free 1-800-846-4464 or (804) 786-0016/TTY ☎

Calendar of Events


BOARD OF PHARMACY

† **June 13, 2000 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street,
Fifth Floor, Conference Room 2, Richmond, Virginia. 


The board will consider the strategy plan arising from the April workshop, adopt emergency regulations for pilot projects and regulations for radiopharmaceuticals, and consider other agenda items as may be presented. Public comment will be received at the beginning of the meeting.

Contact: Elizabeth Scott Russell, R.Ph., Executive Director, Board of Pharmacy, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9911, FAX (804) 662-9313, (804) 662-7197/TTY , e-mail erussell@dhp.state.va.us.


Regulatory/Legislative Committee

† **May 25, 2000 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street,
Fifth Floor, Conference Room 3, Richmond, Virginia. 


A meeting of the committee to review issues relating to the practice of pharmacy arising from the board workshop, recommend priorities and a plan of action, and recommend certain changes to regulations based on legislation passed by the 2000 Session of the General Assembly.

Contact: Elizabeth Scott Russell, RPh, Executive Director, Board of Pharmacy, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9911, FAX (804) 662-9313, (804) 662-7197/TTY , e-mail erussell@dhp.state.va.us.


POLYGRAPH EXAMINERS ADVISORY BOARD

June 13, 2000 - 10 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, 4th Floor, Richmond, Virginia. 
(Interpreter for the deaf provided upon request)


An open meeting to discuss regulatory review and other matters requiring board action, including disciplinary cases. A public comment period will be held at the beginning of the meeting. All meetings are subject to cancellation. The time of the meeting is subject to change. Any persons desiring to attend the meeting and requiring special accommodations or interpretative services should contact the department at 804-367-8590 or 804-367-9753/TTY at least 10 days prior to the meeting so that suitable arrangements can be made for an appropriate accommodation. The department fully complies with the Americans with Disabilities Act.

Contact: Nancy Taylor Feldman, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8590, FAX (804) 367-6295, (804) 367-9753/TTY , e-mail polygraph@dpor.state.va.us.


BOARD OF PSYCHOLOGY

† **May 23, 2000 - 10 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street,
Fifth Floor, Conference Room 1, Richmond, Virginia. 


An informal Conference to hear compliance with the board's order. No public comment will be heard.


Contact: Arnice N. Covington, Administrative Assistant, Board of Psychology, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9913, FAX (804) 662-9943, (804) 662-7197/TTY , e-mail acovington@dhp.state.va.us.

VIRGINIA PUBLIC GUARDIAN AND CONSERVATOR ADVISORY BOARD


† **June 22, 2000 - 11 a.m.** -- Open Meeting
Department for the Aging, 1600 Forest Avenue, Conference
Room, Richmond, Virginia.  (Interpreter for the deaf
provided upon request)

A meeting of the Bylaws Committee to discuss proposed changes to the bylaws.

Contact: Kimlah Hyatt, Administrative Staff Assistant, 1600 Forest Ave., Suite 102, Richmond, VA 23229, telephone (804) 662-9318, FAX (804) 662-9354, (804) 662-9333/TTY , or e-mail: khyatt@vdh.state.va.us.

† **September 18, 2000 - 11 a.m.** -- Open Meeting
Department for the Aging, 1600 Forest Avenue, Conference
Room, Richmond, Virginia.  (Interpreter for the deaf
provided upon request)

A regular quarterly meeting.


Contact: Kimlah Hyatt, Administrative Staff Assistant, 1600 Forest Ave., Suite 102, Richmond, VA 23229, telephone (804) 662-9318, FAX (804) 662-9354, (804) 662-9333/TTY , or e-mail: khyatt@vdh.state.va.us.

VIRGINIA RACING COMMISSION

† **May 24, 2000 - 9:30 a.m.** -- Open Meeting
Tyler Building, 1300 East Main Street, Richmond, Virginia. 

A monthly meeting, including a segment for public participation. The commission will also consider revisions to regulations pertaining to medication in racehorses and participants in horse racing.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, 10700 Horsemen's Rd., New Kent, VA 23124, telephone (804) 966-7404 or FAX (804) 966-7418.

† **June 14, 2000 - 9:30 a.m.** -- Open Meeting
Tyler Building, 1300 East Main Street, Richmond, Virginia. 

A monthly meeting, including a segment for public participation. The commission will also hear a report from Colonial Downs regarding the live racing meets for the year 2000.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, 10700 Horsemen's Rd., New Kent, VA 23124, telephone (804) 966-7404 or FAX (804) 966-7418.

REAL ESTATE BOARD

† **June 1, 2000 - 9 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia.

A regular meeting.

Contact: Karen W. O'Neal, Assistant Director, Real Estate Board, 3600 W. Broad St., Richmond, VA, telephone (804) 367-8552, FAX (804) 367-2475.

Fair Housing Committee

† **June 1, 2000 - 8:30 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia.

A regular business meeting.

Contact: Karen W. O'Neal, Assistant Director, Real Estate Board, 3600 W. Broad St., Richmond, VA, telephone (804) 367-8552, FAX (804) 367-2475.


Real Estate Education Committee

† **May 31, 2000 - 4 p.m.** -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia.


A regular meeting.

Contact: Karen W. O'Neal, Assistant Director, Real Estate Board, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8552, FAX (804) 367-2475.

BOARD OF REHABILITATIVE SERVICES

May 24, 2000 - 3:30 p.m. -- Open Meeting
Hyatt Fair Lakes, 12777 Fair Lakes Circle, Dominion B Boardroom, Fairfax, Virginia.  (Interpreter for the deaf provided upon request)

A quarterly business meeting. Public comments will be received at 3:45 p.m.

Contact: Barbara G. Tyson, Administrative Staff Assistant, Department of Rehabilitative Services, 8004 Franklin Farms Dr., P.O. Box K-300, Richmond, VA 23288-0300, telephone (804) 662-7010, toll-free 1-800-552-5019 or (804) 662-7000/TTY 


VIRGINIA RESOURCES AUTHORITY

† **June 13, 2000 - 9 p.m.** -- Open Meeting
Norfolk Sheraton Waterside, Norfolk, Virginia.

A regular meeting of the Board of Directors to (i) review and, if appropriate, approve the minutes from the most recent monthly meeting; (ii) review the authority's operations for the prior month; (iii) review applications for loans submitted to the authority for approval; (iv) consider loan commitments for approval and ratification under its various programs; (v) approve the issuance of any bonds; (vi) review the results of any bond sales; and (vii) consider such other matters and take such other actions as it may deem appropriate. Various committees of the Board of Directors may also meet immediately before or after the regular meeting and consider matters within their purview. The planned agenda of the meeting and any committee meetings will be available at the offices of the authority one week prior to the date of the meeting. Any person who needs any accommodation in order to participate in the meeting should contact the authority at least 10 days before the meeting so that suitable arrangements can be made.

Contact: Benjamin Hoyle, Virginia Resources Authority, 707 East Main Street, Suite 1350, Richmond, Virginia 23219, telephone (804) 644-3100, FAX (804) 644-3109, e-mail bhoyle@vra.state.va.us.


SEWAGE HANDLING AND DISPOSAL APPEAL REVIEW BOARD

May 24, 2000 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room A, Richmond, Virginia. 

A meeting to hear appeals of the Department of Health's denials of septic tank permits.

Contact: Susan C. Sherertz, Board Secretary, Sewage Handling and Disposal Appeal Review Board, 1500 E. Main St., Room 115, Richmond, VA 23219, telephone (804) 371-4236 or FAX (804) 225-4003.

VIRGINIA SMALL BUSINESS FINANCING AUTHORITY

May 23, 2000 - 10 a.m. -- Public Hearing
Department of Business Assistance, 707 East Main Street, 3rd Floor, Board Room, Richmond, Virginia. 

A meeting of the Board of Directors to review applications for loans submitted to the authority for approval and to conduct general business of the board. Meeting time is subject to change depending upon the agenda of the board.

Contact: Cathleen M. Surface, Executive Director, Department of Business Assistance, P.O. Box 446, Richmond, VA 23218-0446, telephone (804) 371-8254, FAX (804) 225-3384, e-mail csurface@dba.state.va.us

Calendar of Events

STATE BOARD OF SOCIAL SERVICES


June 9, 2000 - Public 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 Board of Social Services intends to amend regulations entitled: **22 VAC 40-600-10 et seq. Food Stamp Program - Administrative Disqualification Hearings**. Changes to the procedures for administrative hearings include that the decisions of the hearing officer is the final action, that notices may be sent by regular mail, and that the hearing may be held when the mail is returned to the agency.


Statutory Authority: §§ 63.1-25 and 63.1-124.2 of the Code of Virginia.


Contact: Patricia Duva, Food Stamp Program Manager, Division of Temporary Assistance Programs, Department of Social Services, 730 E. Broad St., Richmond, VA 23219, telephone (804) 692-1712 or FAX (804) 692-1704.

BOARD FOR PROFESSIONAL SOIL SCIENTISTS


† **June 15, 2000 - 9 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting of the Regulatory Review Committee to discuss and review the current edition of their regulations. The department fully complies with the Americans with Disabilities Act. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact Kelley L. Hellams.

Contact: Kelley L. Hellams, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-3917, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail soilscientist@dpor.state.va.us.

† **June 29, 2000 - 10 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting to address policy and procedural issues and other business matters which may require board action. The meeting is open to the public, however, a portion of the board's business may be discussed in a closed meeting. The department fully complies with the Americans with Disabilities Act. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact Kelley L. Hellams.

Contact: Kelley L. Hellams, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-3917, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail soilscientist@dpor.state.va.us.

COMMISSION ON VIRGINIA'S STATE AND LOCAL TAX STRUCTURE FOR THE 21ST CENTURY

† **May 23, 2000 - 2 p.m.** -- Public Hearing
Oliver Hall, Temple Building, Danville Community College, Danville, Virginia.

A public hearing to receive testimony on the issues raised by HJR 578/1999 and on matters referred to it during the 2000 Session of the General Assembly.

Contact: Mich Wilkinson/Rob Hodder, Staff Director/Deputy Staff Director, Commission on Virginia's State and Local Tax Structure for the 21st Century, Weldon Cooper Center for Public Service, 700 E. Franklin St., Suite 700, Richmond, VA 23219-2318, telephone (804) 786-4273, FAX (804) 371-0234.

† **May 23, 2000 - 7 p.m.** -- Open Meeting
Howard Johnson Hotel, 100 Tower Road (Highway 58), Piedmont Room, Danville, Virginia.

A regular meeting of the commission devoted to the discussion and consideration of issues concerning the adequacy of Virginia's State and Local tax structure to address the needs of the Commonwealth in the 21st Century.

Contact: Mich Wilkinson/Rob Hodder, Staff Director/Deputy Staff Director, Commission on Virginia's State and Local Tax Structure for the 21st Century, Weldon Cooper Center for Public Service, 700 E. Franklin St., Suite 700, Richmond, VA 23219-2318, telephone (804) 786-4273, FAX (804) 371-0234.

COUNCIL ON TECHNOLOGY SERVICES


June 6, 2000 - 9 a.m. -- Open Meeting
Location to be announced.

A regular monthly organizational meeting of the council.

Contact: Jamie Breeden, Administrative Staff Specialist, Secretary of Technology, 110 S. 7th St., 3rd Floor, Richmond, VA 23219, telephone (804) 371-5506, FAX (804) 371-5273, e-mail jvbreeden@dit.state.va.us.

VIRGINIA TOURISM AUTHORITY

Ad Hoc Committee on Marketing and Promotion Board of Directors


† **May 30, 2000 - 10 a.m.** -- Open Meeting
Virginia Tourism Authority, 901 E. Byrd St., 19th Floor, Board Room, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting of the Ad Hoc Committee on Marketing and Promotion to review cooperative marketing agreements.


Contact: Winston Evans, Administrative Staff Assistant, Virginia Tourism Authority, 901 E. Byrd St., Richmond, VA 23219, telephone (804) 371-8174, FAX (804) 786-1919, e-mail wevans@virginia.

BOARD FOR THE VISUALLY HANDICAPPED

† **July 18, 2000 - 1 p.m.** -- Open Meeting

Department for the Visually Handicapped, 397 Azalea Avenue, Richmond, Virginia.  (Interpreter for the deaf provided upon request)


A regular meeting of the board to review information regarding department activities and operations, review expenditures from the board's endowment fund, and discuss other issues raised for board members.

Contact: Katherine C. Proffitt, Administrative Staff Assistant, Department for the Visually Handicapped, 397 Azalea Ave., Richmond, VA 23227, telephone (804) 371-3145, FAX (804) 371-3157, toll-free (800) 622-2155, (804) 371-3140/TTY , e-mail proffikc@dvh.state.va.us.

DEPARTMENT FOR THE VISUALLY HANDICAPPED

Statewide Rehabilitation Council for the Blind

June 10, 2000 - 10 a.m. -- Open Meeting

Department for the Visually Handicapped, 397 Azalea Avenue, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular quarterly meeting to advise the department on matters related to vocational rehabilitation services for the blind and visually impaired citizens of the Commonwealth.

Contact: James G. Taylor, VR Program Director, Department for the Visually Handicapped, 397 Azalea Ave., Richmond, VA 23227, telephone (804) 371-3111, FAX (804) 371-3351, toll-free (800) 622-2155, (804) 371-3140/TTY 

VIRGINIA WASTE MANAGEMENT BOARD

May 25, 2000 - 9 a.m. -- Open Meeting


June 15, 2000 - 9 a.m. -- Open Meeting

Department of Environmental Quality, 629 East Main Street, Richmond, Virginia.

A meeting of the ad hoc advisory group assisting the Virginia Waste Management Board in the development of proposed amendments to 9 VAC 20-70-10 et seq., Financial Assurance Regulations for Solid Waste Facilities.

Contact: Melissa Porterfield, Virginia Waste Management Board, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4238, e-mail msporterfi@deq.state.va.us.

June 6, 2000 - 10 a.m. -- Open Meeting


Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Training Room, Glen Allen, Virginia. 

A meeting of the technical advisory committee assisting the department in the development of proposed amendments to 9 VAC 20-130-10 et seq., Regulations for

the Development of Solid Waste Management Plans, for the Virginia Waste Management Board's consideration.

Contact: Robert G. Wickline, Virginia Waste Management Board, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4213, e-mail rgwickline@deq.state.va.us.


† **June 26, 2000 - 9 a.m.** -- Open Meeting

Department of Environmental Quality, 629 East Main Street, 1st Floor Conference Room, Richmond, Virginia. 

A meeting of the advisory committee established to assist the department in the development of amendments to 9 VAC 20-140-10 et seq., Certification of Recycling Machinery and Equipment for Tax Exemption Purposes.

Contact: Dan Gwinner, Virginia Waste Management Board, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4218, FAX (804) 698-4327, e-mail dsgwinner@deq.state.va.us.

† **June 29, 2000 - 9 a.m.** -- Open Meeting

Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Glen Allen, Virginia. 


A public meeting to receive comments on the Notice of Intended Regulatory Action to amend 9 VAC 20-120-10 et seq., Regulated Medical Waste Management Regulations.

Contact: Michael Dieter, Virginia Waste Management Board, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4146, e-mail mjdieter@deq.state.va.us.

STATE WATER CONTROL BOARD

† **May 23, 2000 - 10 a.m.** -- Open Meeting


† **June 21, 2000 - 10 a.m.** -- Open Meeting

Department of Environmental Quality, 429 East Church Street, Kilmarnock, Virginia. 


A meeting of the advisory committee established to assist the department in the development of amendments to 9 VAC 25-115-10 et seq., General VPDES Permit for Seafood Processing Facilities.

Contact: Michael B. Gregory, State Water Control Board, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4065, FAX (804) 698-4032, e-mail mbgregory@deq.state.va.us.


May 30, 2000 - 2 p.m. -- Public Hearing

Eastern Shore Community College, Lecture Hall, Melfa, Virginia.  (Interpreter for the deaf provided upon request)


June 1, 2000 - 7 p.m. -- Public Hearing


Turner Ashby High School, 800 North Main Street, Auditorium, Bridgewater, Virginia.  (Interpreter for the deaf provided upon request)

June 2, 2000 - 10 a.m. -- Public Hearing

General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

Calendar of Events

June 5, 2000 - 7 p.m. -- Public Hearing
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia. 

June 8, 2000 - 7 p.m. -- Public Hearing
Hampton City Council Chambers, 22 Lincoln Street, Hampton, Virginia. 

June 23, 2000 - Public comments may be received 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: **9 VAC 25-630-10 et seq. Virginia Pollution Abatement General Permit Regulation for Poultry Waste Management.** The purpose of the proposed amendments is to establish requirements for the proper storage, management and tracking of poultry waste.

Affected Locality: The regulation will be applicable statewide and will not affect any one locality disproportionately.

Question and Answer Period: A question and answer period will be held one-half hour prior to each of the public hearings at the same locations. Interested citizens will have an opportunity to ask questions pertaining to the proposal at that time. The board reserves the right to limit oral presentations at the public hearings to three minutes per speaker.


Accessibility to Persons with Disabilities: The public hearings will be held at facilities believed to be accessible to persons with disabilities. Any person with questions should contact Mr. Richard W. Ayers, Office of Water Permit Programs, Department of Environmental Quality, P.O. Box 10009, Richmond, Virginia 23240-0009, telephone (804) 698-4075. Persons needing interpreter services for the deaf should notify Mr. Ayers no later than April 28, 2000.

Request for Comments: The board is seeking written comments from interested persons on both the proposed regulatory action and the draft permit. Comments are also solicited regarding alternative approaches that meet the statutory mandate given by the General Assembly. Written comments on the proposed issuance of the permit and on the proposed regulation must be received no later than 4 p.m. on Friday, June 23, 2000, and should be submitted to Mr. Ayers. Comments shall include the name, address, and telephone number of the writer and contain a complete, concise statement of the factual basis for comments. Only those comments received within this period will be considered by the board.

Statutory Authority: § 62.1-44.17:1.1 of the Code of Virginia.


Contact: Richard W. Ayers, Office of Water Permit Programs, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240-0009, telephone (804) 698-4075 or FAX (804) 698-4032.

† **May 31, 2000 - 9 a.m.** -- Open Meeting

† **June 21, 2000 - 9 a.m.** -- Open Meeting
Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Glen Allen, Virginia 

A meeting of the advisory committee established to assist the department in the development of amendments to 9 VAC 25-110-10 et seq., General VPDES Permit for Domestic Sewage Discharges of Less Than or Equal To 1,000 Gallons Per Day.

Contact: Lily Choi, State Water Control Board, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4054, FAX (804) 698-4032, e-mail ychoi@deq.state.va.us.


† **June 1, 2000 - 6:30 p.m.** -- Public Hearing
Sherwood Public Library, 2501 Sherwood Hall Lane, Fairfax County, Virginia 

A public hearing to receive comments on the proposed issuance of a Virginia Water Protection Permit to the FHWA and VDOT for the Woodrow Wilson Bridge Project.


Contact: Tracey Harmon, State Water Control Board, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4105, e-mail teharmon@deq.state.va.us.

† **June 28, 2000 - 9 a.m.** -- Open Meeting

† **July 10, 2000 - 9 a.m.** -- Open Meeting


† **August 10, 2000 - 9 a.m.** -- Open Meeting
Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Glen Allen, Virginia. 

A meeting of the advisory committee assisting the department in the development of General VWP Permits for Activities Impacting Wetlands regulations and in amendments to 9 VAC 25-210-10 et seq., Virginia Water Protection Permit Regulation.


Contact: Ellen Gilinsky, Virginia Water Protection Permit Program Manager, State Water Control Board, Department of Environmental Quality, P.O. Box 10009, Richmond, Virginia 23240, telephone (804) 698-4375, FAX (804) 698-4032, (804) 698-4021/TTY , e-mail egilinsky@deq.state.va.us.

VIRGINIA WORKFORCE COUNCIL

May 23, 2000 - 10 a.m. -- Open Meeting

Virginia Employment Commission, Central Office, 703 East Main Street, Conference Room 303, Richmond, Virginia. 
(Interpreter for the deaf provided upon request)

A meeting of the Existing Workforce and the Hard-to-Employ Committee to consider the option afforded the state to use a discretionary formula for up to 30% of the Workforce Investment Act (WIA) youth and adult local allocation for the fiscal year beginning July 1, 2001. Public comment will begin at 11 a.m. A written copy of comments must be provided.

Contact: Gail Robinson, Virginia Workforce Council Liaison, Virginia Employment Commission, P.O. Box 1358, Richmond, VA 23218-1358, telephone (804) 225-3070, FAX (804) 225-2190 or (804) 371-8050/TTY 

CHRONOLOGICAL LIST

OPEN MEETINGS

May 22

- † Agriculture and Consumer Services, Department of
 - Virginia Cattle Industry Board
- Alcoholic Beverage Control Board
- Conservation and Recreation, Department of
 - Board for Conservation and Development of Public Beaches
- Outdoors Foundation, Virginia
 - Open Space Land Preservation Trust Fund - Region II

May 23

- Compensation Board
- † Contractors, Board for
 - Tradesman Committee
- † Economic Development Partnership, Virginia
 - Personnel Committee
- † Environmental Quality, Department of
- Forestry, Board of
- Marine Resources Commission
- † Psychology, Board of
 - Special Conference Committee
- Small Business Financing Authority, Virginia
 - Board of Directors
- † State and Local Tax Structure for the 21st Century, Commission on Virginia's
- † Water Control Board, State
- Workforce Council, Virginia
 - Existing Workforce and the Hard-to-Employ Committee

May 24

- Emergency Planning Committee, Local - Gloucester County
- Innovative Technology Authority
- Outdoors Foundation, Virginia
 - Preservation Trust Fund Advisory Board - Region II
- † Racing Commission, Virginia
- Rehabilitative Services, Board of
- Sewage Handling and Disposal Appeal Review Board

May 25

- Education, Board of
- Environmental Quality, Department of
 - Virginia Pollution Prevention Advisory Committee
- † Mines, Minerals and Energy, Department of
 - Coal Mine Safety Board
- Nursing, Board of
- † Pharmacy, Board of
 - Regulatory/Legislative Committee
- Waste Management Board, Virginia
 - Ad Hoc Advisory Committee

May 26

- Dentistry, Board of
 - Special Conference Committee
- Education, Board of
- Medicine, Board of

- Legislative Committee

May 30

- Aging, Commonwealth Council on
- Funeral Directors and Embalmers, Board of
- † Local Government, Commission on
- † Tourism Authority, Virginia
 - Ad Hoc Committee on Marketing and Promotion

May 31

- Aging, Commonwealth Council on
- At-Risk Youth and Their Families, Comprehensive Services for
 - State Executive Council
- † Conservation and Recreation, Department of
 - Chippokes Plantation Farm Foundation Fund Raising Committee
- † Local Government, Commission on
- Outdoors Foundation, Virginia
 - Preservation Trust Fund Advisory Board - Region V
- People with Disabilities, Virginia Board for
 - Executive Committee
- † Real Estate Board
 - Real Estate Education Committee
- † Water Control Board, State

June 1

- Game and Inland Fisheries, Board of
- People with Disabilities, Virginia Board for
- † Real Estate Board
 - Fair Housing Committee
- † Water Control Board, State

June 5

- † Environmental Quality, Department of
 - Water Resources Committee
- † Nursing, Board of
 - Special Conference Committee

June 6

- Environmental Quality, Department of
 - Technical Advisory Committee
- Hopewell Industrial Safety Council
- † Nursing, Board of
 - Special Conference Committee
- Technology Services, Council on
- Waste Management Board, Virginia

June 7

- † Contractors, Board for
- † Local Emergency Planning Committee - Alexandria
- † Local Emergency Planning Committee - Winchester
- † Nursing Home Administrators, Board of
 - Special Conference Committee

June 8

- Agriculture and Consumer Services, Department of
 - Virginia Charity Food Assistance Board
- Medicine, Board of
- † Nursing, Board of
 - Special Conference Committee

June 9

- † Agriculture and Consumer Services, Department of
 - Virginia Aquaculture Advisory Board

Calendar of Events

Health Professions, Department of
- Health Practitioners' Intervention Program
Opticians, Board for

June 10

Visually Handicapped, Department for the
- Statewide Rehabilitation Council for the Blind

June 13

Dentistry, Board of
- Special Conference Committee
Medical Assistance Services, Board of
† Pharmacy, Board of
Polygraph Examiners Advisory Board
† Resources Authority, Virginia
- Board of Directors

June 14

Agriculture and Consumer Services, Department of
- Virginia Marine Products Board
† Historic Resources Board and State Review Board
Interagency Coordinating Council, Virginia
† Nursing, Board of
- Special Conference Committee
† Racing Commission, Virginia

June 15

Labor and Industry, Department of
- Virginia Apprenticeship Council
† Nursing, Board of
- Special Conference Committee
† Soil Scientists, Board for Professional
Waste Management Board, Virginia
- Ad Hoc Advisory Committee

June 19

Barbers, Board for
Cosmetology, Board for
† Nursing, Board of
- Special Conference Committee

June 21

† Water Control Board, State

June 22

† Public Guardian and Conservator Advisory Board,
Virginia
- By-Laws Committee

June 26

Medical Assistance Services, Department of
- Pharmacy Liaison Committee
† Waste Management Board, Virginia

June 27

Marine Resources Commission

June 28

At-Risk Youth and Their Families, Comprehensive
Services for
- State Executive Council
† Waste Management Board, Virginia

June 29

† Soil Scientists, Board for Professional
† Waste Management Board, Virginia

July 6

Conservation and Recreation, Department of
- Virginia Agricultural BMP Implementation Advisory
Committee

July 10

† Water Control Board, State

July 11

† Hopewell Industrial Safety Council

July 13

Medicine, Board of
- Informal Conference Committee

July 18

† Board for the Visually Handicapped

July 27

† Agriculture and Consumer Services, Department of
- Virginia Small Grains Board

August 1

† Hopewell Industrial Safety Council

August 10

† Water Control Board, State

September 5

† Hopewell Industrial Safety Council

September 18

† Public Guardian and Conservator Advisory Board,
Virginia

PUBLIC HEARINGS

May 24

† Environmental Quality, Department of

May 30

† Local Government, Commission on
Water Control Board, State

June 1

Water Control Board, State

June 2

Water Control Board, State

June 5

Water Control Board, State

June 8

Water Control Board, State

June 14

Air Pollution Control Board, State

June 21

† Funeral Directors and Embalmers, Board of