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).

July 2000 through June 2001

Volume:Issue	Material Submitted By Noon*	Will Be Published On
16:23	July 12, 2000	July 31, 2000
16:24	July 26, 2000	August 14, 2000
16:25	August 9, 2000	August 28, 2000
16:26	August 23, 2000	September 11, 2000
FINAL INDEX - Volume 16		**October 2000**
17:1	September 6, 2000	September 25, 2000
17:2	September 20, 2000	October 9, 2000
17:3	October 4, 2000	October 23, 2000
17:4	October 18, 2000	November 6, 2000
17:5	November 1, 2000	November 20, 2000
17:6	November 14, 2000 **(Tuesday)**	December 4, 2000
17:7	November 29, 2000	December 18, 2000
INDEX 1 - Volume 17		**January 2001**
17:8	December 12, 2000 **(Tuesday)**	January 1, 2001
17:9	December 27, 2000	January 15, 2001
17:10	January 10, 2001	January 29, 2001
17:11	January 24, 2001	February 12, 2001
17:12	February 7, 2001	February 26, 2001
17:13	February 21, 2001	March 12, 2001
17:14	March 7, 2001	March 26, 2001
INDEX 2 - Volume 17		**April 2001**
17:15	March 21, 2001	April 9, 2001
17:16	April 4, 2001	April 23, 2001
17:17	April 18, 2001	May 7, 2001
17:18	May 2, 2001	May 21, 2001
17:19	May 16, 2001	June 4, 2001
17:20	May 30, 2001	June 18, 2001
INDEX 3 - Volume 17		**July 2001**

*Filing deadlines are Wednesdays unless otherwise specified.

TABLE OF CONTENTS

CUMULATIVE TABLE OF VIRGINIA ADMINISTRATIVE CODE SECTIONS ADOPTED, AMENDED, OR REPEALED

Cumulative Table 2831

NOTICES OF INTENDED REGULATORY ACTION

TITLE 9. ENVIRONMENT

State Air Pollution Control Board 2842

State Water Control Board 2843

TITLE 12. HEALTH

State Board of Health 2844

Department of Medical Assistance Services 2845

TITLE 16. LABOR AND EMPLOYMENT

Virginia Workers' Compensation Commission 2845

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

Board for Hearing Aid Specialists 2846

Board of Psychology 2846

PUBLIC COMMENT PERIODS - PROPOSED REGULATIONS

TITLE 12. HEALTH

Department of Medical Assistance Services 2847

TITLE 18. PROFESSIONAL AND OCCUPATIONAL REGULATION

Board for Opticians 2848

PROPOSED REGULATIONS

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Residential and Psychiatric Treatment for Children and Adolescents.

State Plan under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (amending 12 VAC 30-10-150). 2849

Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-30, 12 VAC 30-50-70, 12 VAC 30-50-130, and 12 VAC 30-50-250). 2849

Methods and Standards for Establishing Payment Rates; Other Types of Care (adding 12 VAC 30-80-21). 2849

Amount, Duration and Scope of Selected Services (adding 12 VAC 30-130-850 through 12 VAC 30-130-890). 2849

Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-229.1) 2859

Case Management for Treatment Foster Care:

Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-480) 2864

Standards Established and Methods Used to Assure High Quality Care (amending 12 VAC 30-60-170). 2864

Methods and Standards for Establishing Payment Rates; Other Types of Care (adding 12 VAC 30-80-111). 2864

Amount, Duration and Scope of Selected Services (adding 12 VAC 30-130-900 through 12 VAC 30-130-950). 2864

TITLE 13. HOUSING

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

Rules and Regulations for Administration of Rent Reduction Tax Credits (amending 13 VAC 10-160-10, 13 VAC 10-160-30, and 13 VAC 10-160-55 through 13 VAC 10-160-90; repealing 13 VAC 10-160-41 and 13 VAC 10-160-51) 2875

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD FOR OPTICIANS

Board for Opticians Regulations (amending 18 VAC 100-20-10, 18 VAC 100-20-50, 18 VAC 100-20-60, 18 VAC 100-20-70, 18 VAC 100-20-90, 18 VAC 100-20-100, and 18 VAC 100-20-110; adding 18 VAC 100-20-5, 18 VAC 100-20-54, 18 VAC 100-20-55, 18 VAC 100-20-56, 18 VAC 100-20-65, 18 VAC 100-20-81, 18 VAC 100-20-85, 18 VAC 100-20-87, 18 VAC 100-20-120, and 18 VAC 100-20-130; repealing 18 VAC 100-20-20, 18 VAC 100-20-30, 18 VAC 100-20-40, and 18 VAC 100-20-80). 2881

FINAL REGULATIONS

TITLE 4. CONSERVATION AND NATURAL RESOURCES

MARINE RESOURCES COMMISSION

Pertaining to Crab Pots (amending 4 VAC 20-700-20). ... 2890

Pertaining to the Hampton Roads and Bayside Eastern Shore Blue Crab Management Areas (amending 4 VAC 20-752-20 and 4 VAC 20-752-30). 2890

Pertaining to Scup (Porgy) (amending 4 VAC 20-910-45). 2891

Table of Contents

TITLE 11. GAMING

VIRGINIA RACING COMMISSION

Medication (amending 11 VAC 10-180-10 through 11 VAC 10-180-80). 2891

TITLE 13. HOUSING

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

Change in Effective Date

Virginia Certification Standards (amending 13 VAC 5-21-10 and 13 VAC 5-21-20; adding 13 VAC 5-21-31, 13 VAC 5-21-41, 13 VAC 5-21-51, 13 VAC 5-21-61, and 13 VAC 5-21-71; repealing 13 VAC 5-21-30, 13 VAC 5-21-40, 13 VAC 5-21-50, and 13 VAC 5-21-60). 2902

Reprint and Change in Effective Date

Virginia Statewide Fire Prevention Code (amending 13 VAC 5-51-130, 13 VAC 5-51-150, and 13 VAC 5-51-170; adding 13 VAC 5-51-11 through 13 VAC 5-51-121 and 13 VAC 5-51-181 through 13 VAC 5-51-200; repealing 13 VAC 5-51-10 through 13 VAC 5-51-120)..... 2902

Reprint and Change in Effective Date

Virginia Uniform Statewide Building Code (amending 13 VAC 5-61-200, 13 VAC 5-61-220, 13 VAC 5-61-230, 13 VAC 5-61-290, 13 VAC 5-61-310, 13 VAC 5-61-340, 13 VAC 5-61-360, 13 VAC 5-61-390, 13 VAC 5-61-400, 13 VAC 5-61-410, 13 VAC 5-61-430, 13 VAC 5-61-440, and 13 VAC 5-61-450; adding 13 VAC 5-61-11, 13 VAC 5-61-15, 13 VAC 5-61-21, 13 VAC 5-61-25, 13 VAC 5-61-31, 13 VAC 5-61-35, 13 VAC 5-61-41, 13 VAC 5-61-45, 13 VAC 5-61-51, 13 VAC 5-61-55, 13 VAC 5-61-61, 13 VAC 5-61-65, 13 VAC 5-61-71, 13 VAC 5-61-75, 13 VAC 5-61-81, 13 VAC 5-61-85, 13 VAC 5-61-91, 13 VAC 5-61-95, 13 VAC 5-61-101, 13 VAC 5-61-105, 13 VAC 5-61-111, 13 VAC 5-61-115, 13 VAC 5-61-121, 13 VAC 5-61-125, 13 VAC 5-61-131, 13 VAC 5-61-135, 13 VAC 5-61-141, 13 VAC 5-61-145, 13 VAC 5-61-151, 13 VAC 5-61-155, 13 VAC 5-61-165, 13 VAC 5-61-171, 13 VAC 5-61-225, 13 VAC 5-61-245, 13 VAC 5-61-315, 13 VAC 5-61-317, 13 VAC 5-61-345, 13 VAC 5-61-395, 13 VAC 5-61-415, 13 VAC 5-61-447, and 13 VAC 5-61-460; repealing 13 VAC 5-61-10 through 13 VAC 5-61-190). ... 2903

TITLE 20. PUBLIC UTILITIES AND TELECOMMUNICATIONS

STATE CORPORATION COMMISSION

Regulations Governing the Separation of Regulated and Unregulated Businesses of Utility Consumer Services Cooperatives and Utility Aggregation Cooperatives. (20 VAC 5-203-10 et seq.)..... 2907

EMERGENCY REGULATIONS

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Provider Reimbursement Appeals:

State Plan under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (adding 12 VAC 30-10-1000). 2911

Administration of Medical Assistance Services (adding 12 VAC 30-20-500 through 12 VAC 30-20-599)..... 2911

Methods and Standards for Establishing Payment Rates; Inpatient Hospital Care (repealing 12 VAC 30-70-140 through 12 VAC 30-70-143)..... 2911

Methods and Standards for Establishing Payment Rates for Long-Term Care (repealing 12 VAC 30-90-130 through 12 VAC 30-90-133). 2911

Individual and Family Developmental Disabilities Support Waiver Services..... 2917

Amount, Duration, and Scope of Medical and Remedial Care Services (adding 12 VAC 30-50-490)..... 2917

Waivered Services (adding 12 VAC 30-120-700 through 12 VAC 30-120-799). 2917

Nursing Home Payment System: Methods and Standards for Establishing Payment Rates for Long-Term Care (amending 12 VAC 30-90-20, 12 VAC 30-90-34, 12 VAC 30-90-40, 12 VAC 30-90-41, 12 VAC 30-90-50, 12 VAC 30-90-51, 12 VAC 30-90-60, 12 VAC 30-90-65, 12 VAC 30-90-160, and 12 VAC 30-90-264; adding 12 VAC 30-90-35, 12 VAC 30-90-36, 12 VAC 30-90-37, and 12 VAC 30-90-136; repealing 12 VAC 30-90-30, 12 VAC 30-90-31, 12 VAC 30-90-32, 12 VAC 30-90-33, 12 VAC 30-90-42, 12 VAC 30-90-43, 12 VAC 30-90-53, 12 VAC 30-90-54, 12 VAC 30-90-220, 12 VAC 30-90-221, 12 VAC 30-90-222, 12 VAC 30-90-260, and 12 VAC 30-90-280). 2946

FORMS

TITLE 4. CONSERVATION AND NATURAL RESOURCES

DEPARTMENT OF MINES, MINERALS AND ENERGY

Minerals Other Than Coal Surface Mining Regulations. (4 VAC 25-30-10 et seq.) 2967

GOVERNOR

GOVERNOR'S COMMENTS

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD FOR BRANCH PILOTS

Board for Branch Pilots Rules and Regulations. (18 VAC 45-20-10 et seq.) 2968

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Virginia Energy Assistance Program. (22 VAC 40-680-10 et seq.) 2968

THE LEGISLATIVE RECORD

SB 1269: Legislative Transition Task Force of the Virginia Electric Utility Restructuring Act 2969

HJR 658: Interstate Route 73 Communications Committee 2970

Joint Commission on Technology and Science 2970

GENERAL NOTICES/ERRATA

STATE CORPORATION COMMISSION

ADMINISTRATIVE LETTERS

Medicare Supplement Insurance. (2000-9) 2973

Equity Indexed Annuities - Equity Indexed Life Insurance Products. (2000-10) 2973

ORDER PRESCRIBING NOTICE AND INVITING COMMENTS

In the Matter Concerning a Draft Plan for Retail Electric Metering and Billing Services 2976

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Legal Notice Regarding DRG Payment Rates and DRG Weights 2982

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Notice of Periodic Review of Regulations 2987

STATE MILK COMMISSION

Notice of Periodic Review of Regulations 2987

Notice of Periodic Review of Regulations 2988

DEPARTMENT OF SOCIAL SERVICES

Notice of Periodic Review of Regulations 2988

VIRGINIA DEPARTMENT OF TAXATION

VIRGINIA TAX BULLETIN

Interest Rates - Third Quarter 2000 (00-4) 2989

BOARD OF VETERINARY MEDICINE

Notice of Periodic Review of Regulations 2991

STATE WATER CONTROL BOARD

Proposed Consent Special Order - Po River Water and Sewer Company - Indian Acres of Thornburg Sewage Treatment Plant 2991

Proposed Consent Special Order - Town of New Market 2991

Proposed Consent Special Order - Virginia Metalcrafters, Inc. 2991

VIRGINIA CODE COMMISSION

Notice to State Agencies 2992

Forms for Filing Material for Publication in *The Virginia Register of Regulations* 2992

CALENDAR OF EVENTS

EXECUTIVE

Open Meetings and Public Hearings 2993

INDEPENDENT

Open Meetings and Public Hearings 3008

LEGISLATIVE

Open Meetings and Public Hearings 3009

CHRONOLOGICAL LIST

Open Meetings 3011

Public Hearings 3013

Table of Contents

CUMULATIVE TABLE OF VIRGINIA ADMINISTRATIVE CODE SECTIONS ADOPTED, AMENDED, OR REPEALED

The table printed below lists regulation sections, by Virginia Administrative Code (VAC) title, that have been amended, added or repealed in the *Virginia Register* since the regulations were originally published or last supplemented in VAC (the Spring 2000 VAC Supplement includes final regulations published through *Virginia Register* Volume 16, Issue 11, dated February 14, 2000). Emergency regulations, if any, are listed, followed by the designation "emer," and errata pertaining to final regulations are listed. Proposed regulations are not listed here. The table lists the sections in numerical order and shows action taken, the volume, issue and page number where the section appeared, and the effective date of the section.

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
Title 2. Agriculture			
2 VAC 5-600-10	Amended	16:20 VA.R. 2458	5/31/00
Title 4. Conservation and Natural Resources			
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 20-310-30	Amended	16:19 VA.R. 2378	5/15/00
4 VAC 20-310-35	Added	16:19 VA.R. 2378	5/15/00
4 VAC 20-310-40	Amended	16:19 VA.R. 2378	5/15/00
4 VAC 20-310-50	Amended	16:19 VA.R. 2379	5/15/00
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 20-620-10 emer	Amended	16:18 VA.R. 2292	4/26/00-5/25/00
4 VAC 20-620-20	Amended	16:20 VA.R. 2463	5/25/00
4 VAC 20-620-20 emer	Amended	16:18 VA.R. 2292	4/26/00-5/25/00
4 VAC 20-620-30	Amended	16:20 VA.R. 2463	5/25/00
4 VAC 20-620-30 emer	Amended	16:18 VA.R. 2292	4/26/00-5/25/00
4 VAC 20-620-40	Amended	16:20 VA.R. 2463	5/25/00
4 VAC 20-620-40 emer	Amended	16:18 VA.R. 2292	4/26/00-5/25/00
4 VAC 20-620-50	Amended	16:14 VA.R. 1861	3/1/00
4 VAC 20-620-50	Amended	16:20 VA.R. 2464	5/25/00
4 VAC 20-620-50 emer	Amended	16:18 VA.R. 2293	4/26/00-5/25/00
4 VAC 20-620-70	Amended	16:14 VA.R. 1861	3/1/00
4 VAC 20-620-70	Amended	16:20 VA.R. 2465	5/25/00
4 VAC 20-620-70 emer	Amended	16:18 VA.R. 2294	4/26/00-5/25/00
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 20-1040-10	Amended	16:20 VA.R. 2465	5/26/00
4 VAC 20-1040-20	Amended	16:20 VA.R. 2465	5/26/00
4 VAC 20-1040-30	Repealed	16:20 VA.R. 2465	5/26/00
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

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
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	*
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	*
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	*
9 VAC 5-40-20*	Amended	16:17 VA.R. 2145	*
9 VAC 5-40-30*	Amended	16:17 VA.R. 2149	*
9 VAC 5-40-40*	Amended	16:17 VA.R. 2150	*
9 VAC 5-40-50*	Amended	16:17 VA.R. 2151	*
9 VAC 5-40-6000 through 9 VAC 5-40-6230	Added	16:17 VA.R. 2164-2178	7/1/00
9 VAC 5-40-6180	Erratum	16:19 VA.R. 2399	--
9 VAC 5-50-10*	Amended	16:17 VA.R. 2152	*
9 VAC 5-50-20*	Amended	16:17 VA.R. 2152	*
9 VAC 5-50-30*	Amended	16:17 VA.R. 2155	*
9 VAC 5-50-40*	Amended	16:17 VA.R. 2156	*
9 VAC 5-50-50*	Amended	16:17 VA.R. 2157	*
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	*
9 VAC 5-60-20*	Amended	16:17 VA.R. 2158	*
9 VAC 5-60-30*	Amended	16:17 VA.R. 2159	*
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 11. Gaming			
11 VAC 10-60-10	Amended	16:21 VA.R. 2623	8/4/00
11 VAC 10-60-15	Added	16:21 VA.R. 2627	8/4/00
11 VAC 10-60-20	Amended	16:21 VA.R. 2628	8/4/00
11 VAC 10-60-30	Repealed	16:21 VA.R. 2628	8/4/00
11 VAC 10-60-40	Amended	16:21 VA.R. 2629	8/4/00
11 VAC 10-60-60	Repealed	16:21 VA.R. 2631	8/4/00
11 VAC 10-60-70	Amended	16:21 VA.R. 2631	8/4/00
11 VAC 10-60-120	Amended	16:21 VA.R. 2633	8/4/00
11 VAC 10-60-130	Amended	16:21 VA.R. 2636	8/4/00
11 VAC 10-60-140	Amended	16:21 VA.R. 2637	8/4/00
11 VAC 10-60-150	Amended	16:21 VA.R. 2637	8/4/00
11 VAC 10-60-290	Added	16:21 VA.R. 2637	8/4/00
11 VAC 10-60-300	Added	16:21 VA.R. 2637	8/4/00
11 VAC 10-60-310	Added	16:21 VA.R. 2637	8/4/00
11 VAC 10-60-320	Added	16:21 VA.R. 2637	8/4/00
Title 12. Health			
12 VAC 5-80-10	Amended	16:16 VA.R. 2042	7/1/00

* Effective date suspended.

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
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 5-165-100	Erratum	16:19 VA.R. 2399	--
12 VAC 5-590-370	Amended	16:21 VA.R. 2647	8/3/00
12 VAC 5-590-545	Added	16:21 VA.R. 2662	8/3/00
12 VAC 5-590 Appendix O	Added	16:21 VA.R. 2667	8/3/00
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
12 VAC 5-610-360	Amended	16:16 VA.R. 2051	7/1/00
12 VAC 5-610-370	Repealed	16:16 VA.R. 2051	7/1/00
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 5-610-450	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

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
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 30-10-140	Amended	16:18 VA.R. 2239	7/1/00
12 VAC 30-40-345	Added	16:15 VA.R. 1973	5/10/00
12 VAC 30-50-10	Amended	16:18 VA.R. 2240	7/1/00
12 VAC 30-50-100	Amended	16:18 VA.R. 2244	7/1/00
12 VAC 30-50-105	Amended	16:18 VA.R. 2246	7/1/00
12 VAC 30-50-140	Amended	16:18 VA.R. 2247	7/1/00
12 VAC 30-50-180	Amended	16:19 VA.R. 2380	7/5/00
12 VAC 30-50-220	Amended	16:18 VA.R. 2248	7/1/00
12 VAC 30-50-320	Added	16:18 VA.R. 2240	7/1/00
12 VAC 30-50-560	Amended	16:18 VA.R. 2249	7/1/00
12 VAC 30-50-570	Amended	16:18 VA.R. 2250	7/1/00
12 VAC 30-50-580	Added	16:18 VA.R. 2251	7/1/00
12 VAC 30-70-200	Repealed	16:18 VA.R. 2253	7/1/00
12 VAC 30-70-201	Added	16:18 VA.R. 2261	7/1/00
12 VAC 30-70-210	Repealed	16:18 VA.R. 2253	7/1/00
12 VAC 30-70-211	Added	16:18 VA.R. 2261	7/1/00
12 VAC 30-70-220	Repealed	16:18 VA.R. 2256	7/1/00
12 VAC 30-70-221	Added	16:18 VA.R. 2261	7/1/00

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
12 VAC 30-70-230	Repealed	16:18 VA.R. 2256	7/1/00
12 VAC 30-70-231	Added	16:18 VA.R. 2263	7/1/00
12 VAC 30-70-240	Repealed	16:18 VA.R. 2257	7/1/00
12 VAC 30-70-241	Added	16:18 VA.R. 2264	7/1/00
12 VAC 30-70-250	Repealed	16:18 VA.R. 2257	7/1/00
12 VAC 30-70-251	Added	16:18 VA.R. 2264	7/1/00
12 VAC 30-70-260	Repealed	16:18 VA.R. 2258	7/1/00
12 VAC 30-70-261	Added	16:18 VA.R. 2264	7/1/00
12 VAC 30-70-270	Repealed	16:18 VA.R. 2258	7/1/00
12 VAC 30-70-271	Added	16:18 VA.R. 2264	7/1/00
12 VAC 30-70-280	Repealed	16:18 VA.R. 2258	7/1/00
12 VAC 30-70-281	Added	16:18 VA.R. 2265	7/1/00
12 VAC 30-70-290	Repealed	16:18 VA.R. 2258	7/1/00
12 VAC 30-70-291	Added	16:18 VA.R. 2265	7/1/00
12 VAC 30-70-300	Repealed	16:18 VA.R. 2258	7/1/00
12 VAC 30-70-301	Added	16:18 VA.R. 2265	7/1/00
12 VAC 30-70-310	Repealed	16:18 VA.R. 2259	7/1/00
12 VAC 30-70-311	Added	16:18 VA.R. 2266	7/1/00
12 VAC 30-70-320	Repealed	16:18 VA.R. 2259	7/1/00
12 VAC 30-70-321	Added	16:18 VA.R. 2266	7/1/00
12 VAC 30-70-330	Repealed	16:18 VA.R. 2260	7/1/00
12 VAC 30-70-331	Added	16:18 VA.R. 2266	7/1/00
12 VAC 30-70-340	Repealed	16:18 VA.R. 2260	7/1/00
12 VAC 30-70-341	Added	16:18 VA.R. 2267	7/1/00
12 VAC 30-70-350	Repealed	16:18 VA.R. 2260	7/1/00
12 VAC 30-70-351	Added	16:18 VA.R. 2267	7/1/00
12 VAC 30-70-360	Repealed	16:18 VA.R. 2260	7/1/00
12 VAC 30-70-361	Added	16:18 VA.R. 2267	7/1/00
12 VAC 30-70-370	Repealed	16:18 VA.R. 2260	7/1/00
12 VAC 30-70-371	Added	16:18 VA.R. 2267	7/1/00
12 VAC 30-70-380	Repealed	16:18 VA.R. 2260	7/1/00
12 VAC 30-70-381	Added	16:18 VA.R. 2268	7/1/00
12 VAC 30-70-390	Repealed	16:18 VA.R. 2261	7/1/00
12 VAC 30-70-391	Added	16:18 VA.R. 2268	7/1/00
12 VAC 30-70-400	Amended	16:18 VA.R. 2269	7/1/00
12 VAC 30-70-410	Amended	16:18 VA.R. 2269	7/1/00
12 VAC 30-70-420	Amended	16:18 VA.R. 2269	7/1/00
12 VAC 30-70-435	Added	16:18 VA.R. 2269	7/1/00
12 VAC 30-70-450	Amended	16:18 VA.R. 2270	7/1/00
12 VAC 30-70-460	Amended	16:18 VA.R. 2270	7/1/00
12 VAC 30-80-160	Repealed	16:19 VA.R. 2380	7/5/00
12 VAC 30-100-260	Amended	16:18 VA.R. 2252	7/1/00
12 VAC 30-120-61 through 12 VAC 30-120-68	Added	16:18 VA.R. 2240-2243	7/1/00
Title 13. Housing			
13 VAC 5-21-10	Amended	16:20 VA.R. 2468	8/15/00
13 VAC 5-21-20	Amended	16:20 VA.R. 2468	8/15/00
13 VAC 5-21-30	Repealed	16:20 VA.R. 2468	8/15/00
13 VAC 5-21-31	Added	16:20 VA.R. 2470	8/15/00
13 VAC 5-21-40	Repealed	16:20 VA.R. 2469	8/15/00
13 VAC 5-21-41	Added	16:20 VA.R. 2470	8/15/00
13 VAC 5-21-50	Repealed	16:20 VA.R. 2470	8/15/00
13 VAC 5-21-51	Added	16:20 VA.R. 2471	8/15/00
13 VAC 5-21-60	Repealed	16:20 VA.R. 2470	8/15/00
13 VAC 5-21-61	Added	16:20 VA.R. 2471	8/15/00
13 VAC 5-21-71	Added	16:20 VA.R. 2472	8/15/00
13 VAC 5-51-10 through 13 VAC 5-51-120	Repealed	16:20 VA.R. 2473-2476	8/15/00

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
13 VAC 5-51-11 through 13 VAC 5-51-121	Added	16:20 VA.R. 2477-2484	8/15/00
13 VAC 5-51-130	Amended	16:20 VA.R. 2484	8/15/00
13 VAC 5-51-131	Added	16:20 VA.R. 2484	8/15/00
13 VAC 5-51-133	Added	16:20 VA.R. 2484	8/15/00
13 VAC 5-51-135	Added	16:20 VA.R. 2485	8/15/00
13 VAC 5-51-136	Added	16:20 VA.R. 2485	8/15/00
13 VAC 5-51-150	Amended	16:20 VA.R. 2485	8/15/00
13 VAC 5-51-170	Amended	16:20 VA.R. 2485	8/15/00
13 VAC 5-51-181	Added	16:20 VA.R. 2486	8/15/00
13 VAC 5-51-182	Added	16:20 VA.R. 2487	8/15/00
13 VAC 5-51-190	Added	16:20 VA.R. 2487	8/15/00
13 VAC 5-51-200	Added	16:20 VA.R. 2487	8/15/00
13 VAC 5-61-10 through 13 VAC 5-61-190	Repealed	16:20 VA.R. 2488-2495	8/15/00
13 VAC 5-61-11	Added	16:20 VA.R. 2495	8/15/00
13 VAC 5-61-15	Added	16:20 VA.R. 2496	8/15/00
13 VAC 5-61-21	Added	16:20 VA.R. 2496	8/15/00
13 VAC 5-61-25	Added	16:20 VA.R. 2497	8/15/00
13 VAC 5-61-31	Added	16:20 VA.R. 2497	8/15/00
13 VAC 5-61-35	Added	16:20 VA.R. 2498	8/15/00
13 VAC 5-61-41	Added	16:20 VA.R. 2498	8/15/00
13 VAC 5-61-45	Added	16:20 VA.R. 2499	8/15/00
13 VAC 5-61-51	Added	16:20 VA.R. 2499	8/15/00
13 VAC 5-61-55	Added	16:20 VA.R. 2501	8/15/00
13 VAC 5-61-61	Added	16:20 VA.R. 2502	8/15/00
13 VAC 5-61-65	Added	16:20 VA.R. 2503	8/15/00
13 VAC 5-61-71	Added	16:20 VA.R. 2503	8/15/00
13 VAC 5-61-75	Added	16:20 VA.R. 2503	8/15/00
13 VAC 5-61-81	Added	16:20 VA.R. 2504	8/15/00
13 VAC 5-61-85	Added	16:20 VA.R. 2504	8/15/00
13 VAC 5-61-91	Added	16:20 VA.R. 2504	8/15/00
13 VAC 5-61-95	Added	16:20 VA.R. 2504	8/15/00
13 VAC 5-61-101	Added	16:20 VA.R. 2505	8/15/00
13 VAC 5-61-105	Added	16:20 VA.R. 2505	8/15/00
13 VAC 5-61-111	Added	16:20 VA.R. 2506	8/15/00
13 VAC 5-61-115	Added	16:20 VA.R. 2507	8/15/00
13 VAC 5-61-121	Added	16:20 VA.R. 2508	8/15/00
13 VAC 5-61-125	Added	16:20 VA.R. 2508	8/15/00
13 VAC 5-61-131	Added	16:20 VA.R. 2508	8/15/00
13 VAC 5-61-135	Added	16:20 VA.R. 2509	8/15/00
13 VAC 5-61-141	Added	16:20 VA.R. 2509	8/15/00
13 VAC 5-61-145	Added	16:20 VA.R. 2510	8/15/00
13 VAC 5-61-151	Added	16:20 VA.R. 2510	8/15/00
13 VAC 5-61-155	Added	16:20 VA.R. 2511	8/15/00
13 VAC 5-61-165	Added	16:20 VA.R. 2511	8/15/00
13 VAC 5-61-171	Added	16:20 VA.R. 2512	8/15/00
13 VAC 5-61-200	Amended	16:20 VA.R. 2512	8/15/00
13 VAC 5-61-220	Amended	16:20 VA.R. 2513	8/15/00
13 VAC 5-61-225	Added	16:20 VA.R. 2515	8/15/00
13 VAC 5-61-245	Added	16:20 VA.R. 2515	8/15/00
13 VAC 5-61-290	Amended	16:20 VA.R. 2516	8/15/00
13 VAC 5-61-310	Amended	16:20 VA.R. 2516	8/15/00
13 VAC 5-61-315	Added	16:20 VA.R. 2516	8/15/00
13 VAC 5-61-317	Added	16:20 VA.R. 2516	8/15/00
13 VAC 5-61-340	Amended	16:20 VA.R. 2516	8/15/00
13 VAC 5-61-345	Added	16:20 VA.R. 2517	8/15/00
13 VAC 5-61-360	Amended	16:20 VA.R. 2517	8/15/00

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
13 VAC 5-61-390	Amended	16:20 VA.R. 2517	8/15/00
13 VAC 5-61-395	Added	16:20 VA.R. 2517	8/15/00
13 VAC 5-61-400	Amended	16:20 VA.R. 2517	8/15/00
13 VAC 5-61-410	Amended	16:20 VA.R. 2518	8/15/00
13 VAC 5-61-415	Added	16:20 VA.R. 2518	8/15/00
13 VAC 5-61-430	Amended	16:20 VA.R. 2518	8/15/00
13 VAC 5-61-440	Amended	16:20 VA.R. 2520	8/15/00
13 VAC 5-61-447	Added	16:20 VA.R. 2522	8/15/00
13 VAC 5-61-450	Amended	16:20 VA.R. 2522	8/15/00
13 VAC 5-61-460	Added	16:20 VA.R. 2522	8/15/00
13 VAC 5-100-10 through 13 VAC 5-100-20	Added	16:20 VA.R. 2523	5/31/00
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
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
13 VAC 10-40-20	Amended	16:19 VA.R. 2384	5/17/00
13 VAC 10-40-120	Amended	16:19 VA.R. 2386	5/17/00
13 VAC 10-40-160	Amended	16:19 VA.R. 2386	5/17/00
13 VAC 10-40-170	Amended	16:19 VA.R. 2387	5/17/00
13 VAC 10-40-230	Amended	16:19 VA.R. 2387	5/17/00
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	--
14 VAC 5-215-30 through 14 VAC 5-215-70	Amended	16:21 VA.R. 2675-2677	7/1/00
14 VAC 5-215-110	Amended	16:21 VA.R. 2678	7/1/00
Title 15. Judicial			
15 VAC 5-80-10 through 15 VAC 5-80-50	Added	16:20 VA.R. 2524-2526	5/24/00
15 VAC 10-10-10	Amended	16:16 VA.R. 2069	3/24/00
Title 16. Labor and Employment			
16 VAC 15-40-10	Amended	16:18 VA.R. 2272	6/22/00
16 VAC 15-40-50	Amended	16:18 VA.R. 2272	6/22/00
Title 18. Professional and Occupational Licensing			
18 VAC 30-20-10	Amended	16:18 VA.R. 2273	6/21/00
18 VAC 30-20-80	Amended	16:18 VA.R. 2273	6/21/00
18 VAC 30-20-170	Amended	16:18 VA.R. 2273	6/21/00
18 VAC 30-20-180	Amended	16:18 VA.R. 2274	6/21/00
18 VAC 30-20-230	Amended	16:18 VA.R. 2274	6/21/00
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 60-20-30	Amended	16:18 VA.R. 2278	6/21/00
18 VAC 60-20-110	Amended	16:18 VA.R. 2281	6/21/00
18 VAC 60-20-120	Amended	16:18 VA.R. 2281	6/21/00
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 85-20-22	Amended	16:21 VA.R. 2679	8/2/00
18 VAC 85-20-131	Amended	16:21 VA.R. 2680	8/2/00

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
18 VAC 85-20-240	Amended	16:13 VA.R. 1767	4/12/00
18 VAC 85-20-280	Amended	16:21 VA.R. 2680	8/2/00
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 85-50-115	Amended	16:21 VA.R. 2682	8/2/00
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 85-110-10	Amended	16:21 VA.R. 2683	8/2/00
18 VAC 85-110-30	Amended	16:21 VA.R. 2683	8/2/00
18 VAC 85-110-35	Amended	16:13 VA.R. 1771	4/12/00
18 VAC 85-110-90	Amended	16:21 VA.R. 2683	8/2/00
18 VAC 85-110-100	Amended	16:21 VA.R. 2683	8/2/00
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 90-40-10	Amended	16:21 VA.R. 2683	8/2/00
18 VAC 90-40-80	Repealed	16:21 VA.R. 2684	8/2/00
18 VAC 90-40-90	Amended	16:21 VA.R. 2684	8/2/00
18 VAC 90-40-120	Amended	16:21 VA.R. 2684	8/2/00
18 VAC 105-30-70	Amended	16:20 VA.R. 2534	7/19/00
18 VAC 110-20-10	Amended	16:21 VA.R. 2685	8/2/00
18 VAC 110-20-220	Amended	16:21 VA.R. 2687	8/2/00
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
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

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
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 20. Public Utilities and Telecommunications			
20 VAC 5-311-10 through 20 VAC 5-311-60	Added	16:20 VA.R. 2541-2553	5/26/00
20 VAC 5-315-10 through 20 VAC 5-315-90	Added	16:20 VA.R. 2555-2558	5/25/00
Title 22. Social Services			
22 VAC 15-30-10	Amended	16:18 VA.R. 2282	6/21/00
22 VAC 40-30-10 et seq.	Repealed	16:18 VA.R. 2284	6/21/00
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
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

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
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
22 VAC 40-60-1030 through 22 VAC 40-60-1060	Repealed	16:12 VA.R. 1701-1702	7/1/00
22 VAC 40-130-10	Amended	16:22 VA.R. 2745	11/1/00
22 VAC 40-130-25	Added	16:22 VA.R. 2748	11/1/00
22 VAC 40-130-30 through 22 VAC 40-130-140	Amended	16:22 VA.R. 2749-2751	11/1/00

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
22 VAC 40-130-155	Added	16:22 VA.R. 2751	11/1/00
22 VAC 40-130-160	Repealed	16:22 VA.R. 2751	11/1/00
22 VAC 40-130-170 through 22 VAC 40-130-190	Amended	16:22 VA.R. 2751-2752	11/1/00
22 VAC 40-130-195	Added	16:22 VA.R. 2753	11/1/00
22 VAC 40-130-198	Added	16:22 VA.R. 2754	11/1/00
22 VAC 40-130-200	Amended	16:22 VA.R. 2754	11/1/00
22 VAC 40-130-202	Added	16:22 VA.R. 2754	11/1/00
22 VAC 40-130-210	Amended	16:22 VA.R. 2754	11/1/00
22 VAC 40-130-211	Added	16:22 VA.R. 2756	11/1/00
22 VAC 40-130-212	Added	16:22 VA.R. 2757	11/1/00
22 VAC 40-130-213	Added	16:22 VA.R. 2758	11/1/00
22 VAC 40-130-220	Amended	16:22 VA.R. 2758	11/1/00
22 VAC 40-130-221	Added	16:22 VA.R. 2759	11/1/00
22 VAC 40-130-223	Added	16:22 VA.R. 2759	11/1/00
22 VAC 40-130-230 through 22 VAC 40-130-250	Amended	16:22 VA.R. 2760	11/1/00
22 VAC 40-130-251	Added	16:22 VA.R. 2760	11/1/00
22 VAC 40-130-260	Amended	16:22 VA.R. 2760	11/1/00
22 VAC 40-130-261	Added	16:22 VA.R. 2760	11/1/00
22 VAC 40-130-270	Amended	16:22 VA.R. 2761	11/1/00
22 VAC 40-130-271	Added	16:22 VA.R. 2765	11/1/00
22 VAC 40-130-272	Added	16:22 VA.R. 2765	11/1/00
22 VAC 40-130-280	Amended	16:22 VA.R. 2766	11/1/00
22 VAC 40-130-289	Added	16:22 VA.R. 2767	11/1/00
22 VAC 40-130-290	Amended	16:22 VA.R. 2767	11/1/00
22 VAC 40-130-300	Amended	16:22 VA.R. 2768	11/1/00
22 VAC 40-130-301	Added	16:22 VA.R. 2768	11/1/00
22 VAC 40-130-310	Amended	16:22 VA.R. 2769	11/1/00
22 VAC 40-130-312	Added	16:22 VA.R. 2770	11/1/00
22 VAC 40-130-314	Added	16:22 VA.R. 2771	11/1/00
22 VAC 40-130-320 through 22 VAC 40-130-360	Amended	16:22 VA.R. 2771-2772	11/1/00
22 VAC 40-130-365	Added	16:22 VA.R. 2773	11/1/00
22 VAC 40-130-370 through 22 VAC 40-130-400	Amended	16:22 VA.R. 2773-2776	11/1/00
22 VAC 40-130-401	Added	16:22 VA.R. 2776	11/1/00
22 VAC 40-130-402	Added	16:22 VA.R. 2777	11/1/00
22 VAC 40-130-403	Added	16:22 VA.R. 2778	11/1/00
22 VAC 40-130-404	Added	16:22 VA.R. 2778	11/1/00
22 VAC 40-130-406	Added	16:22 VA.R. 2778	11/1/00
22 VAC 40-130-410	Amended	16:22 VA.R. 2778	11/1/00
22 VAC 40-130-420	Amended	16:22 VA.R. 2779	11/1/00
22 VAC 40-130-424	Added	16:22 VA.R. 2779	11/1/00
22 VAC 40-130-430 through 22 VAC 40-130-450	Amended	16:22 VA.R. 2779-2780	11/1/00
22 VAC 40-130-452 through 22 VAC 40-130-459	Added	16:22 VA.R. 2780-2784	11/1/00
22 VAC 40-130-470 through 22 VAC 40-130-550	Amended	16:22 VA.R. 2784-2785	11/1/00
22 VAC 40-130-600 through 22 VAC 40-130-820	Added	16:22 VA.R. 2785-2796	11/1/00
22 VAC 40-325-10	Added	16:22 VA.R. 2797	8/16/00
22 VAC 40-325-20	Added	16:22 VA.R. 2797	8/16/00
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
Title 24. Transportation and Motor Vehicles			
24 VAC 30-40-30	Amended	16:18 VA.R. 2285	7/1/00
24 VAC 30-40-580	Amended	16:18 VA.R. 2287	7/1/00
24 VAC 30-40-600 through 24 VAC 30-40-640	Amended	16:18 VA.R. 2288-2290	7/1/00

NOTICES OF INTENDED REGULATORY ACTION

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

TITLE 9. ENVIRONMENT

STATE AIR POLLUTION CONTROL 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 State Air Pollution Control Board intends to consider amending regulations entitled: **9 VAC 5-20-10 et seq. General Provisions.** The regulation amendments are being proposed to incorporate the latest edition of referenced technical documents into the Regulations for the Control and Abatement of Air Pollution.

Section 110, paragraph 2 of Title I of the Clean Air Act Amendments of 1990 (42 USC § 7471) requires that the state implementation plan shall "provide for the establishment and operation of appropriate devices, methods, systems, and procedures necessary to . . . monitor, compile, and analyze data on ambient air quality . . ." This law is implemented by EPA through 40 CFR 51.212, which states that the plan must provide for "enforceable test methods for each emission limit specified in the plan."

To meet this requirement, the department has, where appropriate, incorporated by reference a series of mostly industry-generated test methods that reflect the most current technical information available and that will enable the state to meet this Act requirement.

Need: The amendments are needed because the regulations must be current and timely, which means that the technical documents incorporated must be the most recent edition. EPA has indicated that it will not approve state plans if the technical documents referenced are not up to date and accurate. In addition to meeting federal requirements for the provision of enforceable test methods which are acceptable to EPA, incorporation of these documents has many additional advantages to the public and to the state.

The amendments concern documents that are technical in nature and pertain to areas in which the agency has limited expertise or resources to conduct extensive research. For example, the "Flammable and Combustible Liquids Code," which is published by the National Fire Protection Association as an American National Standard contains important information that would not otherwise be readily determined by the state with its own devices.

In addition, the agency must ensure that its references to technical standards--for example, test methods--must be consistent with standards developed and accepted by the scientific and industrial communities. By keeping state requirements consistent with these standards, the state and the regulated community avoid conflict and confusion, and ensure technical accuracy.

Use of these standards is advantageous to industry. Most of the standards have been developed by industrial professional societies. Like the state, many industries do not have the wherewithal to do their own research and develop their own standards. Use of these standards assures convenience and consistency for their users, as well as a strong degree of confidence in their accuracy.

Relying on existing standards also saves the state time and financial resources by eliminating duplication of research. Finally, the regulations must reflect the most up-to-date technical information available to ensure that public health and welfare are protected.

Potential Issues:

1. To amend 9 VAC 5-20-21 of 9 VAC 5 Chapter 20 to update information related to technical documents incorporated by reference.

2. To amend 9 VAC 5-20-21 of 9 VAC 5 Chapter 20 as may be necessary to maintain consistency with Title 40 of the Code of Federal Regulations.

Alternatives: Alternatives to the proposed regulation amendments are being considered by the department. The department has tentatively determined that the first alternative is appropriate, as it is the least burdensome and least intrusive alternative that fully meets the purpose of the regulatory action. The alternatives being considered by the department, along with the reasoning by which the department has rejected any of the alternatives being considered, are discussed below.

1. Amend the regulations to satisfy the provisions of the law and associated regulations and policies. This option is being selected because it meets the stated purpose of the regulatory action: to ensure that technical documents incorporated by reference into the Commonwealth's regulations are complete and accurate.

2. Take no action to amend the regulations and continue using outdated references. This option is not being considered because it would result in the use of outdated and inaccurate information.

Public Participation: The department is soliciting comments on (i) the intended regulatory action, to include ideas to assist the department in the development of the proposal and (ii) the costs and benefits of the alternatives stated in this notice or other alternatives. A public meeting will be held by the department to receive comments on and to discuss the intended action. Information on the date, time, and place of the meeting is published in the Calendar of Events section of the Virginia Register. Unlike a public hearing, which is intended only to receive testimony, this meeting is being held to discuss and exchange ideas and information relative to regulation development.

The department is soliciting comments on the advisability of forming an ad hoc advisory group, utilizing a standing advisory committee or consulting with groups or individuals registering interest in working with the department to assist in the drafting and formation of any proposal. The primary function of any group, committee or individuals that may be utilized is to develop recommended regulation amendments for department consideration through the collaborative approach of regulatory negotiation and consensus. Any comments relative to this issue may be submitted using the same procedures as those used for submitting written comments pursuant to this notice.

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Public comments may be submitted until September 8, 2000.

Contact: Karen G. Sabasteanski, Policy Analyst, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4426 or FAX (804) 698-4510.

VA.R. Doc. No. R00-223; Filed July 12, 2000, 7:29 a.m.

STATE WATER CONTROL 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 State Water Control Board intends to consider amending regulations entitled: **9 VAC 25-210-10 et seq. Virginia Water Protection Permit Regulation.** The purpose of the proposed action is to amend the regulation to incorporate changes to §§ 62.1-44.3, 62.1-44.5, 62.1-44.15, 62.1-44.15:5 and 62.1-44.29 of the Code of Virginia relating to wetlands as mandated by the 2000 General Assembly in Senate Bill 648 and House Bill 1170 and other changes that the department or the public deems necessary and are warranted. These changes are designed to clarify and streamline the permitting process and to establish and implement policies and programs to protect and enhance the Commonwealth's wetland resources, using a regulatory approach to achieve no net loss of wetlands and a voluntary approach to achieve a net resource gain.

The board is seeking comments on the intended regulatory action, including ideas to assist in the revisions to the regulation. An informational public meeting will be held and notice of the meeting will be posted in the Calendar of Events section of the Virginia Register of Regulations. In addition, a Technical Advisory Committee has been formed to assist in the development of the regulation; notice of the meeting dates will be posted in the Calendar of Events section of the Virginia Register of Regulations. The board is using the participatory approach to assist the agency in the revisions to the regulation. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 62.1-44.15(10) and 62.1-44.15:5 of the Code of Virginia.

Public comments may be submitted until August 16, 2000.

Contact: Ellen Gilinsky, Virginia Water Protection Permit Program Manager, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4375 or FAX (804) 698-4032.

VA.R. Doc. No. R00-201; Filed May 31, 2000, 11:41 a.m.

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 Water Control Board intends to consider amending regulations entitled:

1. 9 VAC 25-660-10 et seq. General Virginia Water Protection Permit for Wetland Impacts Less than One-Half Acre;

2. 9 VAC 25-670-10 et seq. General Virginia Water Permit for Wetland Impacts Related to Facilities and Activities of Utility and Public Service Companies Regulated by FERC and SCC;

3. 9 VAC 25-680-10 et seq. General Virginia Water Permit for Wetland Impacts from Linear Transportation Projects;

4. 9 VAC 25-690-10 et seq. General Virginia Water Permit for Wetland Impacts from Development Activities;

5. 9 VAC 25-700-10 et seq. General Virginia Water Permit for Wetland Impacts from Mining Activities; and

6. 9 VAC 25-710-10 et seq. General Virginia Water Permit for Wetland Restoration and Creation Activities.

The purpose of the proposed action is to develop general permits for activities in wetlands as specified in changes to § 62.1-44.15:5 of the Code of Virginia relating to wetlands as mandated by the General Assembly in Senate Bill 648 and House Bill 1170. The new regulations are needed to expedite and streamline the wetland permitting process in Virginia.

Need: Pursuant to the actions of the 2000 General Assembly, Virginia Water Protection Permit General Permits are to be developed in accordance with changes to § 62.1-44.15:5 of the Code of Virginia relating to wetlands. General permits are to be developed for such activities in wetlands as the board deems appropriate, and are to include such terms and conditions as the board deems necessary to protect state resources and fish and wildlife resources from significant impairment. The adoption of general permits for wetland impacts is essential to protect the health, safety and welfare of citizens because they will streamline the permitting process, allowing agencies and applicants to save time and money.

Substance: The proposed regulatory action is to develop a series of Virginia Water Protection Permit General Permits in response to the requirements of new legislation. These general permits are for classes of similar activities with minimal environmental consequence. The board shall develop general permits for:

1. Activities causing wetland impacts of less than one-half of an acre;

2. Facilities and activities of utilities and public service companies regulated by the Federal Energy Regulatory Commission or State Corporation Commission;

3. Coal, natural gas, and coal bed methane gas mining activities authorized by the Department of Mines, Minerals and Energy, and for sand mining activities;

4. Virginia Department of Transportation or other linear transportation projects; and

5. Activities governed by nationwide or regional permits approved by the board and issued by the U.S. Army Corps of Engineers. Conditions contained in the general permits shall include, but not be limited to, filing with the board copies of any preconstruction notification, postconstruction report and certificate of compliance required by the U.S. Army Corps of Engineers. The permits will contain specific thresholds for use and mitigation ratios for compensation for unavoidable wetland impacts.

Alternatives: The alternative of not developing these general permits is not feasible as the proposed changes are mandated by action of the General Assembly. The alternative of developing these permits will clarify and streamline the permitting process and help alleviate duplicative requirements of state and federal programs.

Public Participation: The board is seeking comments on the intended regulatory action, including ideas to assist in the development of general permits. An informational public meeting will be held and notice of the meeting posted in the Calendar of Events section of the Virginia Register of Regulations. In addition, a Technical Advisory Committee has been formed to assist in the development of the general permits; notice of the meeting dates will be posted in the Calendar of Events section of the Virginia Register of Regulations.

The board is using the participatory approach in the development of these regulations.

Statutory Authority: §§ 62.1-44.15(10) and 62.1-44.15:5 of the Code of Virginia.

Public comments may be submitted until August 16, 2000.

Contact: Ellen Gilinsky, Virginia Water Protection Permit Program Manager, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4375 or FAX (804) 698-4032.

VA.R. Doc. Nos. R00-195 through R00-200; Filed May 31, 2000, 11:41 a.m.

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TITLE 12. HEALTH

STATE BOARD OF HEALTH

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 Health intends to consider amending regulations entitled: **12 VAC 5-65-10 et seq. Rules and Regulations Governing Emergency Medical Services Do Not Resuscitate Program.** The purpose of the proposed action is to amend existing emergency medical services regulations governing do not resuscitate orders in accordance with legislation of the 1999 Session of the General Assembly. The agency does not intend to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 32.1-111.1, 54.1-2987.1 and 54.1-2991 of the Code of Virginia.

Public comments may be submitted until August 17, 2000.

Contact: Dave Cullen, Regulatory and Compliance Manager, Department of Health, 158 East Parham Road, Richmond, Virginia 23228, telephone (804) 371-3500, FAX (804) 371-3543.

VA.R. Doc. No. R00-213; Filed June 22, 2000, 3:48 p.m.

† 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 Health intends to consider amending regulations entitled: **12 VAC 5-371-10 et seq. Regulations for the Licensure of Nursing Facilities.** The purpose of the proposed action is to make permanent emergency amendments to the nursing facility regulations made necessary by 1999 legislation. The amendment to 12 VAC 5-371-40 will implement authority for the Health Commissioner to condition license renewal on whether facilities have provided previously agreed levels of charity care. The agency does not intend to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Public comments may be submitted until August 31, 2000.

Contact: Carrie Eddy, Policy Analyst, Department of Health, Center for Quality Care Services, 3600 W. Broad St., Suite 216, Richmond, VA 23230, telephone (804) 367-2157 or FAX (804) 367-2149.

VA.R. Doc. No. R00-226; Filed July 17, 2000, 2:33 p.m.

† 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 Health intends to consider amending regulations entitled: **12 VAC 5-410-10 et seq. Rules and Regulations for the Licensure of**

Hospitals. The purpose of the proposed action is to make permanent emergency amendments to the hospital regulations made necessary by 1999 legislation. The amendment to 12 VAC 5-410-70 will implement authority for the Health Commissioner to condition license renewal on whether facilities have provided previously agreed levels of charity care. The agency does not intend to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Public comments may be submitted until August 31, 2000.

Contact: Carrie Eddy, Policy Analyst, Department of Health, Center for Quality Care Services, 3600 W. Broad St., Suite 216, Richmond, VA 23230, telephone (804) 367-2157 or FAX (804) 367-2149.

VA.R. Doc. No. R00-224; Filed July 17, 2000, 2:33 p.m.

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 Health intends to consider amending regulations entitled: **12 VAC 5-610-10 et seq. Sewage Handling and Disposal Regulations.** The purpose of the proposed action is to incorporate standards to regulate the amount or percentage of rock allowed in the soil around and below a soil absorption system and develop standards for mass sewage disposal systems. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 32.1-12 and 32.1-164 of the Code of Virginia.

Public comments may be submitted until August 2, 2000.

Contact: Donald J. Alexander, Director, Division Onsite Sewage/Water Services, Department of Health, P.O. Box 2448, Room 117, Richmond, Virginia 23218, telephone (804) 786-1620, FAX (804) 225-4003.

VA.R. Doc. No. R00-207; Filed June 14, 2000, 12:06 p.m.

† 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 Health intends to consider promulgating regulations entitled: **12 VAC 5-615-10 et seq. Regulations for Authorized Onsite Soil Evaluators.** The purpose of the proposed action is to make permanent certain emergency regulations made necessary by 1999 legislation. The regulations will implement a program that will allow private sector soil evaluators a role in approving private septic systems. The agency does not intend to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 32.1-12, 32.1-163.5 and 32.1-164 of the Code of Virginia.

Public comments may be submitted until August 31, 2000.

Contact: Donald J. Alexander, Director, Division of Onsite Sewage and Water Services, Department of Health, P.O. Box 2448, Room 117, Richmond, Virginia 23218, telephone (804) 786-1620, FAX (804) 225-4003.

VA.R. Doc. No. R00-225; Filed July 11, 2000, 12:03 p.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending regulations entitled: **12 VAC 30-120-10 et seq. Waivered Services.** The purpose of the proposed action is to provide family planning services (only) up to 24 months post delivery for women who were Medicaid eligible for their prenatal care and deliveries. Presently, DMAS is permitted by federal law to extend Medicaid eligibility for all covered services for only 60 days to these women. The 1999 Session of the General Assembly directed DMAS to seek a § 1115 (a) waiver from the Health Care Financing Administration. The agency does not intend to hold a public hearing on the proposed regulation after publication.

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

Public comments may be submitted until August 30, 2000, to Anita Cordill, Analyst, Policy Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-8850 or (804) 371-4981.

VA.R. Doc. No. R00-218; Filed June 30, 2000, 4:21 p.m.

TITLE 16. LABOR AND EMPLOYMENT

VIRGINIA WORKERS' COMPENSATION COMMISSION

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 Workers' Compensation Commission intends to consider promulgating regulations entitled: **16 VAC 30-100-10 et seq. Regulations For Professional Employer Organizations.** The purpose of the proposed action is to promulgate regulations governing the registration of and periodic reporting by professional employer organizations as provided in § 65.2-803.1 of the Code of Virginia and to address insuring for workers' compensation liability by such organizations as provided in § 65.2-801 of the Code of Virginia. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 65.2-201, 65.2-801, and 65.2-803.1 of the Code of Virginia.

Public comments may be submitted until August 7, 2000.

Contact: Sam Lupica, Virginia Workers' Compensation Ombudsman, 1000 DMV Drive, Richmond, Virginia 23220, telephone (804) 367-8269, toll-free 1-877-664-2566, FAX (804) 367-9740 or (804) 367-8600/TTY ☎

VA.R. Doc. No. R00-206; Filed June 14, 2000, 10:37 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD FOR HEARING AID SPECIALISTS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Hearing Aid Specialists intends to consider amending regulations entitled: **18 VAC 80-20-10 et seq. Board for Hearing Aid Specialists Regulations.** The purpose of the proposed action is to clarify entry requirements for licensure, modify the procedures and provisions regarding renewal and reinstatement, and ensure that the standards of practice and conduct meet all current laws and statutes. The board proposes to review several provisions of the regulations and simplify them thereby ensuring that the board is meeting its statutory mandate to ensure minimal competence of all licensees without burdensome requirements. The agency does not intend to hold a public hearing on the proposed regulation after publication.

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

Public comments may be submitted until August 2, 2000.

Contact: Nancy T. Feldman, Assistant Director, Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, VA 23230-4917, e-mail hearingaidspec@dpor.state.va.us, telephone (804) 367-8590, FAX (804) 367-6295 or (804) 367-9753/TTY ☎

VA.R. Doc. No. R00-202; Filed June 8, 2000, 1:47 p.m.

BOARD OF PSYCHOLOGY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Psychology intends to consider amending regulations entitled: **18 VAC 125-20-10 et seq. Regulations Governing the Practice of Psychology.** The purpose of the proposed action is to develop continuing education for licensure renewal in compliance with legislation enacted by the 2000 Session of the General Assembly. The board also intends to promulgate a provision for inactive licensure for individuals who are not practicing due to illness, retirement or relocation to another jurisdiction. Otherwise, these individuals would be forced to let their licenses lapse if they are unable to meet the continuing education requirement for renewal. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 54.1-2400 and 54.1-3606.1 of the Code of Virginia.

Public comments may be submitted until August 2, 2000.

Contact: Evelyn B. Brown, Executive Director, Board of Psychology, 6606 West Broad Street, 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9913 or FAX (804) 662-9943.

VA.R. Doc. No. R00-212; Filed June 22, 2000, 3:41 p.m.

PUBLIC COMMENT PERIODS - PROPOSED REGULATIONS

PUBLIC COMMENT PERIODS REGARDING STATE AGENCY REGULATIONS

This section gives notice of public comment periods and public hearings to be held on proposed regulations. The notice will be published once at the same time the proposed regulation is published in the Proposed Regulations section of the *Virginia Register*. The notice will continue to be carried in the Calendar of Events section of the *Virginia Register* until the public comment period and public hearing date have passed.

Notice is given in compliance with § 9-6.14:7.1 of the Code of Virginia that the following public hearings and public comment periods regarding proposed state agency regulations are set to afford the public an opportunity to express their views.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

September 29, 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 Department of Medical Assistance Services intends to amend regulations entitled:

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

12 VAC 30-50-10 et seq. Amount, Duration and Scope of Medical and Remedial Care Services.

12 VAC 30-80-10 et seq. Methods and Standards for Establishing Payments Rates; Other Types of Care.

12 VAC 30-130-10 et seq. Amount, Duration and Scope of Selected Services.

These proposed amendments provide for Medicaid coverage of residential psychiatric treatment services for children and adolescents.

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

Public comments may be submitted until September 29, 2000, to Anita Cordill, Analyst, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-8854 or FAX (804) 371-4981.

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September 29, 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 Department of Medical Assistance Services intends to amend regulations entitled: **12 VAC 30-50-10 et seq. Amount, Duration, and Scope of Medical and Remedial Care Services.** The proposed amendments provide for the expansion of health care services that can be rendered by employees of school divisions to special education children and be reimbursed by Medicaid.

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

Public comments may be submitted until September 29, 2000, to Jeff Nelson, Analyst, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-8854 or FAX (804) 371-4981.

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September 29, 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 Department of Medical Assistance Services intends to amend regulations entitled:

12 VAC 30-50-10 et seq. Amount, Duration and Scope of Medical and Remedial Care Services.

12 VAC 30-60-10 et seq. Standards Established and Methods Used to Assure High Quality Care.

12 VAC 30-80-10 et seq. Methods and Standards for Establishing Payment Rates; Other Types of Care.

12 VAC 30-130-10 et seq. Amount, Duration and Scope of Selected Services.

These proposed amendments provide for coverage by Medicaid of case management services for children who are receiving treatment foster care services.

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

Public comments may be submitted until September 29, 2000, to Anita Cordill, Analyst, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-8854 or FAX (804) 371-4981.

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TITLE 18. PROFESSIONAL AND OCCUPATIONAL REGULATION

BOARD FOR OPTICIANS

September 29, 2000 - Public comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Opticians intends to amend regulations entitled: **18 VAC 100-20-10 et seq. Board for Opticians Regulations.** The purpose of the proposed amendments is to (i) establish a definitions section; (ii) clarify entry requirements for licensure; (iii) specify examination procedures and examination content for licensure and contact lens examinations; and (iv) modify the procedures and provisions regarding renewal, reinstatement, and the standards of practice and conduct.

Statutory Authority: §§ 54.1-201 and 54.1-1700 et seq. of the Code of Virginia.

Contact: Nancy T. Feldman, Assistant Director, Board for Opticians, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-6295 or (804) 367-9753/TTY ☎, e-mail opticians@dpor.state.va.us.

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TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulation: **Residential and Psychiatric Treatment for Children and Adolescents.**
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 30-10-150).
12 VAC 30-50-10 et seq. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-30, 12 VAC 30-50-70, 12 VAC 30-50-130, and 12 VAC 30-50-250).
12 VAC 30-80-10 et seq. Methods and Standards for Establishing Payment Rates; Other Types of Care (adding 12 VAC 30-80-21).
12 VAC 30-130-10 et seq. Amount, Duration and Scope of Selected Services (adding 12 VAC 30-130-850 through 12 VAC 30-130-890).

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

Public Hearing Date: N/A -- Public comments may be submitted until September 29, 2000.
(See Calendar of Events section for additional information)

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of board action pursuant to the board's requirements.

Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA. The emergency regulation became effective on January 1, 2000.

Chapter 464 of the 1998 Acts of Assembly, Item 335.X.2 mandated that the department promulgate regulations to amend the State Plan for Medical Assistance to expand coverage of inpatient psychiatric services under the Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT) to include services in residential treatment facilities. The act mandated that such regulations be in effect on January 1, 2000, and address coverage limitations and utilization review. Such services, defined at 42 CFR 440.160, are nevertheless being covered herein under the authority of 42 CFR 440.40.

Purpose: The purpose of this proposal is to provide Medicaid reimbursement for a new service: residential psychiatric services for children and adolescents under the early and periodic screening, diagnosis and treatment service. Since this will be a newly covered service, the health of Medicaid children who need this service will be benefited.

Substance: The Comprehensive Services Act for At-Risk Youth and Families (CSA) (§§ 2.1-745 through 2.1-759.1 of the Code of Virginia) is a Virginia law designed to help troubled youths and their families. State and local agencies, parents, and private service providers work together to plan and provide services. In each community, local teams decide how to do this. The community policy and management team coordinates agency efforts, manages the available funds, and sees that eligible youths and their families get help. The family assessment and planning team looks at the strengths and needs of individual youths and families, decides what services to provide, and prepares a service plan for each family. Both teams include parents, staff from community services boards, court service units, the departments of health and social services, the schools, and private providers.

In 1997, the Joint Legislative Audit and Review Commission (JLARC) published its "Review of the Comprehensive Services Act." This report made a number of recommendations for improvement of the Comprehensive Services Act. One recommendation urged the use of Medicaid funding to serve children whose placements were in facilities and programs for which Medicaid payment could be made. In this way, federal matching funds could be obtained for services currently funded from state and local funds. As a result of the JLARC report, the 1998 Appropriation Act directed the Department of Medical Assistance Services to add coverage of residential treatment for children and adolescents to the coverage of inpatient psychiatric treatment under the Early and Periodic Screening, Diagnosis and Treatment Program. Medicaid coverage of this new residential treatment became effective on January 1, 2000.

Medicaid currently covers inpatient psychiatric treatment for individuals under age 21 only in psychiatric units of acute care general hospitals or in freestanding psychiatric hospitals. This regulation will provide a lower, less intensive level of inpatient services for children and adolescents who do not require the intensity of services offered by a hospital setting.

Prior to the current emergency regulations, residential psychiatric services were purchased by the Comprehensive Services Act for children and adolescents who could not be treated on an outpatient basis and who did not need hospital care. These placements were funded from state and local funds. Since Medicaid now covers the service, federal matching funds are available and reduce the amount of state and local funds needed to purchase residential services for these vulnerable children.

The regulations include the definition of the service, coverage limitations, provider qualifications, utilization review, and reimbursement methodology.

The provision of these services through Medicaid will make it possible for children and adolescents who need this service to access it quicker (spending less time on waiting lists) and from a larger number of enrolled providers. This should facilitate service provision, enabling children and adolescents to get better faster and return to their regular life routine.

Issues: The primary advantage of this action is the addition of a Medicaid reimbursable service to replace a service currently paid from only state and local funds. By making federal funding available, savings can be achieved in state general funds and in expenditures of local governments for children and adolescents served through the Comprehensive Services Act.

The primary disadvantage of this regulatory action arises from the federal mandated requirements for Medicaid reimbursement. The federal regulations are prescriptive of provider requirements and utilization management requirements. Because of the prescriptive provider requirements, only a few of the residential care facilities licensed in the Commonwealth can participate in Medicaid payments. These regulations reflect the current federal regulations.

Providers of residential treatment may resist the additional cost of complying with Medicaid's federal regulations. In addition, they may resist Medicaid reimbursement methodologies. Currently, each facility negotiates a unique rate of reimbursement with each local community policy and management team. The fact that Medicaid will be paying for this service will force the standardization of payment rates. Local governments will have to consider Medicaid reimbursement policies when referring Medicaid eligible children to a Medicaid enrolled residential treatment provider.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 9-6.14:7.1 G of the Administrative Process Act and Executive Order Number 25 (98). Section 9-6.14:7.1 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The proposed regulations amend the State Plan for Medical Assistance to expand coverage of inpatient psychiatric services under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) to include services in residential treatment facilities. Under existing regulations, Medicaid only covers inpatient (acute hospital care) and outpatient (therapeutic counseling sessions, home-based services, or day treatment services) psychiatric treatment services for children under age 21. Currently, children receive residential psychiatric services primarily through the Comprehensive Services Act although some other government programs (e.g., Department of Juvenile Justice and Community Service Boards) also place children in residential care.

Background. Residential psychiatric treatment is defined as out-of-home placements in therapeutic group homes where youths receive education, counseling, and physical conditioning on site. Children in certain mandated populations (foster care, foster care prevention, special education students) can receive residential psychiatric treatment services under the Comprehensive Services Act (CSA). The CSA was established by the 1992 Session of the General Assembly as a comprehensive, interagency system of care for at-risk children. In addition to residential care, CSA also provides many other services, such as foster care, specialized education programs, and therapeutic counseling. Services under the CSA are funded by localities and merged state funds from the Department of Education, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Department of Social Services, and the Department of Youth and Family Services.[1] In FY 1997, 14,501 children were provided services under the CSA. While the CSA is the primary vehicle for child and adolescent residential treatment services, other government programs (e.g., Department of Juvenile Justice and community services boards) also place children in residential care.

In 1997, the Joint Legislative Audit and Review Commission (JLARC) published a "Review of the Comprehensive Services Act" (Senate Document No. 26). This report made a number of recommendations for improvement of the CSA, including proposing the use of Medicaid funding to serve children for which Medicaid payment could be made. By doing so, federal matching funds could be obtained for services currently paid completely by the state and localities. The 1998 Session of the General Assembly acted on the JLARC report and directed the Department of Medical Assistance Services (DMAS) to add coverage of residential treatment for children and adolescents to the State Plan for Medical Assistance. Medicaid coverage of this new residential treatment became effective on January 1, 2000, under emergency regulations. The agency is now promulgating these permanent replacement regulations.

Estimated economic impact. The proposed regulations will implement Medicaid coverage of residential psychiatric treatment and allow Virginia to draw on federal matching funds to pay for services that are now paid for with 100% state and local funds. As of October 1, 1999, the federal participation rate for medical assistance services in Virginia is 51.67% but it is estimated that this rate will rise to 51.85% on October 1, 2000.

In its 1997 report, JLARC reported that $56.2 million was spent by the CSA program on residential care for 1,595 Medicaid-eligible children, at an average cost of $35,000 per child.[2,3] If Medicaid funding had been used for each of these

[1] The Department of Youth and Family Services was the predecessor to the current Department of Juvenile Justice.

[2] Cost estimates reported are in 1995 dollars.

children, state and local governments could have saved $29 million.[4] Due to the large number of unknowns associated with implementation of this policy change, it is difficult to project an exact annual fiscal impact. However, any projection would require that the 1997 estimate be adjusted for the following factors:

1. Growth in the CSA population: JLARC identified 1,595 children in FY1997 whose treatment could potentially be funded by Medicaid. This represented 11% of the total FY1997 CSA population (14,501). CSA caseloads have been growing at 1.5% to 2.0% per year for the past two years.[5] Assuming that the percentage of children for whom Medicaid funding could be used remains constant, the population eligible for Medicaid coverage is likely to be higher than 1,595. The general funds for services for CSA-children are to be transferred from CSA to DMAS as funds are expended.

2. Services will be available to ALL Medicaid-eligible children: As a Medicaid-covered service, coverage of residential treatment facilities will be available for all Medicaid-eligible children, regardless of whether they seek assistance through CSA. DMAS expects to serve approximately 160 non-CSA children when this program reaches maturity. These 160 non-CSA children are currently receiving residential care through the Department of Juvenile Justice (DJJ) or Community Service Boards. Since these services are now being paid for with state and local money, taking advantage of Medicaid funding will increase total savings to the Commonwealth. However, coverage of these children will result in a shifting of costs from DJJ and the Community Service Boards to DMAS.

JLARC estimated the costs associated with coverage of the 160 non-CSA children would be $5.6 million using the FY1997 average cost of care. The General Assembly appropriated approximately $861,000 total funds for FY2000 ($417,000 general funds) for coverage of these non-CSA children based on the fact that the program is not expected to be fully operational until the middle of FY2000. Based on the assumption that a new service traditionally takes three to four years to reach maturity, DMAS estimates FY2001 expenditures of $2.8 million and FY2002 expenditures of $4.5 million for coverage of non-CSA children.

There may also be additional Medicaid-eligible children in need of residential care who are currently not receiving treatment. The magnitude of this population is unknown at this time. While coverage of any such children would reduce the aggregate level of savings realized by the Medicaid expansion, the benefits to providing appropriate treatment for these children are probably roughly the same as the benefits of treating children now covered under other state programs.

3. Services will be available to VCMSIP children: The Virginia Children's Medical Security Insurance Plan (VCMSIP) went into effect in October 1998. At that time, DMAS estimated enrollment of 63,200 children within three years. To date, 23,025 children have been enrolled.[6] Since all services covered under Medicaid EPSDT automatically apply for VCMSIP children, this population will also be eligible for residential treatment services. There is no way at this time to estimate the number of VCMSIP children who may need and qualify for residential care. Coverage of this population is not currently accounted for in DMAS's technical budget request but will be included as the programs (both VCMSIP and EPSDT expansion) mature and the size of this population becomes clear.

As with other Medicaid-eligible children not currently receiving needed residential care services, expanding coverage will reduce the aggregate level of savings associated with this policy change. However, the federal match rate for VCMSIP children is approximately 66%, which is higher than the Medicaid match rate of 52%. Therefore, the reduction in savings will be less than that resulting from expanded coverage of additional Medicaid-eligible children while the benefits of providing needed treatment remain the same.

4. Cost savings under Medicaid: Federal Medicaid matching funds are accompanied by prescriptive provider requirements and utilization management requirements. Although some of these requirements may involve administrative and program changes by localities, they may also reduce the average cost of service paid for each child. Currently, each facility negotiates a rate of reimbursement with each local Community Policy and Management Team. Under the proposed policy, DMAS will set a uniform reimbursement rate. Utilization management under Medicaid may also decrease the average length of stay for some recipients as cases are more actively monitored. The extent of any cost reductions are not known at this time, however, they will only increase the fiscal savings associated with this proposal.

5. Responsiveness of localities to proposed policy change: The proposed regulation does not require that localities utilize Medicaid funding for eligible children. Although localities would save money, the federal requirements that accompany the federal funds may deter some localities from taking advantage of Medicaid reimbursement. The potential savings of this policy

[3] The estimate includes only children that were Medicaid eligible in FY1995, who received CSA funded residential care services, and were assessed to have the risk factors and/or psychiatric symptoms that indicate that they may potentially meet Medicaid's program eligibility criteria. For more details, please refer to Appendix D of the JLARC 1997 "Review of the Comprehensive Services Act" (Senate Document No. 26).

[4] State and local savings estimated here are based on the FY 1997 Medicaid match rate of 51.45 federal, 48.55 state. Using average state and local shares of 62.7% and 37.3%, respectively, the state savings would be $18 million and local savings $11 million.

[5] Unofficial estimates provided by the Office of Comprehensive Services: FY1998 CSA population approximately 14,700 (1.4% growth); FY1999 CSA population approximately 15,000 (2.0% growth).

[6] Enrollment figure as of 4/24/00.

change will depend on the extent it is used by localities, which is not known at this time.

Aside from the expected fiscal savings, this regulatory change will provide a complete continuum of care for Medicaid participants, allowing the most appropriate level of care. Under existing regulations, Medicaid only covers inpatient (acute hospital care) and outpatient (therapeutic counseling sessions, home-based services, or day treatment services) psychiatric treatment services for children under age 21. Providing the most cost-effective and least restrictive placement will be beneficial for children in need of residential psychiatric treatment.

The primary disadvantages to the proposed regulation are the federal requirements that accompany federal funding. This will primarily affect service providers, although localities may also have administrative and program requirements to comply with. There are 200 licensed residential service providers in Virginia. Twelve of those currently qualify to enroll as Medicaid providers and others are seeking the necessary accreditation. It is not known at this time how many providers will qualify and enroll or if there will be any change in the quality of care provided.

Businesses and entities affected. The proposed regulation will affect all children in Virginia who receive or are in need of residential psychiatric treatment, estimated to be approximately 1,755.[7] Providers of these services who enroll as Medicaid providers will also be affected by this regulation in addition to localities responsible for placing children in residential care.

Localities particularly affected. The proposed regulation should not uniquely affect any particular localities as it applies statewide.

Projected impact on employment. The proposed regulation is not anticipated to have any significant impact on employment in Virginia.

Effects on the use and value of private property. The proposed regulation is not anticipated to have any significant effects on the use and value of private property in Virginia.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The agency concurs with the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning Amount, Duration, and Scope of Services: EPSDT Residential Psychiatric Treatment for Children.

Summary:

The proposed amendments expand coverage of inpatient psychiatric services under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) to include services in residential treatment facilities. Under existing regulations, Medicaid only covers inpatient (acute hospital care) and outpatient (therapeutic counseling sessions, home-based services, or day treatment services) psychiatric treatment services for children under age 21. Currently, children receive residential psychiatric services primarily through the Comprehensive Services Act although some other government programs (e.g., Department of Juvenile Justice and community services boards) also place children in residential care.

12 VAC 30-10-150. Amount, duration, and scope of services: Medically needy.

This State Plan covers the medically needy. The services described below and in 12 VAC 30-50-40 et seq. are provided. Services for medically needy include:

(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in § 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in § 1902(a)(1) through (20). The services are provided as defined in 42 CFR 440, Subpart A and in § 1902, 1905, and 1915 of the Act.

The above-stated is applicable with respect to nurse-midwife services under § 1902(a)(17).

(ii) Prenatal care and delivery services for pregnant women.

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the 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.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in 12 VAC 30-50-40 for recipients under age 18 and recipients entitled to institutional services.

(vi) Home health services to recipients entitled to nursing facility services as indicated in 12 VAC 30-10-220 ~~of this plan~~.

(vii) Services for the medically needy do not include services in an institution for mental diseases for individuals over age 65.

(viii) Services for the medically needy do not include services in an intermediate care facility for the mentally retarded.

(ix) Services for the medically needy do not include inpatient psychiatric services for individuals under age 21*, other than those covered under early and periodic screening, diagnosis, and treatment (at 12 VAC 30-50-130)*.

(x) Services for the medically needy do not include respiratory care services provided to ventilator dependent individuals. See 12 VAC 30-10-300 ~~of this plan~~.

[7] This figure reflects 1,595 CSA-children and 160 non-CSA children.

(xi) Home and community care for functionally disabled elderly individuals is not covered.

12 VAC 30-50-40 et seq. identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also 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 30-50-30. Services not provided to the categorically needy.

The following services and devices are not provided to the categorically needy:

1. Chiropractors' services.

2. Private duty nursing services.

3. Dentures.

4. Other diagnostic and preventive services other than those provided elsewhere in this plan: diagnostic services (see 12 VAC 30-50-95 et seq.).

5. Inpatient psychiatric facility services for individuals under ~~22~~ *21* years of age*, other than those covered under early and periodic screening, diagnosis, and treatment (at 12 VAC 30-50-130)*.

6. Special tuberculosis (TB) related services under § 1902(z)(2)(F) of the Act.

7. Respiratory care services (in accordance with § 1920(e)(9)(A) through (C) of the Act).

8. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with § 1920 of the Act).

9. Any other medical care and any type of remedial care recognized under state law specified by the Secretary: services of Christian Science Nurses; personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

12 VAC 30-50-70. Services or devices not provided to the medically needy.

1. Chiropractors' services.

2. Private duty nursing services.

3. Dentures.

4. Diagnostic or preventive services other than those provided elsewhere in the State Plan.

5. Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals age 65 or older in institutions for mental disease(s).

6. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with § 1905(a)(4)(A) of the Act, to be in need of such care in a public institution, or a distinct part thereof, for the mentally retarded or persons with related conditions.

7. Inpatient psychiatric facility services for individuals under ~~22~~ *21* years of age*, other than those covered under early and periodic screening, diagnosis, and treatment (at 12 VAC 30-50-130)*.

8. Special tuberculosis (TB) services under § 1902(z)(2)(F) of the Act.

9. Respiratory care services (in accordance with § 1920(e)(9)(A) through (C) of the Act).

10. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with § 1920 of the Act).

11. Services of Christian Science nurses.

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

13. Home and community care for functionally disabled elderly individuals, as defined, described and limited in ~~12 VAC 30-50-410 through~~ *12 VAC 30-50-460 and* 12 VAC 30-50-470.

14. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (i) authorized for the individual by a physician in accordance with a plan of treatment, (ii) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (iii) furnished in a home.

12 VAC 30-50-130. Skilled nursing facility services, EPSDT, c~~ommunity mental health services~~ and family planning.

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

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

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

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

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are

covered for foster children of the local social services departments on specific referral from those departments.

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

4. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act § 1905(a).

~~C.~~ *5.* Community mental health services.

a. Intensive in-home services to children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks.

b. Therapeutic day treatment shall be provided in sessions of two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; medication; education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

a. A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children.

b. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12 VAC 30-50-100, 12 VAC 30-50-105, and 12 VAC 30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12 VAC 30-130-850 et seq.) of this chapter.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with 42 CFR Part 441 Subpart D, as contained in 42 CFR 441.151 (a) and (b) and 441.152 through 441.156. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

~~D.~~ *C.* Family planning services and supplies for individuals of child-bearing age.

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

2. Family planning services shall be defined as those services which delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

12 VAC 30-50-250. Inpatient psychiatric facility services for individuals under ~~22~~ *21* years of age.

Inpatient psychiatric facility services for individuals under ~~22~~ *21* years of age are not provided*, other than those provided under early and periodic screening, diagnosis, and treatment (12 VAC 30-50-130)*.

12 VAC 30-80-21. Inpatient psychiatric services in residential treatment facilities (under EPSDT).

A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.

B. Methodology. Effective January 1, 2000, payment will be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute payment for all residential psychiatric treatment facility services, excluding all professional services.

C. Data collection. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the Program shall take action in accordance with its policies to assure that an overpayment is not being made.

PART XIV.
RESIDENTIAL PSYCHIATRIC TREATMENT FOR CHILDREN AND ADOLESCENTS.

12 VAC 30-130-850. Definitions.

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

"Active treatment" means implementation of a professionally developed and supervised individual plan of care that must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

"Certification" means a statement signed by a physician that inpatient services in a residential treatment facility are or were needed. The certification must be made at the time of admission, or, if an individual applies for assistance while in a mental hospital or residential treatment facility, before the Medicaid agency authorizes payment.

"Comprehensive individual plan of care" or "CIPOC" means a written plan developed for each recipient in accordance with 12 VAC 30-130-890 to improve his condition to the extent that inpatient care is no longer necessary.

"Initial plan of care" means a plan of care established at admission, signed by the attending physician or staff physician, that meets the requirements in 12 VAC 30-130-890.

"Recertification" means a certification for each applicant or recipient that inpatient services in a residential treatment facility are needed. Recertification must be made at least every 60 days by a physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician.

"Recipient" or "recipients" means the child or adolescent younger than 21 years of age receiving this covered service.

12 VAC 30-130-860. Service coverage; eligible individuals; service certification.

A. Residential treatment programs shall be 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address the special mental health and behavioral needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services must include, but shall not be limited to, assessment and evaluation, medical treatment (including drugs), individual and group counseling, and family therapy necessary to treat the child.

B. Residential treatment programs shall provide a total, 24 hours per day, specialized form of highly organized, intensive and planned therapeutic interventions that shall be utilized to treat some of the most severe mental, emotional, and behavioral disorders. Residential treatment is a definitive therapeutic modality designed to deliver specified results for a defined group of problems for children or adolescents for whom outpatient day treatment or other less intrusive levels of care are not appropriate, and for whom a protected, structured milieu is medically necessary for an extended period of time.

C. Active treatment shall be required. Residential treatment services shall be designed to serve the mental health needs of children. In order to be reimbursed for residential treatment, the facility must provide active mental health treatment beginning at admission and it must be related to the recipient's principle diagnosis and admitting symptoms. To the extent that any recipient needs mental health treatment and his needs meet the medical necessity criteria for the service, he will be approved for these services. The service definitions do not include interventions and activities designed only to meet the supportive nonmental health special needs, including but not limited to personal care, habilitation or academic educational needs of the recipients.

D. An eligible individual is a recipient under the age of 21 years whose treatment needs cannot be met by ambulatory care resources available in the community, for whom proper treatment of his psychiatric condition requires services on an inpatient basis under the direction of a physician, and the services can reasonably be expected to improve his condition or prevent further regression so that the services will no longer be needed.

E. In order for Medicaid to reimburse for residential treatment to be provided to a recipient, the need for the service must be certified according to the standards and requirements set forth in subdivisions 1 and 2 of this subsection. At least one member of the independent certifying team must have pediatric mental health expertise.

1. For an individual who is already a Medicaid recipient when he is admitted to a facility or program, certification must be made by an independent certifying team that:

a. Includes a licensed physician;

b. Has competence in diagnosis and treatment of pediatric mental illness; and

c. Has knowledge of the recipient's mental health history and current situation.

2. For a recipient who applies for Medicaid while an inpatient in the facility or program, the certification must:

a. Be made by the team responsible for the plan of care;

b. Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and

c. Be signed by a physician member of the team.

12 VAC 30-130-870. Preauthorization.

A. Authorization for residential treatment shall be required within 24 hours of admission and shall be conducted by DMAS or its utilization management contractor using medical necessity criteria specified by DMAS. At preauthorization, an initial length of stay shall be assigned and the residential treatment provider shall be responsible for obtaining authorization for continued stay. Reimbursement for residential treatment will be implemented on January 1, 2000. For cases already in care, DMAS will reimburse beginning January 1, 2000, or from the date when the required

documentation is received and approved if the provider has a valid Medicaid provider agreement in effect on that date.

B. DMAS will not pay for admission to or continued stay in residential facilities that were not authorized by DMAS.

C. Information that is required in order to obtain admission preauthorization for Medicaid payment shall include:

1. A completed state-designated uniform assessment instrument approved by the department.

2. A certification of the need for this service by the team described in 12 VAC 30-130-860 that:

a. The ambulatory care resources available in the community do not meet the specific treatment needs of the recipient;

b. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

c. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will not be needed.

3. Additional required written documentation shall include all of the following:

a. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, effective October 1, 1996), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation, Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

b. A description of the child's behavior during the seven days immediately prior to admission;

c. A description of alternative placements tried or explored and the outcomes of each placement;

d. The child's functional level and clinical stability;

e. The level of family support available; and

f. The initial plan of care as defined and specified at 12 VAC 30-130-890.

D. Denial of service may be appealed by the recipient consistent with 12 VAC 30-110-10 et seq.; denial of reimbursement may be appealed by the provider consistent with the Administrative Process Act (§ 9-6.14:4.1 et seq. of the Code of Virginia).

12 VAC 30-130-880. Provider qualifications.

A. Providers must provide all residential treatment services as defined within this part and set forth in 42 CFR Part 441 Subpart D.

B. Providers must be:

1. A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations;

2. A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a psychiatric unit of an acute general hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

3. A psychiatric facility that is (i) accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children and (ii) licensed by DMHMRSAS as a residential treatment program for children and adolescents.

12 VAC 30-130-890. Plans of care; review of plans of care.

A. An initial plan of care must be completed at admission and a Comprehensive Individual Plan of Care must be completed no later than 14 days after admission.

B. Initial plan of care must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the recipient;

3. Treatment objectives with short-term and long-term goals;

4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and

6. Plans for discharge.

C. The Comprehensive Individual Plan of Care (CIPOC) must meet all of the following criteria:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and must reflect the need for inpatient psychiatric care;

2. Be developed by an interdisciplinary team of physicians and other personnel specified under subsection F of this section, who are employed by, or provide services to, patients in the facility in consultation with the recipient and his parents, legal guardians, or appropriate others in whose care he will be released after discharge;

3. Include state treatment objectives that must include measurable short-term and long-term goals;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

5. Describe discharge plans and coordination of inpatient services and post-discharge plans with related community services to ensure continuity of care upon

discharge with the recipient's family, school, and community.

D. Review of the Comprehensive Individual Plan of Care. The CIPOC must be reviewed every 30 days by the team specified in subsection F of this section to:

1. Determine that services being provided are or were required on an inpatient basis; and

2. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

E. The development and review of the plan of care as specified in this section satisfies the facility's utilization control requirements for recertification and establishment and periodic review of the plan of care, as required in 42 CFR 456.160 and 456.180.

F. Team developing the Comprehensive Individual Plan of Care. The following requirements must be met:

1. At least one member of the team must have expertise in pediatric mental health. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of all of the following:

a. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

b. Assessing the potential resources of the recipient's family;

c. Setting treatment objectives; and

d. Prescribing therapeutic modalities to achieve the plan's objectives.

2. The team must include, at a minimum, either:

a. A board-eligible or board-certified psychiatrist;

b. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

3. The team must also include one of the following:

a. A psychiatric social worker;

b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;

c. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals; or

d. A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

G. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement.

DOCUMENT INCORPORATED BY REFERENCE

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV Manual), Fourth Edition, Effective October 1, 1996, American Psychiatric Association.

NOTICE: The forms used in administering 12 VAC 30-130-10 et seq., Amount, Duration and Scope of Selected Services, are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS

Forms accompanying Part II of this chapter:

Virginia Uniform Assessment Instrument.

Forms accompanying Part III of this chapter:

MI/MR Supplement Level I (form and instructions).
MI/MR Supplement Level II.

Forms accompanying Part VII of this chapter:

Request for Hospice Benefits DMAS-420, Revised 5/91.

Forms accompanying Part VIII of this chapter:

Inventory for Client and Agency Planning (ICAP) Response Booklet, D9200/D9210, 1986.

Forms accompanying Part IX of this chapter:

Patient Information form.
Instructions for Completion DMAS-122 form.

Forms accompanying Part XII of this chapter:

Health Insurance Premium Payment (HIPP) Program Insurance Information Request Form.
Health Insurance Premium Payment (HIPP) Program Medical History Form (HIPP Form-7, Rev. 11/92).
Health Insurance Premium Payment (HIPP) Program Employers Insurance Verification Form (HIPP Form-2, Rev. 11/92).
Health Insurance Premium Payment (HIPP) Program Employer Agreement (HIPP Form-3, Rev. 11/92).
Health Insurance Premium Payment (HIPP) Program Notice of HIPP Determination (HIPP Form-4, Rev. 11/92).
Health Insurance Premium Payment (HIPP) Program Notice of HIPP Approval.
Health Insurance Premium Payment (HIPP) Program Notice of HIPP Status (HIPP Form-6, Rev. 11/92).
Inventory for Client and Agency Planning (ICAP) Response Booklet, D9200/D9210, 1986.

Forms accompanying Part XIV of this chapter:

Residential Psychiatric Treatment for Children and Adolescents, FH/REV (eff. 10/20/99).

DO NOT WRITE IN SHADED AREAS. DO NOT ADD CONDITIONS TO THE AGREEMENT. WE DO NOT ACCEPT AGREEMENTS VIA FAX OR AGREEMENTS ON THERMAL PAPER.

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Residential Psychiatric Treatment for Children and Adolescents

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

Enter 6-digit MEDICARE provider number here→ _____

This is to certify:	PAYMENT/CORRESPONDENCE ADDRESS	PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. The provider is a psychiatric entity licensed by DMHMRSAS as a Residential Treatment Program and accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) OR Council on Accreditation of Services for Families and Children OR the Commission on Accreditation of Rehabilitation Facilities and meets all the requirements in 42 CFR 441, Subpart D.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.§ 794) in DMAS.
3. The applicant agrees to keep such records as DMAS determines necessary. The applicant will furnish DMAS, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized DMAS representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
4. The provider agrees to care for patients at the DMAS rate as of the date the service is rendered, which is an all-inclusive fee.
5. Payment made by DMAS at its established rates constitutes full payment except for patient pay amounts determined by DMAS, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider will reimburse DMAS upon demand.
6. The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to DMAS.
7. The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.
8. This agreement may be terminated at will on 30 (thirty) days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.
9. All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
10. This agreement shall commence on _____ and terminate on _____

For First Health's use *only*

Director, Division of Program Operations Date

IRS Name (required)

mail one completed original agreement to: First Health - VMAP-Provider Enrollment Unit
4461 Cox Rd. Suite 102
Glen Allen, VA 23060-3331

For Provider of Services:

Original Signature of Provider Date

Title

____City OR ____County of _____

IRS Identification Number (Area Code) Telephone Number

Medicare Carrier and Vendor Number (if applicable)

residential

FH/REV 10/20/1999

VA.R. Doc. No. R00-81; Filed June 29, 2000, 3:55 p.m.

* * * * * * * *

Title of Regulation: **School Health Services: 12 VAC 30-50-10 et seq. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-229.1).**

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

Public Hearing Date: N/A -- Public comments may be submitted until September 29, 2000.
(See Calendar of Events section for additional information)

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of board action pursuant to the board's requirements.

Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA. The emergency regulation became effective on January 12, 2000.

Purpose: The purpose of this proposal is to promulgate permanent regulations, to supersede the current emergency regulations and to provide for the expansion of health care services which can be rendered by employees of school divisions to special education children and be reimbursed by Medicaid. This action is expected to benefit the health and welfare of special education children because it will permit them to obtain daily needed medical care while remaining in their educational settings.

Substance: In 1991, the Department of Medical Assistance Services began covering physical, occupational and speech-language therapies for the special education population in Virginia school divisions. This DMAS coverage expansion began as a result of a study by the Governor's Child Health Task Force as described in its report entitled "Investing in Virginia's Future" (December 1991). Under federal law, Virginia school divisions are required to offer special education services to children with handicapping conditions. DMAS became involved in covering special education services due to budgetary initiatives within the Commonwealth to utilize available federal Medicaid funding for services that otherwise had been funded by state and local sources. The particular services were selected by DMAS for coverage because the existing DMAS requirements for covering them were similar to the definitions and provider qualifications already implemented by the school divisions.

The federal Individuals with Disabilities Education Act (IDEA), as amended (20 USC § 1400 et seq.), requires school divisions to provide all special education and related services to children with one or more of 13 specified disabilities. Under the federal IDEA, school divisions prepare an Individualized Education Program (IEP) plan for each child qualifying under IDEA, specifying all special education and related services needed by the child. The IEP is the child-specific definitive document enumerating the care and services required. The children are to receive a "free appropriate" education (federally defined as special education and related services which include transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education), at no cost to the parents. The 1997 federal amendments reauthorizing IDEA added specificity as to the role of Medicaid and other noneducation entities in reimbursing for special education services. The greater specificity provided that agencies other than the local school authority had an obligation to precede the local school division in financing necessary special education services.

Federal funds are authorized under IDEA for the services but the majority of the funds have historically been from state and local revenues. The Medicare Catastrophic Coverage Act of 1988 amended Title XIX of the Social Security Act (the authority for the Medicaid program), providing that nothing under the Medicaid statute should be interpreted to prohibit Medicaid payments for services simply because they are prescribed in a child's Individualized Education Program. The IEP may refer to services such as speech therapy or nursing services for the treatment of the child.

For the special education services covered by DMAS, reimbursement is only for the federal portion of the payment. DMAS does not receive a general fund appropriation to reimburse for these school-based services. The school divisions provide documentation to DMAS that they expended funds for the services billed to DMAS. DMAS then reimburses the local school divisions for the federal share of the payment.

Since the initial DMAS coverage of school-based services in 1991, discussions have been ongoing between DMAS and the Department of Education (DOE) into further service expansions resulting in the changes that were effective July 1, 1997. In the fall of 1998, a joint legislative subcommittee discussed Medicaid coverage of school-based services resulting in Chapter 967 of The 1999 Virginia Acts of Assembly.

The 1999 Virginia Acts of Assembly Chapter 967 addressed several areas of Medicaid coverage of special education services and prompted the current emergency regulation. For example, the legislation addresses coverage of psychological/psychiatric services in schools and changes in provider qualifications for psychologists and speech therapists, substantially revises the DMAS/DOE interagency agreement, revises the payment rates for services, requires development of methods to assist school divisions in identifying Medicaid eligible children, and requires development of a document that combines elements of the DMAS Plan of Care with the DOE Individualized Education Program plan. Chapter 967 includes language not only to address qualifications of psychologists but also speech therapists and directs DMAS to recognize qualifications for services beyond what is currently recognized for reimbursement in nonschool settings.

DMAS is also extending, with these regulations, the length of coverage of skilled nursing services for children in special education. Currently in schools, DMAS covers a maximum 90 minutes a day of skilled nursing services. The decision to

cover beyond 90 minutes a day of skilled nursing services is based on a Virginia Office of Attorney General memorandum in August of 1999 citing language in Chapter 967 that DMAS coverage is to assist school divisions in the funding of medically necessary services "…by making use of every possible, cost-effective means…", the 1997 amendments to IDEA, and the Garret court decision.

In addition to Virginia's legislative activity, the U.S. Supreme Court issued a decision (Cedar Rapids Community School District v. Garret. 526 U.S.66, 143 L. Ed.2d 154, 119 S.Ct. 992 (1999)) in March of 1999 further affecting DMAS' considerations in expanding coverage of special education services. The Garret case involved a special education child who was wheelchair bound and ventilator dependent who required all day nursing services. The school division (Cedar Rapids) maintained that Garret needed medical services that are not included under the federal Individuals with Disabilities Education Act. The Court rejected this position finding that supportive services (such as nursing care) are included under the IDEA and school districts were required to fund the care, even for children having extensive nursing needs.

While Medicaid was not mentioned in this decision, the Garret case has received considerable publicity and underscores the extensive health care services school divisions must provide to children with special education needs under IDEA. The 1997 federal amendments re-authorizing IDEA provided that states identify agencies, other than education agencies, with responsibility for paying for special education services. These agencies are to have financial responsibility for the special education services preceding the local education agency. Title XIX Medicaid programs are specifically mentioned as part of this process.

These regulatory changes are essential for the economical performance of an important governmental function in that local school divisions will obtain federal Medicaid dollars for these special education services whereas, prior to the current emergency regulations, these services were provided out of state/local budgets.

Issues: The advantage for the affected children and their families is that these children will receive necessary health care services, with the parents' knowledge and approval, during the school day without requiring the parents to lose time from their jobs. The advantage to the schools by using their own employees is that the children will lose less instruction time (by eliminating the necessity for travel to a doctor's office). Medicaid coverage of therapy and screening services also serves as a source of income for the schools which replaces previously used local and state dollars. The agency projects no negative issues involved in implementing this proposed change.

Family Impact Statement: This regulatory action will not have any negative affects on the institution of the family or family stability. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, nor the assumption of family responsibilities. These proposed regulatory changes will have a positive impact on families of special education children. Since parents will be involved in developing their children's Individualized Education Plan, their consent for all of these covered services will be mandatory. These special needs children will be able to obtain some of the daily needed medical care from school nursing staffs which will permit these children to attend school while relieving their families of these demands.

Fiscal/Budget Impact: For the 1998-99 school year, DMAS "reimbursed" approximately $1.76 million to school divisions for Medicaid covered special education services. Slightly more than one-half of this amount is federal funds reimbursed by DMAS and the remaining portion is documented matching funds from school divisions allowing DMAS to draw-down the federal funds. The 1998-99 school year reimbursement represents about 11,200 claims paid for services.

Currently only about 44 school divisions actively bill Medicaid since enrollment by school divisions is voluntary. The expanded coverage in this regulatory package is also only for federal funds reimbursed by DMAS. The three items that account for the federal fund fiscal impact are: coverage for psychiatry and psychological services; the additional speech therapists providing services; and the longer duration of skilled nursing services covered. The total annual federal funds estimated to be needed are $884,000 but which will be prospectively adjusted (in the HCFA-37 requested funds report). There are no localities that are uniquely affected by these regulations as they apply statewide in so far as local school divisions choose to participate in Medicaid.

Funding Source/Cost to Localities/Affected Entities: The Department of Medical Assistance Services is established under the authority of Title XIX of the federal Social Security Act, Public Law 89-97, as amended; and Title 32.1, Chapter 10, of the Code of Virginia. The Virginia Medicaid Program is funded with both federal and state funds. The current federal funding participation (FFP) for medical assistance expenditures is 51.67%, which became effective October 1, 1999. This rate will increase to 51.85% on October 1, 2000.

This program is not expected to have any impact on local departments of social services as it does not affect eligible groups nor the eligibility determination process.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 9-6.14:7.1 G of the Administrative Process Act and Executive Order Number 25 (98). Section 9-6.14:7.1 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. This proposed regulatory change expands the health care services that can be rendered by employees of school divisions to special education children and be reimbursed by Medicaid. Specifically, the proposed regulation:

1. Expands the number of visits a student may have for therapy services;

2. Expands the provider qualifications for speech therapists;

3. Provides coverage for psychiatric and psychological evaluations and therapy services by appropriately licensed providers with parental involvement and permission;

4. Includes medication administration and monitoring as a skilled nursing service;

5. Extends the length of coverage of skilled nursing services from 90 minutes per day to 6.5 hours per day in order to cover the entire school day;

6. Clarifies that Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) routine screening services are covered for all Medicaid eligible students; and

7. Clarifies that family planning, pregnancy, and abortion services are excluded from coverage.

Medicaid coverage of these new services became effective January 12, 2000, under emergency regulations. The agency is now promulgating these permanent replacement regulations.

Estimated economic impact. The federal *Individuals with Disabilities Education Act* (IDEA) requires school divisions to provide all special education and related services to children with certain specified disabilities. Individual Education Programs (IEPs) are developed for each qualifying student detailing the care and services required for the student to receive a "free appropriate" education. Students receive medical services, such as speech therapy or skilled nursing services, which are required for them to benefit from their educational opportunities. These services are provided by the local school districts using local and state funds.

Since 1991, DMAS has covered physical, occupational, and speech-language therapies rendered by employees of school divisions to Medicaid-eligible special education children. Beginning in 1997, DMAS expanded coverage to include 90 minutes of skilled nursing services per day and IEP services and meetings. For the special education services covered by DMAS, reimbursement is only for the federal portion of the payment. The school divisions provide documentation to DMAS of state and local funds utilized in the delivery of services to special education students eligible for Medicaid. DMAS then reimburses the local school divisions for the federal share of the payment.

During CY1999, DMAS "reimbursed" approximately $1.94 million to school divisions for Medicaid covered special education services. The proposed expanded coverage of school-based services is expected to increase reimbursement to local school divisions by an estimated $844,000 annually. These federal Medicaid dollars will be used for services which, prior to the current emergency regulation, were provided with state and local funds. There will not be any changes in the quantity or quality of services provided to special education children in the school setting, therefore, there are no anticipated costs to the proposed changes to this regulation. Consequently, this proposed regulatory change will represent a net economic benefit.

Businesses and entities affected. The proposed changes to this regulation will affect any local school districts that choose to bill for Medicaid reimbursement. Currently, only about 44 of the 137 Virginia school divisions actively bill Medicaid.

Localities particularly affected. There are no localities uniquely affected by the proposed changes as they will apply statewide in so far as local school divisions choose to bill for Medicaid reimbursement.

Projected impact on employment. The proposed changes to this regulation are not anticipated to have a significant effect on employment.

Effects on the use and value of private property. The proposed changes to this regulation are not anticipated to have a significant effect on the use and value of private property.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The agency concurs with the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning Amount, Duration, and Scope of Services: Expansion of School-Based Services.

Summary:

The proposed amendments conform the State Plan to Chapters 967 and 1005 of the 1999 Acts of Assembly by expanding school health service coverage for special education children. The expanded services include, in accordance with the relevant child's individualized education program and medical necessity criteria, increased skilled nursing and physical, occupational, and speech/language therapy services; the recognition of different types of licenses for reimbursement by DMAS; and the coverage of psychiatric and psychological screenings in the schools. The proposed regulations also recognize the school's authority to conduct routine screenings of children who are not in special education.

12 VAC 30-50-229.1. School health services.

A. School health services *shall require parental consent and* shall be defined as those therapy ~~and~~ *services,* nursing services*, psychiatric/psychological screenings, and well-child screenings* rendered by *employees of* school divisions ~~which~~ *that* are enrolled with DMAS to serve children who*:*

1. Qualify to receive special education services as described under *and consistent with all of the requirements of* Part B of the federal Individuals with Disabilities Education Act, as amended (20 USC § 1400 et seq.). Children qualifying for special education services pursuant to Part B of the federal Individuals with Disabilities Education Act, as amended, shall not be restricted in their choice of enrolled providers of medical care services as described in the State Plan for Medical Assistance~~.~~*; or*

2. Qualify to receive screening services under the State Plan and have parental consent for routine health

screenings, but not diagnostic and treatment services, that are covered under early and periodic screening, diagnosis and treatment services.

B. Physical therapy and related services.

1. The services covered under this subsection shall include physical therapy, occupational therapy, and speech/language pathology services. All of the requirements*, with the exception of the 24-visit limit,* of 12 VAC 30-50-200 and 42 CFR 440.110 applicable to these services shall continue to apply with regard to, but not necessarily limited to, necessary authorizations, documentation requirements, *and* provider qualifications~~, and service limitations~~. *Consistent with the child's Individualized Education Program (IEP), 35 therapy visits will be covered per year per discipline without DMAS prior authorization.*

2. Consultation by physical therapy, occupational therapy, or speech pathology providers in meetings for the development, evaluation, or reevaluation of the ~~Individualized Education Program (IEP)~~ *IEP* for specific children shall be covered when the IEP with the physical therapy, occupational therapy, or speech pathology services is implemented (based on the date of services billed to DMAS) as soon as possible after the IEP meeting, not to exceed 60 days, except where there are extenuating circumstances. This consultation is to be billed to DMAS no earlier than the date such services are implemented. No more than two consultations *(across all three areas of therapies, nursing, and psychiatric/psychological disciplines)* may be billed for each child annually. This annual limitation includes consultations billed to DMAS attended by either registered nurses ~~or~~*,* licensed practical nurses*, therapists, or psychiatrists/psychologists*. If an IEP eligibility meeting is billed to DMAS, then the subsequent IEP plan meeting must also be billed for any DMAS reimbursement to occur.

3. Extenuating circumstances are recognized regarding the coverage of the IEP consultation when the physical therapy, occupational therapy, or speech pathology services cannot be implemented as soon as possible following the effective date of the IEP. Such extenuating circumstances may include, but shall not be limited to, arrangements for transportation, hospitalization of the child, or summer or vacation periods. DMAS or its contractor must approve other extenuating circumstances.

4. Consistent with § 32.1-326.3 of the Code of Virginia, speech-language services must be rendered either by:

a. A speech-language pathologist who meets the qualifications under 42 CFR 440.110(c): (i) has a certificate of clinical competence from the American Speech and Hearing Association; (ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

b. A speech-language pathologist with a current license in speech pathology issued by the Board of Audiology and Speech-Language Pathology;

c. A speech-language pathologist licensed by the Board of Education with an endorsement in speech-language disorders preK-12 and a master's degree in speech-language pathology. These persons also have a license without examination from the Board of Audiology and Speech-Language Pathology; or

d. A speech-language pathologist who does not meet the criteria for subdivisions a, b, or c above and is directly supervised by a speech-language pathologist who meets the criteria of clause a (i) or a (ii) or subdivision b or c above. The speech-language pathologist must be licensed by the Board of Education with an endorsement in speech-language disorders preK-12 but does not hold a master's degree in speech-language pathology. Direct supervision must take place on site at least every 30-calendar days for a minimum of two hours and must be documented accordingly. The speech-language pathologist who meets the criteria for clause a (i) or a (ii) or subdivision b or c above is readily available to offer needed supervision when speech-language services are provided.

C. Skilled nursing services.

1. These *services* must be medically necessary skilled nursing services ~~which~~ *that* are required by a child in order to benefit from an educational program, as described under Part B of the federal Individuals with Disabilities Education Act, as amended (20 USC § 1400 et seq.). These services shall be limited to a maximum of ~~six~~ *26* units a day of medically necessary services. Services not deemed to be medically necessary, upon utilization review, shall not be covered. A unit, for the purposes of this school-based health service, shall be defined as 15 minutes of ~~medical~~ *skilled nursing* care.

2. These services must be performed by a Virginia-licensed registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a licensed RN. The service provider shall be either employed by the school division or under contract to the school division. The skilled nursing services shall be rendered in accordance with the licensing standards and criteria of the Virginia Board of Nursing. Supervision of LPNs shall be provided consistent with the regulatory standards of the Board of Nursing at 18 VAC 90-20-270.

3. Consultation by skilled nursing providers in meetings for the development, evaluation, or reevaluation of the IEP for specific children shall be covered when the IEP with the skilled nursing services is implemented (based on the dates of services billed to DMAS) as soon as possible after the IEP meeting, not to exceed 60 days, except where there are extenuating circumstances. This consultation is to be billed to DMAS no earlier than the date such services are implemented. No more than two consultations *(across all three areas of therapies, nursing, and psychiatric/psychological disciplines)* may

be billed for each child annually. This annual limitation includes consultations billed to DMAS attended by physical therapists, occupational therapists, ~~and~~ speech therapists*, nurses, and psychiatrists/psychologists*. If an IEP eligibility meeting is billed to DMAS, then the subsequent IEP plan meeting must also be billed for any DMAS reimbursement to occur.

4. Extenuating circumstances are recognized regarding the coverage of the IEP consultation when the skilled nursing services cannot be implemented as soon as possible following the effective date of the IEP. Such extenuating circumstances may include, but shall not be limited to, arrangements for transportation, hospitalization of the child, or summer or vacation periods. DMAS or its contractor must approve other extenuating circumstances.

5. The *coverage of skilled nursing* services shall be of a level of complexity and sophistication *(based on assessment, planning, implementation and evaluation)* which ~~are~~ *is* consistent with skilled nursing services *when performed by a registered nurse or a licensed practical nurse*. These skilled nursing services shall include, but not necessarily be limited to, dressing changes, maintaining patent airways, *medication administration/monitoring* and urinary catheterizations. *Skilled nursing services shall be consistent with the medical necessity criteria in the school services manual.*

6. Skilled nursing services shall be directly and specifically related to an active, written plan of care which is based on a physician's or nurse practitioner's written order for skilled nursing services. The registered nurse shall establish, sign, and date the plan of care. The plan of care shall be periodically reviewed by a physician or nurse practitioner after any needed consultation with skilled nursing staff. The services shall be specific and provide effective treatment for the child's condition in accordance with accepted standards of skilled nursing practice. The plan of care is further described in subdivision 7 of this subsection. Skilled nursing services rendered which exceed the physician's or nurse practitioner's written order for skilled nursing services shall not be reimbursed by DMAS. A copy of the plan of care shall be given to the child's Medicaid primary care provider.

7. Documentation of services shall include a written plan of care which identifies the medical condition or conditions to be addressed by skilled nursing services, goals for skilled nursing services, time tables for accomplishing such stated goals, actual skilled nursing services to be delivered and whether the services will be delivered by an RN or LPN. Services which have been delivered and for which reimbursement from Medicaid is to be claimed must be supported with like documentation. Documentation of school-based skilled nursing services shall include the dates and times of services entered by the responsible licensed nurse; the actual nursing services rendered; the identification of the child on each page of the medical record; the current diagnosis and elements of the history and exam which form the basis of the diagnosis; any prescribed drugs which are part of the treatment including the quantities ~~and~~*,* dosage*, and frequency*; and notes to indicate progress made by the child, changes to the diagnosis, or treatment and response to treatment. The plan of care is to be part of the child's medical record. Actions related to the skilled nursing services such as notifying parents, calling the physician, or notifying emergency medical services shall also be documented. All documentation shall be signed and dated by the person performing the service. *Lengthier skilled nursing services shall have more extensive documentation.* The documentation shall be written immediately, or as soon thereafter as possible, after the procedure or treatment was implemented with the date and time specified, unless otherwise instructed in writing by Medicaid. Documentation is further described in the Medicaid school services manual. Skilled nursing services documentation shall otherwise be in accordance with the Virginia Board of Nursing, Department of Health, and Department of Education statutes, regulations, and standards relating to school health. Documentation shall also be in accordance with school division standards.

8. Service limitations. The following general conditions shall apply to reimbursable skilled nursing services in school divisions:

a. Patient must be under the care of a physician or nurse practitioner who is legally authorized to practice and who is acting within the scope of his license.

b. A recertification by a physician or nurse practitioner of the skilled nursing services shall be conducted at least once each school year. The recertification statement must be signed and dated by the physician or nurse practitioner who reviews the plan of care, and may be obtained when the plan of care is reviewed. The physician or nurse practitioner recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

c. Physician or nurse practitioner orders for nursing services shall be required.

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

e. Skilled nursing services are to be terminated when further progress toward the treatment goals are unlikely or when they are not benefiting the child or when the services can be provided by someone other than the skilled nursing professional.

D. Psychiatric and psychological services. Evaluations and therapy services shall be covered when rendered by individuals who are licensed by the Board of Medicine and practice as psychiatrists or by psychologists licensed by the

Board of Psychology as clinical psychologists or by school psychologists-limited licensed by the Board of Psychology. Services by these practitioners shall be subject to coverage at 12 VAC 30-50-140 D.

1. Consultation by psychiatric/psychologist providers in meetings for the development, evaluation, or reevaluation of the IEP for specific children shall be covered when the IEP with the psychiatric/psychological services is implemented (based on the dates of services billed to DMAS) as soon as possible after the IEP meeting, not to exceed 60 days, except where there are extenuating circumstances. This consultation is to be billed to DMAS no earlier than the date such services are implemented. No more than two consultations (across all three therapies, nursing, and psychiatric/psychological disciplines) may be billed for each child annually. This annual limitation includes consultations billed to DMAS attended by physical therapists, occupational therapists, speech therapists, and nurses. If an IEP eligibility meeting is billed to DMAS, then the subsequent IEP plan meeting must also be billed for any DMAS reimbursement to occur.

2. Extenuating circumstances are recognized regarding the coverage of the IEP consultation when the psychological services cannot be implemented as soon as possible following the effective date of the IEP. Such extenuating circumstances may include, but shall not be limited to, arrangements for transportation, hospitalization of the child, or summer or vacation periods. DMAS or its contractor must approve other extenuating circumstances.

E. Early and periodic screening, diagnosis, and treatment (EPSDT) services. Routine screening services shall be covered for school divisions when rendered by either physicians or nurse practitioners. Diagnostic and treatment services also covered under EPSDT shall not be covered for school divisions. School divisions shall be required to refer children who are identified through health assessment screenings as having potential abnormalities to their primary care physician for further diagnostic and treatment procedures.

F. Specific exclusions from school health services. All services encompassing and related to family planning, pregnancy, and abortion services shall be specifically excluded from Medicaid reimbursement if rendered in the school district setting.

VA.R. Doc. No. R00-89; Filed July 10, 2000, 4:06 p.m.

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Title of Regulation: **Case Management for Treatment Foster Care:**

12 VAC 30-50-10 et seq. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-480).

12 VAC 30-60-10 et seq. Standards Established and Methods Used to Assure High Quality Care (amending 12 VAC 30-60-170).

12 VAC 30-80-10 et seq. Methods and Standards for Establishing Payment Rates; Other Types of Care (adding 12 VAC 30-80-111).

12 VAC 30-130-10 et seq. Amount, Duration and Scope of Selected Services (adding 12 VAC 30-130-900 through 12 VAC 30-130-950).

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

Public Hearing Date: N/A -- Public comments may be submitted until September 29, 2000.
(See Calendar of Events section for additional information)

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of board action pursuant to the board's requirements.

Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA. The emergency regulation became effective on January 1, 2000.

Chapter 935 of the 1999 Virginia Acts of Assembly contained the following language to replace similar authority granted in the 1998 Appropriation Act.

"As a condition of this appropriation, the Department [of Medical Assistance Services] shall promulgate regulations to implement Medicaid reimbursement for treatment foster care designed to serve children and youth referred by local Comprehensive Services Act teams. If the Health Care Financing Administration approves treatment foster care for Medicaid reimbursement, emergency regulations as specified in § 9-6.14:4.1 C 5, Code of Virginia, shall be effective January 1, 2000, or earlier. However, emergency regulations may become effective at a later date if the federal Health Care Financing Administration determines, upon submission of a proposal by the Department, that federal regulations preclude earlier implementation."

Furthermore,

"…if the United States Department of Health and Human Services or the Health Care Financing Administration determines that the process for accomplishing the intent of a part, section, subsection, paragraph, clause, or phrase of this item is out of compliance or in conflict with federal law and regulation and recommends another method of accomplishing the same intent, the Director of the Department of Medical Assistance Services, after consultation with the Attorney General, is authorized to pursue the alternative method."

Purpose: The purposes of this proposal are to promulgate permanent regulations to supercede the current emergency regulations and to cover case management for treatment foster care services. This is a new service for Medicaid coverage and will benefit the health of the children who

directly receive this service and provide additional supports to their families to restore healthy functioning and relationships.

Chapter 935 of the 1999 Virginia Acts of Assembly and Chapter 464 of the 1998 Virginia Acts of Assembly directed the department to submit an amendment to the State Plan for Medical Assistance to provide Medicaid coverage for treatment foster care. The amendment was initially to have been effective January 1, 1999. The 1999 Appropriation Act extended the effective date to January 1, 2000. The amendment for treatment foster care was to have taken effect within 280 days of enactment of the act, giving DMAS the authority to promulgate emergency regulations.

This new service was designed to provide federal Medicaid matching funds for a service funded at the present time only through state and local funding. Prior to this legislative mandate, the Joint Legislative Audit and Review Commission (JLARC) completed in 1997 a review of the Comprehensive Services Act (CSA). JLARC recommended that Medicaid coverage be extended to include treatment foster care. More access to this level of care can be instrumental in avoiding the use of more restrictive and expensive institutional services. The 1998 and 1999 Appropriation Act provisions were based upon these JLARC recommendations.

During 1998, DMAS staff worked with a large work group of stakeholders, including representatives from the Office of Comprehensive Services, to redesign a program intended to meet all federal requirements. The proposed State Plan amendment was informally submitted to the Health Care Financing Administration (HCFA) for review in November 1998. In December 1998, federal staff informed DMAS that the coverage of treatment foster care would not be approved as a State Plan amendment because the service included components not qualifying for Medicaid federal matching funds.

During 1999, DMAS continued to explore with HCFA alternative available avenues to federal funding for treatment foster care services for CSA children. Based on technical assistance by staff of HCFA, the covered service was redesigned and redefined as case management of treatment foster care. This revision permits Medicaid reimbursement for case management services that are a major portion of costs for CSA children in treatment foster care. This approach removes other components of treatment foster care that did not qualify for Medicaid federal matching funds, such as the stipend for foster parents.

In 1992, the Virginia General Assembly enacted the Comprehensive Services Act for At-Risk Youth and Families (Chapter 46, Title 2.1 of the Code of Virginia). The intent of the legislation was to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families. The purpose is to preserve families and provide appropriate services in the least restrictive environment while protecting the welfare of children and maintaining public safety. Part of the initiatives to improve services to children was the development of a continuum of care for children including in-home services, specialized foster homes, and residential treatment services. The specialized foster homes include treatment foster homes for children with behavioral or mental health problems.

DMAS expects that coverage of case management for children who are receiving treatment foster care services will provide additional support and services to families in trouble. This is expected to promote family unity and healing of dysfunctional relationships.

Issues: The primary advantages of covering this new service through Medicaid will be the standardization and provision of the service and a uniform quality of care across the Commonwealth, and the reduction of some of these costs of care from general fund and local dollars. The disadvantage that may occur is providers' dislike of Medicaid's federal requirements and uniform reimbursement rates.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 9-6.14:7.1 G of the Administrative Process Act and Executive Order Number 25 (98). Section 9-6.14:7.1 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. DMAS proposes to add coverage of case management for treatment foster care services. Previously, this service was not covered by Medicaid. Including this service under Medicaid coverage will provide federal matching funds for a service that otherwise would be funded with only state and local money.

Background. The Comprehensive Services Act (CSA) was established by the 1992 General Assembly as a comprehensive, interagency system of care for at-risk children. Children in certain mandated populations (foster care, foster care prevention, special education students) can receive residential psychiatric treatment, foster care, specialized education programs, and therapeutic counseling services under the CSA. Services under the CSA are funded by localities and merged state funds from the Department of Education, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Department of Social Services, and the Department of Youth and Family Services.[1] In FY 1997, 14,501 children were provided services under the CSA.

In 1997, the Joint Legislative Audit and Review Commission (JLARC) published a "Review of the Comprehensive Services Act" (Senate Document No. 26). This report made a number of recommendations for improvement of the CSA, including proposing the use of Medicaid funding to serve children for which Medicaid payment could be made. By doing so, federal

[1] The Department of Youth and Family Services was the predecessor to the current Department of Juvenile Justice.

matching funds could be obtained for services currently paid completely by the state and localities. The 1998 General Assembly acted on the JLARC report and directed the Department of Medical Assistance Services (DMAS) to add coverage of treatment foster care to the State Plan for Medical Assistance.

DMAS informally submitted the proposed State Plan amendment to the Health Care Financing Administration (HCFA) for review in November 1998. In December 1998, federal staff at HCFA informed DMAS that coverage of treatment foster care would not be approved as a State Plan amendment because the service included components that did not qualify for Medicaid federal matching funds. Based on technical assistance by HCFA staff, the covered service has been redesigned and redefined as *case management* of treatment foster care. This approach allows Medicaid reimbursement for case management services that are a major part of costs for CSA children in treatment foster care but removes other components, such as the stipend for foster parents, which do not qualify for federal matching funds. Medicaid coverage of this new case management service became effective on January 1, 2000, under emergency regulations. The agency is now promulgating these permanent replacement regulations.

Estimated economic impact. The proposed regulations will implement Medicaid coverage of case management of treatment foster care and allow Virginia to draw on federal matching funds to pay for services that otherwise would be paid with 100% state and local funds. As of October 1, 1999, the federal participation rate for medical assistance services in Virginia is 51.67%, but it is estimated that this rate will rise to 51.85% on October 1, 2000.

In its 1997 report, JLARC reported that $20.8 million was spent by the CSA program on therapeutic foster care for 1,305 Medicaid-eligible children, at an average cost of $16,000 per child.[2,3] Since only a portion of the services included in the JLARC estimate have been approved by the federal government for Medicaid coverage, the estimated average cost for the covered services is $12,143 per child. If Medicaid funding had been used for each of these children, state and local governments could have saved $7.6 million.[4] Due to the large number of unknowns associated with implementation of this policy change, it is difficult to project an exact annual fiscal impact. However, any projection would require that the 1997 estimate be adjusted for the following factors:

1. Growth in the CSA population: JLARC identified 1,305 children in FY1997 whose treatment could potentially be funded by Medicaid. This represented 9.0% of the total FY1997 CSA population (14,501). CSA caseloads have been growing at 1.5% to 2.0% per year for the past two years.[5] Assuming that the percentage of children for whom Medicaid funding could be used remains constant, the population eligible for Medicaid coverage is likely to be higher than 1,305. The general funds for services for CSA-children were appropriated to CSA and will be transferred to DMAS as needed to make expenditures to providers.

2. Cost savings under Medicaid: Federal Medicaid matching funds are accompanied by prescriptive provider requirements and utilization management requirements. Although some of these requirements may involve administrative and program changes by localities, they may also reduce the average cost of service paid for each child. Currently, each facility negotiates a rate of reimbursement with each local Community Policy and Management Team. Under the proposed policy, DMAS will set a maximum allowable reimbursement rate. Localities will continue to negotiate rates and DMAS will pay the negotiated rate up to the maximum allowed. Utilization management under Medicaid may also decrease the average length of stay for some recipients as cases are more actively monitored. The extent of any cost reductions are not known at this time, however, they will only increase the fiscal savings associated with this proposal.

3. Responsiveness of localities to proposed policy change: The proposed regulation does not require that localities utilize Medicaid funding for eligible children. Although localities would save money, the federal requirements that accompany the federal funds may deter some localities from taking advantage of Medicaid reimbursement. The potential savings of this policy change will depend on the extent it is used by localities, which is not known at this time.

Aside from the expected fiscal savings, this regulatory change will also provide standardization across the state with respect to case management of treatment foster care services and consequently should standardize the services and quality of care that those children receive.

The primary disadvantages to the proposed regulation are the federal requirements that accompany federal funding. This will primarily affect service providers, although localities may also have administrative and program requirements to comply with. Case management of treatment foster care will be offered by child placing agencies that operate such programs and that are licensed or certified by the Department of Social Services. There are currently 42 certified/licensed child placing agencies in Virginia. Thirty-four of those have already enrolled as Medicaid providers.

Businesses and entities affected. The proposed regulation will affect all children in Virginia who receive or are in need of

[2] Cost estimates reported are in 1995 dollars.

[3] The estimate includes only children that were Medicaid eligible in FY1995, who received CSA funded therapeutic foster care services, and were assessed to have the risk factors and/or psychiatric symptoms which indicate that they may potentially meet Medicaid's program eligibility criteria. For more details, please refer to Appendix D of the JLARC 1997 "Review of the Comprehensive Services Act" (Senate Document No. 26).

[4] State and local savings estimated here are based on the FY 1997 Medicaid match rate of 51.45 federal, 48.55 State. Using average State and local shares of 62.7% and 37.3%, respectively, the State savings would be $4.8 million and local savings $2.8 million.

[5] Unofficial estimates provided by the Office of Comprehensive Services: FY1998 CSA population approximately 14,700 (1.4% growth); FY1999 CSA population approximately 15,000 (2.0% growth).

treatment foster care, estimated to be approximately 1,305. Providers of these services who enroll as Medicaid providers will also be affected by this regulation in addition to localities responsible for placing children in treatment foster care.

Localities particularly affected. The proposed regulation should not uniquely affect any localities as it applies statewide.

Projected impact on employment. The proposed regulation is not anticipated to have any significant impact on employment in Virginia.

Effects on the use and value of private property. The proposed regulation is not anticipated to have any significant effects on the use and value of private property in Virginia.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The agency concurs with the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning Case Management for Treatment Foster Care.

Summary:

The proposed amendments add coverage of case management for treatment foster care services. Previously, this service was not covered by Medicaid. Including this service under Medicaid coverage will provide federal matching funds for a service that otherwise would be funded with only state and local money.

12 VAC 30-50-480. ~~(Reserved.)~~ *Case management for foster care children.*

A. Target group. Children or youth with behavioral disorders or emotional disturbances who are referred to treatment foster care by the Family Assessment and Planning Team of the Comprehensive Services Act for Youth and Families (CSA). "Child" or "youth" means any Medicaid eligible individual to 21 years of age who is otherwise eligible for CSA services. Family Assessment and Planning Teams (FAPT) are multidisciplinary teams of professionals established by each locality in accordance with §§ 2.1-753, 2.1-754, and 2.1-755 of the Code of Virginia to assess the needs of referred children. The FAPT shall develop individual services plans for youths and families who are reviewed by the team. The FAPT shall refer those children needing treatment foster care case management to a qualified participating case manager.

B. Services will be provided in the entire state.

C. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

D. Definition of services. Case management shall assist individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of a child. Case management services will coordinate services to minimize fragmentation of care, reduce barriers, and link children with appropriate services to ensure comprehensive, continuous access to needed medical, social, educational, and other services appropriate to the needs of the child. The foster care case manager will provide:

1. Periodic assessments to determine clients' needs for psychosocial, nutritional, medical, and educational services.

2. Service planning by developing individualized treatment and service plans to describe what services and resources are needed to meet the service needs of the client and help access those resources. Such service planning shall not include performing medical and psychiatric assessment but shall include referrals for such assessments. The case manager shall collaborate closely with the FAPT and other involved parties in preparation of all case plans.

3. Coordination and referral by assisting the client in arranging for appropriate services and ensuring continuity of care for a child in treatment foster care. The case manager shall link the child to services and supports specified in the individualized treatment and service plan. The case manager shall directly assist the child to locate or obtain needed services and resources. The case manager shall coordinate services and service planning with other agencies and providers involved with the child by arranging, as needed, medical, remedial, and dental services.

4. Followup and monitoring by assessing ongoing progress in each case and ensuring services are delivered. The case manager shall continually evaluate and review each child's plan of care. The case manager shall collaborate with the FAPT and other involved parties on reviews and coordination of services to youth and families.

5. Education and counseling by guiding the client and developing a supportive relationship that promotes the service plan.

E. Provider participation. Any public or private child-placing agency licensed or certified by the Department of Social Services for treatment foster care may be a provider of treatment foster care case management.

Providers may bill Medicaid for case management for children in treatment foster care only when the services are provided by qualified treatment foster care case managers. The case manager must meet, at a minimum, the case worker qualifications found in the Minimum Standards for Licensed Child-Placing Agencies (22 VAC 40-130-10 et seq.).

F. Freedom of choice. Section 1915(g)(1) of the Act specifies that there shall be no restriction on free choice of qualified providers, in violation of § 1902(a)(23) of the Act. The state assures that there will be no restriction on a recipient's free choice of qualified providers of case management services. In addition, the state assures that case management services will not restrict an individual's free choice of providers of other Medicaid services.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible recipients will be free to refuse case management services.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. The case management services will be funded from Medicaid service funds, not administrative. This case management service shall not be construed as case management under EPSDT.

12 VAC 30-60-170. ~~(Reserved.)~~ *Utilization review of treatment foster care case management services (TFC).*

A. Service description and provider qualifications. TFC case management is a community-based program where treatment services are designed to address the special needs of children. TFC case management focuses on a continuity of services, is goal directed, results oriented, and emphasizes permanency planning for the child in care. Services shall not include room and board. Child-placing agencies licensed or certified by the Virginia Department of Social Services and that meet the provider qualifications for treatment foster care set forth in Part XV (12 VAC 30-130-900 et seq.) of this chapter shall provide these services.

B. Utilization control.

1. Assessment. Each child referred for TFC case management must be assessed by a Family Assessment and Planning Team (FAPT) under the Comprehensive Services Act or by an interdisciplinary team approved by the State Executive Council. The team must (i) assess the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; (ii) assess the potential for reunification of the child's family; (iii) set treatment objectives; and (iv) prescribe therapeutic modalities to achieve the plan's objectives.

2. Qualified assessors. A qualified assessor is a Family Assessment and Planning Team as authorized under §§ 2.1-753, 2.1-754, and 2.1-755 of the Code of Virginia.

3. Preauthorization. Preauthorization shall be required for Medicaid payment of TFC case management services for each admission to this service and will be conducted by DMAS or its utilization management contractor. When service is authorized, an initial length of stay will be assigned. The provider must request authorization for continued stay. Failure to obtain authorization of Medicaid reimbursement for this service within 10 days of admission will result in denial of payments or recovery of expenditures.

4. Medical necessity criteria. Children whose conditions meet this medical necessity criteria will be eligible for Medicaid payment for TFC case management. TFC case management will serve children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) or children with behavioral disorders who in the absence of such programs would be at risk for placement into more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs or group homes. The child must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on a state-designated uniform assessment instrument. The child's condition must meet one of the three levels described below.

a. Level I: Moderate impairment with one or more of the following moderate risk factors as documented on the state-designated uniform assessment instrument:

(1) Needs intensive supervision to prevent harmful consequences;

(2) Moderate/frequent disruptive or noncompliant behaviors in home setting which increase the risk to self or others;

(3) Needs assistance of trained professionals as caregivers.

b. Level II: Child must display a significant impairment with problems with authority, impulsivity and caregiver issues as documented on the state-designated uniform assessment instrument. For example, the child must:

(1) Be unable to handle the emotional demands of family living;

(2) Need 24-hour immediate response to crisis behaviors; or

(3) Have severe disruptive peer and authority interactions that increase risk and impede growth.

c. Level III: Child must display a significant impairment with severe risk factors as documented on the state-designated uniform assessment instrument. Child must demonstrate risk behaviors that create significant risk of harm to self or others.

5. TFC case management admission documentation required. Before Medicaid preauthorization will be granted, the referring entity must submit the following documentation. The documentation will be evaluated by DMAS or its designee to determine whether the child's condition meets the department's medical necessity criteria.

a. A completed state-designated uniform assessment instrument;

b. Diagnosis (Diagnostic Statistical Manual, Fourth Revision (DSM IV), including Axis I (Clinical Disorders); Axis II (Personality Disorders/Mental Retardation); Axis III (General Medical Conditions); Axis IV (Psychosocial and Environmental Problems); and Axis V (Global Assessment of Functioning);

c. A description of the child's immediate behavior prior to admission;

d. A description of alternative placements tried or explored;

e. The child's functional level;

f. Clinical stability;

g. The level of family support available;

h. Initial plan of care; and

i. One of the following:

(1) Written documentation that the Community Planning and Management Team (CPMT) has approved the admission to treatment foster care; or

(2) Certification by the FAPT that TFC case management is medically necessary.

6. Penalty for failure to obtain preauthorization or to prepare and maintain the previously described documentation. The failure to obtain authorization for this service within 10 days of admission or to develop and maintain the documentation enumerated above will result in denial of payments or recovery of expenditures.

12 VAC 30-80-111. Treatment foster care (TFC) case management.

The Medicaid agency will reimburse providers for the covered services for TFC case management for each eligible child at the daily rate agreed upon between the local Community Policy and Management Team (CPMT) in the locality which is responsible for the child's care and the TFC case management provider. This daily rate shall be based upon the intensity of the case management needed by the child and be subject to an upper limit set by the Medicaid agency. DMAS shall pay the lesser of the rate negotiated by the CPMT or the maximum rate established by the department.

PART XV.
CASE MANAGEMENT TREATMENT FOSTER CARE SERVICES.

12 VAC 30-130-900. Definitions.

The following words and terms when used in this part shall have the following meanings, unless the context indicates otherwise:

"Case management" means an activity, including casework, which assists Medicaid eligibles in gaining and coordinating access to necessary care and services appropriate to his needs.

"Casework" means both direct treatment with an individual or several individuals, and intervention in the situation on the client's behalf. The objectives of casework include meeting the client's needs, helping the client deal with the problem with which he is confronted, strengthening the client's capacity to function productively, lessening distress, and enhancing opportunities and capacities for fulfillment.

"Child" means any individual less than 18 years of age or under 21 if placed by a local department of social services or through referral from a Family Assessment and Planning Team.

"Child's family" means the birth or adoptive parent or parents, legal guardian or guardians, or family to whom the child may return.

"Child placing agency," "agency" or "agencies" means any person who places children in foster homes, adoptive homes, child-caring institutions or independent living arrangements in response to §§ 63.1-204, 63.1-205, and 63.1-220.2 of the Code of Virginia or a local board of public welfare or social services that places children in foster homes or adoptive homes pursuant to §§ 63.1-56, 63.1-204, and 63.1-220.2 of the Code of Virginia. Officers, employees, or agents of the Commonwealth, or of any county, city, or town, acting within the scope of their authority as such, who serve as or maintain a child-placing agency shall not be required to be licensed if authorized by the Code of Virginia to provide the services of a child-placing agency.

"Client" means Medicaid-eligible and enrolled individual.

"Community Planning and Management Team" means a team described in § 2.1-750 of the Code of Virginia.

"Comprehensive Services Act" means § 2.1-745 et seq. of the Code of Virginia.

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

"Family Assessment and Planning Team" means a team described in §§ 2.1-753, 2.1-754, and 2.1-755 of the Code of Virginia.

"Foster care placement" means placement of a child through (i) an agreement between the parents or guardians and the local board or the public agency designated by the community policy and management team where legal custody remains with the parents or guardians or (ii) an entrustment or commitment of the child to the local board or child-placing agency.

"Foster care services" means the provision of a full range of casework, treatment and community services for a planned period of time to a child under age 21 who is abused or neglected as defined, except for age, in § 63.1-248.2 of the Code of Virginia or in need of services as defined in § 16.1-228 of the Code of Virginia and to his family when the child (i) has been identified as needing services to prevent or eliminate the need for foster care placement, (ii) has been placed through an agreement between the local board of social services or the public agency designated by the community policy and management team and the parents or guardians, and (iii) has been committed or entrusted to a local board of social services or child-placing agency.

"Foster home" means the place of residence of any individual or individuals approved by a local department of social services or licensed child placing agency in which any child other than a child by birth or adoption resides as a member of the household.

"Initial plan of care" means a written plan which delineates the services that are to be provided to the child at admission.

"Records" means the written information assembled in a file relating to the agency, staff, volunteers, the child, the child's birth family, the child's foster family, the child's treatment foster family, and the child's adoptive family.

"Treatment" is the coordinated provision of services and use of professionally developed and supervised interventions designed to produce a planned outcome in a person's behavior, attitude, emotional functioning or general condition.

"Treatment and service plan" means a written comprehensive plan of care, based on an assessment of the medical, psychological, social, behavioral and developmental aspects of the child's situation, containing measurable goals, procedures and interventions for achieving them, and a process for assessing the results. The treatment plan must state the treatment objectives; prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and must include coordination with related community services to ensure continuity of care with the child's family, school and community.

"Treatment foster care (TFC)" means a community-based program where services are designed to address the special needs of children. Services to the children are delivered primarily by treatment foster parents who are trained, supervised, and supported by agency staff. Treatment is primarily foster family based and is planned and delivered by a treatment team.

Treatment foster care focuses on a continuity of services, is goal-directed, results oriented, and emphasizes permanency planning for the child in care.

"Treatment team" means the group that may consist of the child, professional agency staff, other professionals, the child's family members (where appropriate), and the child-placing agency and treatment foster parents who provide mutual support, evaluate treatment, and design, implement and revise the treatment and service plan.

12 VAC 30-130-910. Targeted case management for foster care children in treatment foster care covered services.

Service description. Case management is a component of treatment foster care (TFC) through which a case manager or caseworker provides treatment planning, treatment services, monitors the treatment plan and links the child to other community resources as necessary to address the special identified needs of the child. Services to the children shall be delivered primarily by treatment foster parents who are trained, supervised and supported by professional child-placing agency staff. TFC case management focuses on a continuity of services, is goal directed, results oriented, and emphasizes permanency planning for the child in care. Services shall not include room and board. The following activities are considered covered services related to TFC case management services.

1. Placement activities, which may include, but are not restricted to, care planning, placement monitoring, and discharge planning;

2. Case management and casework services; and

3. Supervision of foster parents to evaluate the effectiveness of the child's plan of treatment.

12 VAC 30-130-920. Provider qualifications.

A. License or certification. Treatment foster care case management shall be provided by child-placing agencies with treatment foster care programs that are licensed or certified by the Virginia Department of Social Services to be in compliance with the Minimum Standards for Licensed Child-Placing Agencies (22 VAC 40-130-10 et seq.) and meet the provider qualifications for treatment foster care set forth in this part.

B. Caseload size.

1. The treatment foster care case manager shall have a maximum of 12 children in his caseload for a full-time professional staff person. The caseload shall be adjusted downward if:

a. The caseworker's job responsibilities exceed those listed in the agency's job description for a caseworker, as determined by the supervisor; or

b. The difficulty of the client population served requires more intensive supervision and training of the treatment foster parents.

c. Exception: A caseworker may have a maximum caseload of 15 children as long as not more than 10 of the children are in treatment foster care and the above criteria for adjusting the caseload downward do not apply.

2. There shall be a maximum of six children in the caseload for a beginning trainee that may be increased to nine by the end of the first year and 12 by the end of the second year.

3. There shall be a maximum of three children in a caseload for a student intern if any student intern works in the agency.

12 VAC 30-130-930. Organization and administration requirements.

A. These standards shall be met by any enrolled provider signing an agreement with DMAS to provide case management services to children in treatment foster care.

B. A Medicaid enrolled treatment foster care case management provider must be licensed by the Department of Social Services (DSS) as a child-placing agency with treatment foster care as defined in this part or shall be certified by DSS as designated by DMAS to meet all the requirements of this part. Officers, employees, or agents of the Commonwealth, or of any county, city, or town acting within the scope of their authority as such, who serve as or maintain a child-placing agency shall not be required to be licensed but shall be required to be certified to meet all the requirements of this part by the DSS.

C. Treatment and service plans in treatment foster care.

1. The treatment foster care case management provider shall prepare and implement an individualized treatment and service plan for each child in its care. When available, the parents shall be consulted unless parental rights have been terminated. If the parents cannot be

consulted, the agency shall document the reason in the child's record.

2. When the treatment foster care case management provider holds custody of the child, a service plan shall be filed with the court within 60 days after the agency receives custody unless the court grants an additional 60 days, or the child is returned home or placed for adoption within 60 days. Providers with legal custody of the child shall follow the requirements of §§ 16.1-281 and 16.1-282 of the Code of Virginia.

3. The permanency planning goals and the requirements and procedures in the Department of Social Services Service Programs Manual, Volume VII, Section III, Chapter B, "Preparing the Initial Service Plan" may be consulted.

4. The initial plan of care for services to the child must be developed within two weeks of placement consistent with 22 VAC 40-130-640.

5. Comprehensive treatment and service plan. The case manager and other designated child-placing agency staff shall develop and implement for each child in care an individualized comprehensive treatment and service plan within the first 45 days of placement that shall include:

a. A comprehensive assessment of the child's emotional, behavioral, educational, nutritional, and medical needs;

b. The treatment goals and objectives including the child's specific problems, behaviors and skills to be addressed, the criteria for achievement and target dates for each goal and objective;

c. The treatment foster care case management provider's program of therapies, activities and services, including the specific methods of intervention and strategies designed to meet the above goals and objectives, and describing how the provider is working with related community resources, including the child's primary care physician to provide a continuity of care;

d. The permanency planning goals and objectives, services to be provided for their achievement, and plans for reunification of the child and the child's family, where appropriate;

e. The target date for discharge from the program;

f. For children age 16 and over, the plan shall include a description of the programs and services that will help the child transition from foster care to independent living; and

g. The dated signature of the case manager and the identity of all members of the treatment team that participated in the plan's development.

6. The case manager shall include and work with the child, the custodial agency, the treatment foster parents and the parents, where appropriate, in the development of the treatment and service plan and a copy shall be provided to the custodial agency. A copy shall be provided to the treatment foster parents as long as confidential information about the child's birth family is not revealed. A copy shall be provided to the parents, if appropriate, as long as confidential information about the treatment foster parents is not revealed. If any of these parties do not participate in the development of the treatment and service plan, the case manager shall document the reasons in the child's record.

7. The case manager shall provide supervision, training, support and guidance to foster families in implementing the treatment and service plan for the child.

8. The case manager shall arrange for and encourage contact and visitation between the foster child, his family and others as specified in the treatment and service plan.

D. Progress report and ongoing services plans.

1. The case manager shall complete written progress reports beginning 90 days after the date of the child's placement and every 90 days thereafter.

2. The progress report shall specify the time period covered and include:

a. Progress on the child's specific problems and behaviors and any changes in the methods of intervention and strategies to be implemented:

(1) Description of the treatment goals and objectives met, goals and objectives to be continued or added, the criteria for achievement and target dates for each goal and objective;

(2) Description of the therapies, activities, and services provided during the previous 90 days toward the treatment goals and objectives; and

(3) Any changes needed for the next 90 days;

b. Services provided during the last 90 days towards the permanency planning goals, including plans for reunification of the child and family or placement with relatives, any changes in these goals, and services to be provided during the next 90 days;

c. The child's assessment of his progress and his description of services needed, where appropriate;

d. Contacts between the child and the child's family, where appropriate;

e. Medical needs, specifying medical treatment provided and still needed and medications provided;

f. An update to the discharge plans, including the projected discharge date; and

g. A description of the programs and services provided to children ages 16 and older to help the child transition from foster care to independent living, where appropriate.

3. Annually, the progress report shall address the above requirements as well as evaluate and update the comprehensive treatment and service plan for the upcoming year.

4. The case manager shall date and sign each progress report.

5. The case manager shall include each child who has the ability to understand in the preparation of the child's treatment and service plans and progress reports or document the reasons this was not possible. The child's comments shall be recorded in the report.

6. The case manager shall include and work with the child, the treatment foster parents, the custodial agency and the parents, where appropriate, in the development of the progress report. A copy shall be provided to the placing agency worker and, if appropriate, to the treatment foster parents.

E. Contacts with child.

1. There shall be face-to-face contact between the case manager and the child, based upon the child's treatment and service plan and as often as necessary to ensure that the child is receiving safe and effective services.

2. Face-to-face contacts shall be no less than twice a month, one of which shall be in the foster home. One of the contacts shall include the child and at least one treatment foster parent and shall assess the relationship between the child and the treatment foster parents.

3. The contacts shall assess the child's progress, provide training and guidance to the treatment foster parents, monitor service delivery, and allow the child to communicate concerns.

4. A description of all contacts shall be documented in the narrative.

5. Children who are able to communicate shall be interviewed privately at least once a month.

6. Unless specifically prohibited by court or custodial agency, foster children shall have access to regular contact with their families as described in the treatment and service plan.

7. The case manager shall work actively to support and enhance child/family relationships and work directly with the child's family toward reunification as specified in the treatment and service plan.

8. The case manager shall record all medications prescribed for each child and all reported side effects or adverse reactions.

F. Professional clinical or consultative services. In consultation with the custodial agency, the case manager or caseworker shall provide or arrange for a child to receive psychiatric, psychological, and other clinical services if the need for them has been recommended or identified.

G. Narratives in the child's record. Narratives shall be in chronological order and current within 30 days. Narratives shall include areas specified in this part and shall cover:

1. Treatment and services provided;

2. All contacts related to the child;

3. Visitation between the child and the child's family; and

4. Other significant events.

H. Treatment teams in treatment foster care.

1. The treatment foster care case management provider shall ensure that a professional staff person provides leadership to the treatment team that includes:

a. Managing team decision making regarding the care and treatment of the child and services to the child's family;

b. Providing information and training as needed to treatment team members; and

c. Involving the child and the child's family in treatment team meetings, plans, and decisions, and keeping them informed of the child's progress, whenever possible.

2. Treatment team members shall consult as often as necessary, but at least on a quarterly basis.

12 VAC 30-130-940. Discharge from care.

A. A discharge summary shall be developed for each child and placed in the child's record within 30 days of discharge. It shall include the date of and reason for discharge, the name of the person with whom the child was placed or to whom he was discharged, and a description of the services provided to the child and progress made while the child was in care. Written recommendations for aftercare shall be made for each child prior to the child's discharge. Such recommendations shall specify the nature, frequency, and duration of aftercare services to be provided to the child and the child's family.

B. The summary shall also include an evaluation of the progress made towards the child's treatment goals.

C. Discharge planning shall be developed with the treatment team and with the child, the child's parents or guardian, and the custodial agency.

D. Children in the custody of a local department of social services or private child-placing agency shall not be discharged without the knowledge, consultation, and notification of the custodial agency.

12 VAC 30-130-950. Entries in case records.

All entries shall be dated and shall identify the individual who performed the service. If a treatment foster care case management provider has offices in more than one location, the record shall identify the office that provided the service. Each child's record shall contain documentation that verifies the services rendered for billing.

NOTICE: The forms used in administering 12 VAC 30-130-10 et seq., Amount, Duration and Scope of Selected Services, are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS

Forms accompanying Part II of this chapter:

Virginia Uniform Assessment Instrument.

Forms accompanying Part III of this chapter:

MI/MR Supplement Level I (form and instructions).
MI/MR Supplement Level II.

Forms accompanying Part VII of this chapter:

Request for Hospice Benefits DMAS-420, Revised 5/91.

Forms accompanying Part VIII of this chapter:

Inventory for Client and Agency Planning (ICAP) Response Booklet, D9200/D9210, 1986.

Forms accompanying Part IX of this chapter:

Patient Information form.
Instructions for Completion DMAS-122 form.

Forms accompanying Part XII of this chapter:

Health Insurance Premium Payment (HIPP) Program Insurance Information Request Form.
Health Insurance Premium Payment (HIPP) Program Medical History Form (HIPP Form-7, Rev. 11/92).
Health Insurance Premium Payment (HIPP) Program Employers Insurance Verification Form (HIPP Form-2, Rev. 11/92).
Health Insurance Premium Payment (HIPP) Program Employer Agreement (HIPP Form-3, Rev. 11/92).
Health Insurance Premium Payment (HIPP) Program Notice of HIPP Determination (HIPP Form-4, Rev. 11/92).
Health Insurance Premium Payment (HIPP) Program Notice of HIPP Approval.
Health Insurance Premium Payment (HIPP) Program Notice of HIPP Status (HIPP Form-6, Rev. 11/92).
Inventory for Client and Agency Planning (ICAP) Response Booklet, D9200/D9210, 1986.

Forms accompanying Part XIV of this chapter:

Treatment Foster Care Case Management Agreement, TFC CM Provider Agreement DMAS-345, FH/REV (eff. 10/20/99).

DO NOT WRITE IN SHADED AREAS * DO NOT ADD CONDITIONS TO THE AGREEMENT * WE DO NOT ACCEPT AGREEMENTS VIA FAX OR AGREEMENTS ON THERMAL PAPER *

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Treatment Foster Care Case Management Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	PAYMENT/CORRESPONDENCE ADDRESS	PHYSICAL ADDRESS *(REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS)*
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. The provider will provide Treatment Foster Care Case Management Services .
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794,) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
4. The provider agrees to care for patients at the lessor of the rate established by the Community Planning and Management Team or the current maximum rate established by VMAP as of the date of service.
5. Payment made under VMAP constitutes full payment for treatment foster care case management on behalf of the recipient except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient or the Community Planning and Management Team for treatment foster care case management services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a VMAP recipient for any service provided under VMAP is expressly prohibited and may subject the provider to federal or state prosecution.
6. The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider shall reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
9. This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.

12. This agreement shall commence on _____ and terminate on _____

For First Health's use only

[redacted]

Director, Division of Program Operations Date

IRS Name (Required)

mail completed original agreement to: First Health - VMAP-Provider Enrollment Unit
4461 Cox Rd. Suite 102
Glen Allen, VA 23060-3331

For Provider of Services:

Original Signature of Provider Date

Title

____City OR ____County of _____

IRS Identification Number (Area Code) Telephone Number

TFC CM Provider Agreement DMAS-345 FH/REV 10/20/1999/

VA.R. Doc. No. R00-84; Filed June 29, 2000, 3:59 p.m.

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TITLE 13. HOUSING

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

REGISTRAR'S NOTICE: The Virginia Housing Development Authority is exempt from the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) pursuant to § 9-6.14:4.1 A 4; however, under the provisions of § 9-6.14:22, it is required to publish all proposed and final regulations.

Title of Regulation: **13 VAC 10-160-10 et seq. Rules and Regulations for Administration of Rent Reduction Tax Credits (amending 13 VAC 10-160-10, 13 VAC 10-160-30, and 13 VAC 10-160-55 through 13 VAC 10-160-90; repealing 13 VAC 10-160-41 and 13 VAC 10-160-51).**

Statutory Authority: § 36-55.30:3 of the Code of Virginia.

Summary:

The proposed amendments (i) continue the rent reduction tax credit program through December 31, 2000, for units for which tax credits were validly claimed for all or part of December 1999; (ii) reduce the maximum annual amount of tax credits which the authority may approve in any fiscal year from $250,000 to $50,000; and (iii) make certain other amendments related to the foregoing proposed changes in the rent reduction tax credit program.

Agency Contact: J. Judson McKellar, Jr., General Counsel, Virginia Housing Development Authority, 601 S. Belvidere Street, Richmond, VA 23220, telephone (804) 343-5540, FAX (804) 783-6701, or e-mail judson.mckellar@vhda.com.

13 VAC 10-160-10. Definitions.

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

"Authority" means the Virginia Housing Development Authority.

"Board" means the Board of Commissioners of the authority.

"Disability" means (i) a physical or mental impairment which substantially limits one or more of the major life activities of such individual and includes any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities (the term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus (HIV) infection, mental retardation, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance, and alcoholism) or (ii) a record of such an impairment; or being regarded as having such an impairment which includes a history of or being misclassified as having a mental or physical impairment that substantially limits one or more major life activities; or a physical or mental impairment that does not substantially limit one or more major life activities but that is treated by another person as constituting such a limitation; or a physical or mental impairment that substantially limits one or more major life activities only as a result of the attitudes of others toward such impairment; or none of the impairments defined above but the individual is treated by another person as having such an impairment; provided, however, that any physical or mental impairment described in (i) or (ii) shall be expected to result in death or shall have lasted continuously during the immediately preceding 12-month period or shall be expected to last continuously during the next succeeding 12-month period.

"Elderly person" means a person who exceeds, by any period of time, 62 years of age.

"Elderly tenant" means (i) an elderly person or (ii) a household in which any member is an elderly person.

"Eligible owner" means any person meeting the criteria for an eligible owner as set forth in the state code and these rules and regulations.

"Eligible tenant" means an elderly tenant, a tenant with a disability or a previously homeless tenant whose income does not exceed the limit described in these rules and regulations.

"Executive director" means the executive director of the authority or any other officer or employee of the authority who is authorized to act on his behalf or on behalf of the authority pursuant to a resolution of the board.

"HUD fair market rent" means the rent published by the U.S. Department of Housing and Urban Development for the Section 8 Rental Certificate Program.

"Income" means gross income (including but not limited to all salary, wages, bonuses, commissions, income from self-employment, interest, dividends, alimony, rental income, pensions, business income, annuities, social security payments, cash public assistance, support payments, retirement income and any other sources of cash income) which is being received by the elderly tenant, a tenant with a disability or a previously homeless tenant or is regularly paid to or on behalf of such tenant by a third party as of the application date. The income of any person who is living with an elderly person or person with a disability for the primary purpose of providing care to such person shall be excluded. All such income, provided it is not temporary, shall be computed on an annual basis to determine income for the purpose of program eligibility.

"Market rent" means the amount of rent, as determined by the authority pursuant to these rules and regulations, charged to other tenants for comparable units (other than tax credit units) in the same property or, if there are no such comparable units in the same property, for comparable units in the same market area.

"Owner" means an applicant for tax credits under these rules and regulations and, upon and subsequent to an allocation of such credits, means the owner of the tax credit unit to whom the tax credits are allocated.

"Person with a disability" means a person having a disability as defined in these rules and regulations.

"Previously homeless" means having, at any time within the 12 months preceding the commencement of the lease term, resided in a domestic violence shelter or homeless shelter.

"Previously homeless tenant" means (i) a previously homeless person or (ii) a household in which any adult member is previously homeless.

"Program" means the low-income housing tax credit program for rent reductions described in these rules and regulations.

"State code" means Article 3 (§ 58.1-331 et seq.) of Chapter 3 of Title 58.1 of the Code of Virginia.

"Tax credit rent" means the reduced amount of rent charged for the tax credit unit to the eligible tenant. As provided in 13 VAC 10-160-30, the tax credit rent shall be at least 15% less than the market rent.

"Tax credits" means the tax credits as described in *§§* 58.1-339 *and 58.1-339.8* of the Code of Virginia~~:~~*, as applicable.*

"Tax credit unit" means a unit occupied or to be occupied by eligible tenants at reduced rents in order for the owner to be entitled to receive tax credits hereunder.

"Tenant" means a person or household who is applying for occupancy of, or is occupying, a tax credit unit.

"Tenant with a disability" means (i) a person with a disability or (ii) a household in which any member is a person with a disability.

13 VAC 10-160-30. General description.

The state code was amended by adding ~~a section~~ *sections* numbered 58.1-339 *and 58.1-339.8* relating to a tax credit for owners providing rent reduction for eligible tenants.

For taxable years beginning on or after January 1, 1991, through December 31, ~~1999~~ *2005*, any individual or corporation receiving an allocation of tax credits pursuant to § 58.1-339 *or § 58.1-339.8, as applicable,* of the Code of Virginia shall, subject to the provisions of the state code and these rules and regulations, be entitled to a credit against the tax levied pursuant to § 58.1-320 or § 58.1-400 of the Code of Virginia, provided that the following requirements are satisfied:

1. The individual or corporation is engaged in the business of the rental of dwelling units (as hereinafter specified) and is subject to the Virginia Residential Landlord and Tenant Act, § 55-248.2 et seq. of the Code of Virginia, either by virtue of the provisions thereof or by virtue of the owner's providing for the applicability thereof pursuant to § 55-248.5 B of the Code of Virginia;

2. The owner provides a reduced rent to eligible tenants;

3. The rent charged to the eligible tenants is at least 15% less than the market rent; ~~and~~

4. To claim a credit *under § 58.1-339 of the Code of Virginia* for reduction of rents charged to a tenant on or after July 1, 1996*, and before January 1, 2000*: (i) a credit for rental reductions must have been validly claimed on the tax credit unit for all or part of the month of June 1996 and such tenant must have been an occupant of such tax credit unit on June 30, 1996, or (ii) the tenant must have been previously homeless~~.~~*; and*

5. To claim a credit under § 58.1-339.8 of the Code of Virginia for reduction of rents charged to a tenant on or after January 1, 2000, on a dwelling unit, a credit for rental reductions must have been validly claimed on such dwelling pursuant to § 58.1-339 of the Code of Virginia for all or part of the month of December 1999.

The allowable tax credit amount shall be 50% of the total rent reductions allowed during the taxable year to the eligible tenants occupying the tax credit units. The amount of the rent reduction shall be equal to the market rent minus the tax credit rent. For this purpose, the tax credit rent shall include any rental subsidy payable on behalf of the eligible tenant under any governmental or private program.

If there are comparable units (other than tax credit units) in the same property, the market rent shall be determined by the authority to be the rent charged to other tenants for such comparable units. For the purpose of determining the amount of rent charged to other tenants for comparable units in the same property, the authority shall assume that the other tenants commenced and, if applicable, renewed their leases as of the same date or dates, and for the same term or terms as the eligible tenants and at the rents in effect on such date or dates.

If there are no other such comparable units in the same property, then the market rent shall be determined by the authority to be the rent charged for comparable units in the same market area. Such rent shall be (i) the rent most recently charged for the tax credit unit to a person (who may be the eligible tenant to be assisted) unrelated to the owner within the one-year period prior to the date of filing of the application, plus a rental increase in an amount determined by the authority to reflect increases in rents in the market area of such tax credit unit since the date such rent was last charged, or (ii) if no rental history as described in (i) exists, the HUD fair market rent allowed for a comparable unit in the same market area (as reduced, to the extent determined by the authority, for any utilities which are not to be included in the tax credit rent under the terms of the lease); provided, however, that the owner may demonstrate to the authority that the rent for a comparable unit in the same market area is higher than (i) or (ii) above, as applicable, and to the extent so demonstrated to the satisfaction of the authority, such higher rent shall be used.

Notwithstanding anything to the contrary herein, the market rent shall in no event exceed 150% of the HUD fair market rent allowed for comparable units in the same market area (as reduced, to the extent determined by the authority, for any

utilities which are not to be included in the tax credit rent under the terms of the lease).

If the tax credit unit is subsidized or assisted under any governmental or private program, the comparable units in the same property or market area, as applicable, shall include only those units similarly subsidized or assisted.

Because the intent of the state code is to provide tax credits for the rental of dwelling units only, tax credits shall not be allocated or claimed for the leasing of land only, including without limitation mobile home lots. Tax credits may be allocated and claimed for the leasing of both a mobile home lot and the mobile home located thereon.

To be eligible for the program, a dwelling unit must contain separate and complete facilities for living, sleeping, eating, cooking and sanitation. Such accommodations may be served by centrally located equipment such as air conditioning or heating. Thus, for example, an apartment containing a living area, a sleeping area, bathing and sanitation facilities and cooking facilities equipped with a cooking range, refrigerator and sink, all of which are separate and distinct from other apartments, would constitute a unit.

In order to satisfy the requirement in § 58.1-339 *or § 58.1-339.8, as applicable,* of the state code that the owner be an individual or corporation engaged in the business of the rental of dwelling units, the owner must intend or have intended at the time of application and must intend at all times thereafter to report, for federal income tax purposes, all rental and other income and any related expenses of the tax credit unit with respect to each tax year for which the tax credits are to be claimed for such tax credit unit.

The amount of credit for each individual or corporation for each taxable year shall not exceed $10,000 or the total amount of tax imposed by Chapter 3 (§ 58.1-300 et seq.) of Title 58.1 of the Code of Virginia, whichever is less. If the amount of such credit exceeds the taxpayer's tax liability for such taxable year, the amount which exceeds the tax liability may be carried over for credit against income taxes of such individual or corporation in the next five taxable years until the total amount of the tax credit has been taken.

Credits granted to a partnership or an electing small business corporation (S corporation) shall be passed through to the individual partners or shareholders in proportion to their ownership or interest in the partnership or S corporation.

The total amount of tax credits which may be approved by the authority in any fiscal year prior to fiscal year 1996-1997 shall not exceed $1,000,000. Commencing in fiscal year 1996-1997, the total amount of tax credits which may be approved by the authority in any fiscal year shall not exceed $250,000. *Commencing in fiscal year 2000-2001, the total amount of tax credits which may be approved by the authority in any fiscal year shall not exceed $50,000.* With the exception of tax credits claimed for units occupied by previously homeless tenants, no tax credits will be approved for a unit for any period after June 30, 1996*, and before January 1, 2000*, unless a tax credit was validly claimed for such unit for all or part of the month of June 1996. *No tax credits will be approved for a unit for any period on or after January 1, 2000, unless a tax credit was validly claimed for such unit for all or part of the month of December 1999.* No tax credits may be claimed for taxable years after December 31, ~~1999~~ *2005*.

The authority may charge to each owner fees in such amount as the executive director shall determine to be necessary to cover the administrative costs to the authority. Such fees shall be payable at such time or times as the executive director shall require.

13 VAC 10-160-41. ~~Solicitations of applications for previously homeless tenants.~~ *(Repealed.)*

~~The executive director may from time to time take such action as he may deem necessary or proper in order to solicit applications for allocation of tax credits for units occupied or to be occupied by previously homeless tenants. Such actions may include advertising in newspapers and other media, mailing of information to prospective applicants and other members of the public, and any other methods of public announcement which the executive director may select as appropriate under the circumstances. The executive director may impose requirements, limitations and conditions with respect to the submission of such applications and the selection thereof as he shall consider necessary or appropriate.~~

13 VAC 10-160-51. ~~Applications for units occupied or to be occupied by previously homeless tenants.~~ *(Repealed.)*

~~Application for an allocation of tax credits for units occupied or to be occupied by previously homeless tenants shall be commenced by filing with the authority an application on such form or forms as the executive director may from time to time prescribe or approve, together with such documents and additional information as may be requested by the authority in order to comply with the state code and to make the allocation of the tax credits in accordance with these rules and regulations.~~

~~The executive director may establish criteria and assumptions to be used by the owner in the calculation of amounts in the application, and any such criteria and assumptions shall be indicated on the application form or instructions.~~

~~The executive director may prescribe such deadlines for submission of applications for allocation of tax credits for units occupied or to be occupied by previously homeless tenants for any calendar year as he shall deem necessary or desirable to allow sufficient processing time for the authority to make such allocations.~~

~~The tax credit unit for which an application is submitted may be, but shall not be required to be, financed by the authority. If any such tax credit unit is to be financed by the authority, the application for such financing shall be submitted to and reviewed by the authority in accordance with its applicable rules and regulations.~~

13 VAC 10-160-55. Review and selection of application; allocation of tax credits.

~~Tax credits shall be allocated to eligible owners for units occupied or to be occupied by previously homeless tenants on a "first come, first served" basis. In the event that the~~

~~amount of tax credits available for such units is sufficient for some but not all of eligible applications received by the authority on the same day, then the authority shall select one or more of such applications by lot.~~ After ~~July 1, 1996~~ *January 1, 2000*, no tax credits shall be allocated ~~to owners of units occupied or to be occupied by elderly tenants or tenants with disabilities~~ *by the authority,* except *allocations made prior to January 1, 2000, may be increased* as provided in 13 VAC 10-160-120.

~~The executive director may exclude and disregard any application which he determines is not submitted in good faith.~~

~~The amount of tax credits which may be allocated for tax credit units in any single development shall not exceed $10,000; provided, however, that the executive director may from time to time terminate or suspend such $10,000 limit for such period of time as he shall deem appropriate to assure full utilization and proper distribution of the tax credits. For the purpose of compliance with such $10,000 limit, the executive director may determine that developments in one or more applications constitute a single development based upon such factors as he may deem relevant, including without limitation the ownership, proximity, age, management, financing and physical characteristics of the developments.~~

~~The executive director shall allocate tax credits, in the manner described above, to eligible owners of units occupied or to be occupied by previously homeless tenants until either all available tax credits are so allocated or all such eligible owners have received allocations. The amount allocated to each such eligible owner shall be equal to the lesser of (i) the amount requested in the application or (ii) the amount, determined by the executive director, to which the eligible owner is entitled under the state code and these rules and regulations as of the date of application.~~

~~The executive director determines whether the owner and the tax credit units are entitled to tax credits under the state code and these rules and regulations. If the executive director determines that the owner or the tax credit units are not so entitled to tax credits, the owner shall be so informed and his application shall be terminated. If the authority determines that the owner and the tax credit units are so entitled to tax credits, then the executive director shall issue to the owner, on behalf of the authority, a commitment for allocation of tax credits with respect to the applicable tax credit units. The allocation shall be subject to the approval or ratification thereof by the authority's board as described below.~~

~~The board shall review and consider the analysis and recommendation of the executive director for the allocation of tax credits, and, if it concurs with such recommendation, it shall by resolution approve or ratify the allocation by the executive director of the tax credits to the eligible owner, subject to such terms and conditions as the board or the executive director shall deem necessary or appropriate to assure compliance with the state code and these rules and regulations. If the board determines not to approve or ratify an allocation of tax credits, the executive director shall so notify the owner.~~

Upon compliance with the state code and these rules and regulations, the owner to whom an allocation ~~is~~ *has been* made ~~hereunder~~ *prior to January 1, 2000,* shall be entitled to tax credits annually, in such amount as is determined by the authority pursuant to these rules and regulations, for each year beginning in the year for which such allocation is made and ending December 31, ~~1999~~ *2005*, unless sooner terminated or reduced pursuant to these rules and regulations.

13 VAC 10-160-60. Eligibility of tenants and verification.

The occupancy of units entitled to tax credits is limited to elderly tenants, tenants with disabilities or previously homeless tenants whose incomes, as of initial occupancy of the tax credit unit by such tenants (or, if any such tax credit unit was occupied by such a tenant on January 1 of the first calendar year for which the tax credits were claimed for such tax credit unit, as of such January 1), did not exceed 80% of the median income for the area. Preference in occupancy of tax credit units must have been given to eligible tenants whose incomes were less than or equal to 50% of the median income for the area. The United States Department of Housing and Urban Development income limits for subsidized programs, as adjusted by family size, must have been used in determining such 80% and 50% of median income for the area.

In the case of tax credits to be claimed for any period after June 30, 1996*, and before January 1, 2000*, in order to be eligible an elderly tenant or a tenant with a disability must have been an occupant of the tax credit unit on June 30, 1996. *In the case of tax credits to be claimed for any period on and after January 1, 2000, in order to be eligible the tenant must occupy a unit for which a tax credit was validly claimed for such unit for all or a part of the month of December 1999.*

Owners must obtain written income verification for eligible tenants who occupy a tax credit unit. The verification of income must be sent by the owner to each employer or the agency providing benefits along with a stamped, self-addressed return envelope. Such verification must be retained by the owner and a copy submitted to the authority (together with an executed confirmation of resident eligibility form and the verification of age, disability or previous homelessness) at the time that the eligible tenant was determined by the owner to be income eligible. Verification of income must be current as of a date no earlier than 90 days prior to the date (see first paragraph in this section) as of which the income of the eligible tenant was determined for eligibility purposes.

With respect to tax credits claimed for rental of tax credit units to tenants with disabilities, owners must have obtained a written verification of disability. Verification of said disability must have been obtained from a physician, diagnostic or vocational rehabilitation service center or the Social Security Administration.

With respect to tax credits claimed for rental of tax credit units to elderly tenants, owners must have verified the age of all persons claiming to exceed 62 years of age. Verification of Social Security benefits paid on the person's behalf is acceptable if a birth certificate could not have been obtained;

provided, however, that any person receiving survivor Social Security benefits who did not exceed 62 years of age or did not have a disability is not eligible for occupancy of a tax credit unit.

With respect to tax credits claimed for rental of tax credit units to previously homeless tenants, owners must obtain a written verification that such tenant resided in a domestic violence shelter or homeless shelter during the 12 months preceding commencement of the lease term for the tax credit unit. Such written verification must be obtained from the homeless shelter or domestic violence shelter in which the previously homeless tenant resided.

The initial lease term for all eligible tenants occupying a tax credit unit must not be less than a 12-month period.

13 VAC 10-160-70. Administration of allocation of tax credits.

Except *for increases in allocation* as provided in 13 VAC 10-160-120, ~~and except for the allocation of tax credits for units occupied or to be occupied by previously homeless tenants pursuant to 13 VAC 10-160-55,~~ tax credits shall not be allocated by the authority after ~~June 30, 1996~~ *January 1, 2000*. Allocations of tax credits made by the authority prior to June 30, 1996, for units occupied by elderly and disabled tenants *or prior to January 1, 2000, for units occupied by previously homeless tenants* shall remain in effect, subject to the provisions of these rules and regulations.

The amount of tax credits claimed by an owner in any taxable year for tax credit units shall not exceed the amount of tax credits allocated to such owner for such tax credit units. The executive director may require that owners to whom tax credits have been allocated shall submit from time to time or at such specified times as he shall require, written confirmation and documentation as to the status of each tax credit unit and its compliance with the application and these rules and regulations. If on the basis of such written confirmation and documentation and other available information the executive director determines that any tax credit unit does not or will not qualify or will not continue to qualify for such tax credits, then the executive director may terminate or reduce the allocation of such tax credits. Without limiting the foregoing, the owner of any tax credit units ~~to be occupied by previously homeless tenants~~ shall lease the tax credit units to eligible ~~previously homeless~~ tenants at reduced rents such that the aggregate of such rent reductions shall be no less than the aggregate of the rent reductions set forth in the application for tax credits for such units. In the event that the owner shall fail to so lease such tax credit units, the authority may, upon its determination that the owner is unable or unwilling to utilize fully its allocation of tax credits for such tax credit units, terminate or reduce such allocation, as it shall deem appropriate.

Commencing with fiscal year 2000-2001, the executive director may terminate or reduce any allocations of tax credits as he shall determine to be necessary or appropriate to satisfy the requirement in the state code that the total amount of tax credits approved by the authority in any fiscal year after June 30, 2000, not exceed $50,000 and to maximize the utilization and geographic distribution of the tax credits.

The authority shall have the right to inspect the tax credit units and related property and improvements from time to time, and the tax credit units and related property and improvements shall be in a state of repair and condition satisfactory to the authority. The authority may require the owner to make necessary repairs or improvements, in a manner acceptable to the authority, as a condition for receiving an allocation of tax credits or for qualifying for certification to the Department of Taxation as described hereinbelow.

The executive director may establish such deadlines for the owner of units ~~for occupancy by previously homeless tenants~~ to qualify for the tax credits and to comply with the application and these rules and regulations as he shall deem necessary or desirable to allow the authority sufficient time, in the event of a reduction or termination of such owner's allocation, to allocate such tax credits to other eligible owners *pursuant to 13 VAC 10-160-120*.

Any material changes to the condition, use or occupancy of the tax credit unit or in any other representations, facts or information, as contained or proposed in the application, occurring subsequent to the submission of the application for the tax credits therefor shall be subject to the prior written approval of the executive director. As a condition to any such approval, the executive director may, as necessary to comply with these rules and regulations and the state code, reduce the amount of tax credits allocated or impose additional terms and conditions with respect thereto. If such changes are made without the prior written approval of the executive director, he may terminate or reduce the allocation of such tax credits or impose additional terms and conditions with respect thereto.

In the event that any allocation of tax credits is terminated or reduced by the executive director under this section, he may allocate such tax credits (in the amount of such termination or reduction) to eligible owners (other than the owners whose tax credit allocation was so terminated or reduced) ~~in the first-come first-served manner described in 13 VAC 10-160-55,~~ in the manner described in 13 VAC 10-160-120~~,~~ or in such other manner as he shall determine consistent with the requirements of the state code.

If an owner shall transfer any of the tax credit units to a transferee which is eligible for such tax credits under the state code and these rules and regulations, such transferee shall thereupon be entitled to the allocation of tax credits for such tax credit units and shall, for the purposes of these rules and regulations, be thereafter deemed the owner for such tax credits.

13 VAC 10-160-80. Tax credit period.

Each period for which an owner may claim tax credits for any tax credit unit shall commence upon the date that the tax credit unit is occupied by an eligible tenant pursuant to a lease providing for a 12-month term and for the payment of rent in the amount of the tax credit rent. Such period shall not commence prior to the allocation of the tax credits by the authority to the owner, except that if the tax credit unit is so occupied from the first day of the month in which the allocation of tax credits is made, such period shall commence

on such first day of the month. Such period shall continue until termination of occupancy as described in 13 VAC 10-160-90 or until December 31, ~~1999~~ *2005*, whichever occurs first. However, in no event shall any such period commence and continue unless the tax credit unit is and remains in a state of repair and condition satisfactory to the authority, all documentation required by 13 VAC 10-160-60 has been and is submitted to the authority in accordance herewith, and all other applicable requirements of the state code and these rules and regulations have been and are satisfied. If the owner shall be entitled to claim tax credits on any tax credit unit for a portion of a month during such period, the rent reduction shall be calculated pro rata based upon the number of days in such month that the owner is so entitled to claim tax credits or, with respect to the termination of occupancy, shall be calculated as provided in 13 VAC 10-160-90.

13 VAC 10-160-90. Maintenance of records; submission requirements; termination of occupancy.

Owners shall be responsible for obtaining and maintaining all documentation required by the authority to evidence that the tax credit units qualify for tax credits under the program. Owners will be responsible for providing this documentation to the authority for review within 30 days following the end of each calendar year; provided, however, that the documents listed in subdivisions 2 a, b, c and g of this section must be submitted at the time that the eligible tenant was determined by the owner to be eligible. The tax credit unit will not qualify for tax credits if all required documents, in the form required by the authority, are not so provided. Required documentation to be submitted to the authority includes, but is not limited to, the following:

1. A listing (including dates of occupancy) of all tenants who occupy or occupied a tax credit unit entitled to a tax credit for that year.

2. A complete certification package for each eligible tenant receiving the reduced rent. The certification must include:

a. A completed and executed confirmation of resident eligibility form.

b. Verification of income.

c. Verification of age, disability or previous homelessness.

d. A certification from the tenant verifying:

(1) What unit type/size was occupied,

(2) Number of months said unit was occupied,

(3) The amount of rent paid,

(4) How many months that amount of rent was paid, and

(5) In the case of the tax credits claimed for any period after June 30, 1996*, and before January 1, 2000* (except for tax credits claimed for units occupied by previously homeless tenants), occupancy of the tax credit unit by the tenant on June 30, 1996.

e. A certification of the owner that preference in occupancy of the tax credit units was given to eligible tenants whose incomes were less than or equal to 50% of the median income for the area (the waiting list for tax credit units during the calendar year identifying the persons applying for such units and their incomes shall be maintained by the owner and shall be available for inspection by the authority).

f. Rent rolls for the comparable units in the same property as the tax credit units setting forth the rents charged to other tenants, if rents for such comparable units are to be used to determine the amount of the rent reduction pursuant to 13 VAC 10-160-30.

g. Copies of leases for each tax credit unit.

h. In the case of the tax credits claimed for any period after June 30, 1996*, and before January 1, 2000*, other than tax credits claimed for units occupied by previously homeless persons, a certification of the owner that a tax credit for rental reductions was validly claimed on the tax credit unit for all or part of the month of June 1996, and that the tenant receiving such rental reductions was an occupant of such tax credit unit on June 30, 1996.

i. In the case of the tax credits claimed for any period on and after January 1, 2000, a certification of the owner that a tax credit was validly claimed for the unit for all or part of the month of December 1999.

In the event of termination of occupancy, the rent reduction shall be calculated pro rata based upon the number of days determined in the following manner. In the event of death of the only elderly person, person with a disability or previously homeless person occupying a tax credit unit, the owner must obtain a copy of the death certificate or must provide other acceptable documentation of death; and the number of days for which an owner is entitled to tax credits on such deceased person's tax credit unit shall be determined by the date of death. If the eligible tenant abandons the tax credit unit, the earliest of the date the owner discovers the tax credit unit is vacant, the date any utility company terminates service on the tax credit unit, or the date 30 days after abandonment will be used to determine the number of days for which the tax credit unit is entitled to the tax credit. If the tax credit unit shall not be so abandoned but the eligible tenant shall not occupy the tax credit unit for a period of 30 days (or such longer period of time as the executive director may approve), the end of such period shall be used to determine the number of days for which the tax credit unit is entitled to the tax credit. If the lease is terminated for any reason other than those set forth above in this paragraph, the effective date of termination shall be used to determine the number of days for which the tax credit unit is entitled to the tax credit.

VA.R. Doc. No. R00-227; Filed July 12, 2000, 9:38 a.m.

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TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD FOR OPTICIANS

Title of Regulation: **18 VAC 100-20-5 et seq. Board for Opticians Regulations (amending 18 VAC 100-20-10, 18 VAC 100-20-50, 18 VAC 100-20-60, 18 VAC 100-20-70, 18 VAC 100-20-90, 18 VAC 100-20-100, and 18 VAC 100-20-110; adding 18 VAC 100-20-5, 18 VAC 100-20-54, 18 VAC 100-20-55, 18 VAC 100-20-56, 18 VAC 100-20-65, 18 VAC 100-20-81, 18 VAC 100-20-85, 18 VAC 100-20-87, 18 VAC 100-20-120, and 18 VAC 100-20-130; repealing 18 VAC 100-20-20, 18 VAC 100-20-30, 18 VAC 100-20-40, and 18 VAC 100-20-80).**

Statutory Authority: §§ 54.1-201 and 54.1-1700 of the Code of Virginia.

Public Hearing Date: N/A -- Public comments may be submitted until September 29, 2000.

(See Calendar of Events section for additional information)

Basis: Section 54.1-201 of the Code of Virginia provides the board with the authority to amend these regulations. Section 54.1-1700 defines "optician" and § 54.1-1704 restricts the practice of opticianry to those holding a license.

Purpose: The purpose of the proposed changes is to ensure that the citizens of Virginia receive competent services from individuals licensed to fit and dispense prescription eyewear including contact lens. The board proposes two substantive changes to its regulations. It proposes to adopt the ANSI standards as its regulations for the preparation of prescription eyeglasses. Although these are the acceptable minimal standards in the industry today, and ones that would be used as a measuring tool in a standard of practice case, they are not specifically stated in the board's regulations. These proposed standards are essential for enforcement purposes to enable the board to take action to prohibit a licensee from committing negligent or incompetent acts. The board proposes to eliminate the requirement that a licensee who allows his license to expire for more than one year must retake the board's examination. The board determined that a licensee remains competent without continuing to practice for a period of two years at which time a refresher course would be sufficient to allow the licensee to re-enter practice. The board proposes to permit refresher courses for reinstatement until the license has been expired for a period of five years. After five years, the board requires that the individual apply as a new applicant. Other proposed amendments are strictly for clarification purposes as a result of questions raised by the regulant population and members of the public.

Substance:

1. The board proposes to define terms which cause confusion for applicants and the public and incorporate terms from § 54.1-1700 of the Code of Virginia.

2. The board proposes to (i) direct the applicant to furnish satisfactory evidence of entry requirements on an application provided by the board; (ii) include language specifically referencing the applicant; (iii) include an exemption to the minimum age for licensure if the person qualifies per § 16.1-333 of the Code of Virginia; (iv) clarify language specifying the "applicant" as the responsible party in each requirement; (v) require nonresident applicants to file and maintain an irrevocable consent for DPOR to be the service agent for all actions filed in any Virginia court in accordance with requirements set forth in § 13.1-763 of the Code of Virginia; and (vi) require the applicant to certify that he has read and understands Chapter 17 of Title 54.1 of the Code of Virginia and the regulations of the board.

3. The board proposes to clarify language by stating "licensed in another state" instead of "licensing of out of state."

4. The board proposes to include the Department of Professional and Occupational Regulation standard examination language, which limits the fee for examinations to $200.

5. The board proposes to incorporate Department of Professional and Occupational Regulation standards for the conduct of the opticians' examination.

6. The board proposes to clarify the contents of the optician examination and reexamination and the contact lens certification examination and reexamination and establish a time frame for passing both portions of the examination.

7. The board proposes to establish basic criteria for the content of the contact lens endorsement examination and reexamination.

8. The board proposes to change license renewal language to establish a staggered renewal date. The fees are not proposed for change.

9. The board proposes to clarify license reinstatement language and proposes no change in current requirements.

10. The board proposes to include ANSI Standards as part of its regulations. These are the acceptable minimal standards in the industry today, and ones that would be used as a measuring tool in a standard of practice case.

11. The board proposes to clarify license placement in the work place as well as in multiple workplaces.

12. The board proposes to change current language specifying "notification of change of address or name" to that consistent with other boards in the department.

13. The board proposes to clarify language authorizing it to discipline licensees. The board also proposes to replace the term "offense" in current regulations to the term "violation."

14. The board proposes to (i) change the referenced Code of Virginia section to one that provides definitions for "nonprescribed controlled substances"; (ii) clarify "professional incompetence or negligence" by including, but not limiting, compliance with Part V, Standards of Practice and Conduct; (iii) clarify language relating to the

presenting of false or fraudulent qualification information on an application; (iv) add language to limit the types of advertisements to those "related to opticianry"; (v) strike language pertaining to various misdemeanors; (vi) add language requiring the licensee to provide a certified copy of any disciplinary action against him within 10 days after all appeal rights have expired; (vii) add clarifying language that identifies the licensee as the person whom must supply documentary evidence of discipline in another jurisdiction; (viii) add language making it a violation to allow any person, except an optician apprentice or a student enrolled in a course in a school of opticianry to work under the direct supervision of a licensed optician; and (ix) add language stating that a finding of improper or dishonest conduct in the practice of the profession by a court of competent jurisdiction shall be cause for disciplinary action.

15. The board proposes to add language making a licensee responsible for his actions or omissions in the performance of opticianry services as well as those of his agents and employees.

16. The board proposes to establish review course requirements for licensees who must apply for reinstatement between 24 and 60 months after the expiration of their license.

Issues: The primary advantage will result in achieving specific needs and consideration to the practitioners as well as public protection to the citizens of the Commonwealth of Virginia. In addition, these changes will identify requirements of state law that affect the administration and enforcement of these regulations. There are no disadvantages related to these proposed changes.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 9-6.14:7.1 G of the Administrative Process Act and Executive Order Number 25 (98). Section 9-6.14:7.1 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. This is a proposed revision to the existing regulations governing the licensure of opticians. Section 54.1-201 of the Code of Virginia provides the Board of Opticians with the authority to amend these regulations. Specific fees for this regulatory program are being reduced under a separate, exempt regulatory action. The proposed changes to this regulation include instituting more lenient remedies for expired licenses, different timing for the expiration dates of licenses, and waiving the minimum age requirement for emancipated individuals.

Estimated economic impact.

Expired License Remedies. Currently, if a Virginia optician's license is expired for more than 12 months, he must retake and pass the practical and written examinations required for a Virginia optician's license. The Board of Opticians is proposing to significantly relax this burden. The proposed amended regulation would allow a licensee to reinstate his license for up to two years following expiration of his license, by only paying a late fee in addition to the usual license renewal fee. Under the proposed amended regulation, if the license has been expired for more than two years, but the optician can show proof of continuous, active, ethical and legal practice outside of Virginia, then the license can be reinstated with only payment of a late fee in addition to the renewal fee. If the license has been expired for between two and five years, but the optician cannot show proof of continuous, active, ethical and legal practice outside of Virginia, he may still reinstate his license by completing a board-approved review course (along with the fees). Under the proposed amended regulation, the optician will be required to retake the practical and written examinations only if his license has been expired for more than five years.

The proposed amended regulation will clearly be less burdensome to opticians with expired licensees. Also, the proposed more lenient treatment of opticians with expired licenses is unlikely to put the citizens of Virginia at any additional risk since the proposed amended regulation still requires opticians out of practice for more than two years to complete a review course. Thus, this proposed change to the regulation would in net be beneficial for Virginia.

Effects of Expiration Date Change. Another proposed change for this regulation concerns the timing of the expiration dates of the licenses. Currently, all Virginia optician licenses expire on December 31 of each even numbered year. Since most opticians do not receive their first license at the beginning of January of odd numbered years, current first licenses last for less than 24 months. Under the proposed amended regulation, licenses would expire 24 months from the last day of the month in which the license was issued. Thus, under the proposed amended regulation, newly licensed opticians would receive more months of license coverage for the same given license fee. The same argument and conclusion are true for opticians who have their expired licenses reinstated.

In any given two-year period, DPOR would receive less in optician license fees under the proposed amended regulation than under the current regulation. There will likely always be some new Virginia opticians that would pay two standard license fees under the current regulation who would only pay one standard license fee under the proposed amended regulation. In addition, opticians who reinstate their licenses also pay two standard license fees (as well as late fees) in the first 24 months under the current regulation, versus one standard license fee (and late fees) in the proposed amended regulation. Thus, DPOR would also receive fewer license fee dollars from opticians with reinstated licenses.

Since DPOR's most recent analysis indicated that the cash/revenue balance exceeded expenditures by 47.7% for the opticians licensure program, the reduced revenue due to the change in expiration dates would not seem to be problematic for the near future. At the same time, the delay in

the second payment of license fees will be beneficial for new opticians and those reinstating their licenses.

However, further in the future when the current large cash/revenue surplus may be reduced, the smaller revenue collections due to the proposed change in expiration dates may cause DPOR to raise fee rates. Thus, the proposed change in expiration dates would likely cause a small transfer in fee costs from newly licensed opticians to experienced opticians renewing their licenses. The actual cost per time licensed (24 months) would be the same for both groups, versus the current higher cost per time licensed for new opticians. Therefore, the proposed change in expiration dates would be more equitable than the current method.

Minimum Age Exception. The amended regulation also includes a proposed exception to the minimum age required for a Virginia optician's license. Individuals under the age of 18 who have been legally emancipated from their parents or guardians and who otherwise meet the required qualifications, would be permitted to obtain an optician's license. This change is unlikely to have any impact in most years since very few if any individuals under 18 will be able to meet the other requirements for optician licensure.

Businesses and entities affected. All current opticians as well as those individuals considering becoming licensed opticians are affected by the proposed amendments to the regulation. According to DPOR, at the end of 1999, there were 1,693 licensed opticians in Virginia.

Localities particularly affected. The proposed amendments to the regulation will affect opticians and potential opticians statewide.

Projected impact on employment. According to DPOR, the establishment of the review course option for licensees applying for reinstatement is anticipated to affect less than five applicants per year. Thus, it is unlikely that any new instructors will need to be hired.

The proposed change in determining when opticians will need to retake the licensing exams will likely produce a small reduction in the demand for the services of private examination firms. However, the reduction in demand is not expected to be significant enough to reduce employment.

Effects on the use and value of private property. This regulation will have negligible effect on the use and value of private property.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: In its economic impact analysis, the Department of Planning and Budget was concerned that new language in 18 VAC 100-20-40 A (Fees) seemed to imply that internal administrative expenses in addition to the vendor fee would both be included in the examination fee, whereas previously the exam fee was based on the vendor fee only and administrative expenses were all incorporated into the application fee. DPB felt that the effect could be very different, as the new language could allow an adjustment in the examination fee without any change in vendor charges. As possible solutions DPB suggested two options: (i) incorporating the exam administrative expenses into the application for licensure fee or (ii) explicitly stating the administrative part of the fee and allowing the other part to flex depending on the vendor.

In order to address this concern the language was changed to specify the various costs associated with the examination. The new language reads as follows:

> The fee for examination(s) shall consist of the combination of an administrative charge $10.00 (spectacle), $25.00 (contact lens), and the appropriate contract charges. Examination service contracts shall be established in compliance with the Virginia Public Procurement Act (§11-35 et seq. of the Code of Virginia). The total examination fee shall not exceed a cost of $300 to the applicant.

Further, in order to eliminate confusion for the applicants the section was modified to clarify that the board's application for licensure fees cover both the applicant for "licensure by exam" and the applicant who is applying as an "out-of-state applicant."

These limited changes were submitted to the Office of the Attorney General for a Letter of Assurance on May 2, 2000. In a letter dated May 5, 2000, Assistant Attorney General William A. Diamond (Board Counsel) provided a statement of legal authority to amend the Regulations for the Board for Opticians under the authority granted the board under §§ 54.1-201(5) of the Code of Virginia. The board approved the changes on June 9, 2000.

Summary:

> *The proposed amendments establish a definitions section; clarify entry requirements for licensure; specify examination procedures and examination content for licensure and contact lens examinations; and modify the procedures and provisions regarding renewal, reinstatement, and the standards of practice and conduct.*

PART I.
GENERAL DEFINITIONS.

18 VAC 100-20-5. Definitions.

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

"Apprentice" means a person at least 16 years of age who is covered by a written agreement with an employer and approved by the Virginia Apprenticeship Council.

"Board" means the Board for Opticians.

"Contact lens certified optician" means any person not exempted by § 54.1-1701 of the Code of Virginia who is a Virginia licensed optician and who has received a contact lens certification from the board, who prepares, fits or dispenses contact lenses on prescription from licensed physicians or licensed optometrists for the intended wearers; or refills contact lens prescriptions from a valid previously prepared prescription from a licensed physician or licensed optometrist.

"Department" means the Virginia Department of Professional and Occupational Regulation.

"Fit and dispense" means to measure, adapt, fit or adjust eyeglasses, spectacles, lenses, or appurtenances to the human face, or to verify the prescription to be correct in the prescription eyeglasses or prescription optical devices.

"Licensed optician" means any person who is the holder of a license issued by the Board for Opticians.

"Optician" means any person not exempted by § 54.1-1701 of the Code of Virginia who prepares or dispenses eyeglasses, spectacles, lenses, or related appurtenances for the intended wearers or users on prescriptions from licensed physicians or licensed optometrists, or as duplications or reproductions of previously prepared eyeglasses, spectacles, lenses, or related appurtenances; or who, in accordance with such prescriptions, duplications or reproductions, measures, adapts, fits, and adjusts eyeglasses, spectacles, lenses, or appurtenances to the human face.

"Opticianry" means the personal health service that is concerned with the art and science of ophthalmic optics as applied to the compounding, filling and adaptations of ophthalmic prescriptions, products, and accessories.

PART ~~I~~ *II*.
ENTRY *REQUIREMENTS*.

18 VAC 100-20-10. Qualifications of applicant.

~~A. Any person desiring to sit for the examination shall submit an application on a form provided by the board with the required examination fee of $55. All fees are nonrefundable and shall not be prorated.~~

~~B. Each applicant shall provide information on his application establishing that he:~~

A. An applicant for license shall furnish satisfactory evidence on an application provided by the board establishing that:

1. *The applicant* is at least 18 years of age *unless emancipated under the provisions of § 16.1-333 of the Code of Virginia*;

2. *The applicant* is a graduate of an accredited high school, or has completed the equivalent of grammar school and a four-year high school course, or is a holder of a certificate of general educational development;

3. *The applicant* is in good standing as a licensed optician in every jurisdiction where licensed;

~~4. Has not been convicted in any jurisdiction of a misdemeanor involving moral turpitude, sexual offense, drug distribution or physical injury, or any felony. Any plea of nolo contendere shall be considered a conviction for the purposes of this subdivision. The record of a conviction authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where convicted shall be admissible as prima facie evidence of such conviction; and~~

~~5.~~ *4. The applicant* has *successfully* completed one of the following education requirements:

a. ~~An approved~~ *A* two-year course in a school of opticianry, including the study of topics essential to qualify for practicing as an optician; or

b. A three-year apprenticeship with a minimum of one school year of related instruction or home study while registered in the apprenticeship program in accordance with the standards established by the State Department of Labor and Industry, Division of Apprenticeship Training and approved by the Board for Opticians~~.~~*;*

5. The applicant has disclosed his current mailing address;

6. The nonresident applicant for a license has filed and maintained with the department an irrevocable consent for the director of the department to serve as service agent for all actions filed in any court in the Commonwealth; and

7. The applicant shall certify, as part of the application, that the applicant has read and understands Chapter 17 (§ 54.1-1700 et seq.) of Title 54.1 of the Code of Virginia and the regulations of the board.

18 VAC 100-20-20. ~~Examination schedule.~~ *(Repealed.)*

~~The board shall schedule an examination to be held at least twice each calendar year at a time and place to be designated by the board. The examination application and fee must be received 60 calendar days prior to the written examination.~~

18 VAC 100-20-30. ~~Content of optician examination.~~ *(Repealed.)*

~~The optician examination given by the board will include the following topics:~~

~~1. Ophthalmic materials;~~

~~2. Ophthalmic optics and equipment;~~

~~3. Ophthalmic spectacle lens grinding;~~

~~4. Prescription interpretation;~~

~~5. Theory of light;~~

~~6. Finishing, fitting and adjusting of eyeglasses and frames;~~

~~7. Ethics of relationship in respect to patient and physician or optometrist;~~

~~8. Anatomy and physiology; and~~

~~9. Administrative duties.~~

18 VAC 100-20-40. ~~Passing grade and reexamination.~~ *(Repealed.)*

~~The passing grade shall be 70% on the written section and 70% on the practical section of the examination.~~

~~1. An applicant who fails any section shall be required to be reexamined on that section and shall pay the required reexamination fee of $70.~~

~~2. Any applicant who fails to pass the previously failed section within the next two successively scheduled~~

~~examinations will be required to take and pass the entire examination and pay the full initial examination fee.~~

18 VAC 100-20-50. ~~Licensing of out-of-state~~ Opticians *licensed in another state*.

A. An ~~out-of-state licensed~~ optician *licensed in another state* seeking to be licensed as an optician in Virginia shall submit an application on a form provided by the board with the required fee of $55. All fees are nonrefundable and shall not be prorated.

B. The board, using the following standards, shall issue a license to any person licensed in another state who:

1. Has met requirements equivalent to those listed in 18 VAC 100-20-10; and

2. Has passed a substantially equivalent examination.

18 VAC 100-20-54. Fees.

A. The fee for examination or examinations shall consist of the combination of an administrative charge of $10 (spectacle), $25 (contact lens), and the appropriate contract charges. Examination service contracts shall be established in compliance with the Virginia Public Procurement Act (§ 11-35 et seq. of the Code of Virginia). The total examination fee shall not exceed a cost of $300 to the applicant.

B. All application fees for licenses are nonrefundable and the date of receipt by the board or its agent is the date which will be used to determine whether it is on time.

C. Application and examination fees must be submitted with the application for licensure.

The following fees shall apply:

FEE TYPE	*AMOUNT DUE*	*WHEN DUE*
Application for licensure by examination or out-of-state applicants	*$55*	*With application*
Application for contact lens certification by examination or for out-of-state applicants	*$70*	*With application*
Renewal	*$60*	*Up to the expiration date on the license with a 30-day grace period*
Late renewal (in addition to renewal fee)	*$25*	*Up to 12 months after the expiration date on the license*
Reinstatement	*$100*	*After 12 calendar months following the expiration date on the license*
Duplicate wall certificate	*$25*	*With written request*

18 VAC 100-20-55. Examinations.

All examinations required for licensure shall be approved by the board and administered by the board, or its agents or employees acting on behalf of the board.

The board shall schedule an examination to be held at least twice each calendar year at a time and place to be designated by the board.

The applicant shall follow all rules established by the board with regard to conduct at an examination. Such rules shall include any written instructions communicated prior to the examination date and any instructions communicated at the site, either written or oral, on the date of the examination. Failure to comply with all rules established by the board with regard to conduct at an examination shall be grounds for denial of application.

18 VAC 100-20-56. Content of optician examination and reexamination.

A. Applicants for licensure shall pass a written examination and a practical examination approved by the board.

B. The optician examination given by the board may include, but is not limited to, the following topics:

1. Ophthalmic materials;

2. Ophthalmic optics and equipment;

3. Ophthalmic spectacle lens grinding;

4. Prescription interpretation;

5. Theory of light;

6. Finishing, fitting and adjusting of eyeglasses and frames;

7. Ethics of relationship in respect to patient and physician or optometrist;

8. Anatomy and physiology; and

9. Applicable laws and regulations.

C. Any applicant who fails the written or practical examination, or both examinations, shall be required to be reexamined on the failed examination(s) and shall pay the reexamination fee(s).

D. An applicant shall pass the written and practical examination within two years of the initial test date. After two years, the applicant shall file a new application and pay the required fee.

18 VAC 100-20-60. Endorsement to fit contact lenses~~; examination~~.

The board shall administer a contact lens examination ~~to Virginia licensed opticians desiring to obtain an endorsement of "Contact Lens Competency"~~ to fit contact lenses. The "Contact Lens ~~Competency~~" endorsement shall be mandatory for *licensed* opticians to fit contact lenses *as set out in §§ 54.1-1705 and 54.1-1706 of the Code of Virginia, and the contact lens endorsement shall not be issued unless the individual's license is in good standing*.

~~1. The applicant must achieve a passing score of 70% on the contact lens examination.~~

~~2. The fee for the contact lens examination or reexamination shall be $70. All fees are nonrefundable and shall not be prorated.~~

18 VAC 100-20-65. Content of contact lens endorsement examination and reexamination.

A. The contact lens endorsement examination administered by the board may include, but is not limited to, the following topics:

1. Rigid lens verification;

2. Lens identification;

3. Keratomy;

4. Slit lamp;

5. Slides (fitting patterns, edge patterns, quality stains); and

6. Insertion/removal.

B. Any applicant who fails the written or practical contact lens examination, or both examinations, who desires to retake the examination(s), shall be required to be reexamined on the failed examination(s) and shall pay the reexamination fee(s).

C. An applicant shall pass the written and practical examination within two years of the initial test date. After two years, the applicant shall file a new application and pay the required fee.

PART ~~II~~ *III*.
RENEWAL~~/REINSTATEMENT~~.

18 VAC 100-20-70. License renewal required.

~~A. Licenses issued under this chapter shall expire on December 31 of each even-numbered year. The Department of Professional and Occupational Regulation shall mail a renewal notice to the licensee outlining the procedures for renewal. Failure to receive this notice shall not relieve the licensee of the obligation to renew.~~

~~B. Each licensee applying for renewal shall return the renewal notice with a fee of $60 to the Department of Professional and Occupational Regulation no later than 5 p.m. on the expiration date shown on the license. If the licensee fails to receive the renewal notice, a copy of the license may be submitted with the required fee.~~

~~C. Applicants for renewal of a license shall continue to meet the standards for entry set forth in subdivisions B 3 and 4 of 18 VAC 100-20-10.~~

~~D. The board may deny renewal of a license for the same reasons as it may refuse licensure.~~

A. Licenses issued under this chapter shall expire 24 months from the last day of the month in which the license was issued.

B. The board shall mail a renewal application form to the licensee at the last known mailing address. Failure to receive this notice does not relieve the licensee of the obligation to renew. Prior to the expiration date shown on the license, each licensee desiring to renew his license must return all of the required forms and the appropriate fee to the board as outlined in 18 VAC 100-20-54. If the licensee fails to receive the renewal notice, a copy of the existing license shall be submitted to the board with the required fee.

C. Licensees shall be required to renew their license by submitting the appropriate fee made payable to the Treasurer of Virginia. Any licensee who fails to renew within 30 days after the license expires shall pay a late renewal fee, in addition to the renewal fee, as set out in 18 VAC 100-20-54.

D. The board, in its discretion and for just cause, may deny renewal of a license. Upon such denial, the applicant for renewal may request that a proceeding be held in accordance with the provision of the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia).

18 VAC 100-20-80. ~~License reinstatement required.~~ *(Repealed.)*

~~A. If the licensee fails to renew his license within 30 days following the expiration date, he must apply for reinstatement of his license on a form provided by the board.~~

~~B. If the renewal application is received by the department more than 30 days after the expiration date of the license, a late fee of $25 is required.~~

~~C. Applicants for reinstatement of a license shall continue to meet the standards for entry as set forth in subdivisions B 3 and 4 of 18 VAC 100-20-10.~~

~~D. The board may deny reinstatement of a license for the same reasons as it may refuse initial licensure.~~

~~E. When an individual fails to renew his license after a period of one year after the expiration date, he must apply as follows:~~

~~1. Submit an application on a form provided by the board establishing that he has met all of the requirements of 18 VAC 100-20-10 B 5 a or b and a fee of $100;~~

~~2. Take and receive a passing score of 70% on the practical examination and 70% on the written examination on his first attempt; and~~

~~3. Meet the requirements of 18 VAC 100-20-10 B 5 a or b before sitting for the written examination and the practical examination again if the applicant fails to pass both the written and the practical examination on his first attempt.~~

PART IV.
REINSTATEMENT.

18 VAC 100-20-81. Reinstatement required.

A. If a licensee fails to renew his license within 12 months after the expiration date on the license, the licensee must apply for reinstatement on a form provided by the board.

1. Individuals for reinstatement shall continue to meet the standards of entry as set out in subdivisions 3 through 7 of 18 VAC 100-20-20.

2. Individuals for reinstatement shall submit the required fee as set out in 18 VAC 100-20-54.

B. Twenty-four months after expiration of the license, the individual may be reinstated if he can show proof of continuous, active, ethical and legal practice outside of Virginia. If not, the individual must show proof of completion of a board-approved review course which measures current competence. Credit will not be allowed for any review course which has not been approved by the board prior to administration of the course.

C. Sixty months after expiration of the license, the individual, who cannot show proof of continuous, active, ethical and legal practice outside of Virginia, shall be required to apply as a new applicant for licensure. He shall be required to meet all current education requirements and retake the board's written and practical examination.

D. The board, in its discretion and for just cause, may deny reinstatement of a license. Upon such denial, the applicant for reinstatement may request that a proceeding be held in accordance with the provisions of the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia).

E. A licensee who reinstates his license shall be regarded as having been continually licensed without interruption. Therefore, the licensee shall remain under the disciplinary authority of the board during the entire period and may be held accountable for his activities during this period. Nothing in these regulations shall divest the board of its authority to discipline a licensee for a violation of the law or regulations during the period of licensure as set out in this provision.

PART ~~III~~ *V*.
STANDARDS OF PRACTICE *AND CONDUCT*.

18 VAC 100-20-85. Lenses and frames standards are as follows:

A. Power Tolerance (diopters).

Sphere: Plano to ± 6.50	*± .13 diopter*
Above ± 6.50	*± 2%*
Cylinder: Plano - 2.00	*± .13 diopter*
-2.12 to -4.50	*± .15 diopter*
above -4.50	*± 4%*

B. Cylinder Axis.

Cyl. Power Diopters	*Degrees ±*
0.12 - 0.37	*7°*
0.50 - 0.75	*5°*
0.87 - 1.50	*3°*
1.62 and above	*2°*

C. Distance P. D. Contribution to net horizontal prism from processing should not exceed 2/3 prism diopter. A maximum of ± 2.5mm variation from the specified distance PD is permissible in higher power lens combinations.

D. Prism Tolerances (Vertical). Contribution to imbalance from processing should not exceed 1/3 prism diopters. A maximum of 1.0mm difference in vertical level is permissible in higher power lens combinations.

E. Segment Location.

Vertical	*± 1.0 mm*
Horizontal	*± 2.5 mm*

Tilt or twist in the case of a flat-top segment, the tilt of its horizontal axis should be less than 1/2 mm in differential elevation between the segment edges.

F. Multifocal Additions.

Plano + 8.00	*± .13 diopter*
Above + 8.00	*± .18 diopter*

G. Thickness. Standard dress thickness for minus power lenses should be 2.0 mm at optical center. Plus power lenses should have an edge thickness of 1.5 mm - 2.00 mm or 2.4 mm for Nylor type frames. When specified thickness is prescribed, the tolerance should be ± 0.3 mm. Lenses to be used for occupational or safety purposes must be 3.00 mm at its thinnest point.

H. Base Curve. When specified, the base curve should be supplied within ± 0.75 diopter.

I. Warpage. The cylindrical surface power induced in the base curve of a lens should not exceed 1 diopter. This recommendation need not apply within 6mm of the mounting eyewire.

J. Localized errors (aberration). Areas outside a 20mm radius from the specified major reference point or optical center need not be tested for aberration. Progressive lenses are exempt from this requirement.

18 VAC 100-20-87. Contact lens standards are as follows:

To fit contact lenses, the following shall be done:

1. The prescription (RX) must show evidence that contact lenses may be worn by the patient before the prescription can be filled by the licensed optician. Verbal approval from the optometrist or ophthalmologist or its agents or employees is acceptable. The licensed optician must make a notation in the patient's record of the name of the authorizing optometrist or ophthalmologist and the date of the authorization.

2. The optician must use all the following to fit contact lenses:

a. Slit Lamp;

b. Keratometer; and

c. Standardized Snellen type acuity chart.

18 VAC 100-20-90. Display of license.

Every person to whom a current license has been granted under ~~these regulations~~ *this chapter* shall *visibly* display ~~it in public view~~ *his unaltered license in a conspicuous place in plain view of the public in the principal office in which they work. A duplicate license which has been notarized shall be posted in any branch offices*.

18 VAC 100-20-100. Notification of change of address or name.

~~A licensee shall notify the board in writing no later than 60 days after the occurrence of a change of address or name.~~

Notice in writing shall be given to the board in the event of any change of name or address. Such notice shall be mailed to the board within 30 days of the change of name or address. The board shall not be responsible for the licensee's failure to receive notices, communications and correspondence caused by the licensee's failure to promptly notify the board in writing of any change of name or address.

18 VAC 100-20-110. ~~Discipline~~ *Grounds for disciplinary action*.

A. The board ~~may~~ *is empowered to* revoke, suspend, or refuse to renew a license and ~~may~~ *is empowered to* impose a fine up to ~~$1,000~~ *the statutory limit, as authorized under § 54.1-202 of the Code of Virginia,* per ~~offense~~ *violation* on a licensee for any of the following reasons:

1. Using ~~alcohol or~~ nonprescribed controlled substances as defined in ~~Chapter 34 (§ 54.1-3400 et seq.) of Title 54.1~~ *54.1-3401* of the Code of Virginia *or alcohol* at the work place during working hours;

2. Displaying professional incompetence or negligence*, including but not limited to failure to comply with this part* in the performance of opticianry;

3. ~~Fraudulently certifying that an applicant possesses~~ *Presenting false or fraudulent information on an application certifying possession of* the qualifications required under 18 VAC 100-20-10;

4. Violating or inducing others to violate any provisions of Chapters 1, 2, 3 or 17 of Title 54.1 of the Code of Virginia, or of any other statute applicable to the practice of the profession herein regulated, or of any provisions of ~~these regulations~~ *this chapter*;

5. Publishing or causing to be published any advertisement *related to opticianry* that is false, deceptive, or misleading;

6. Having been convicted in any jurisdiction of a misdemeanor ~~involving moral turpitude, sexual offense, drug distribution or physical injury,~~ or of any felony *that directly relates to the profession of opticianry. The board shall have the authority to determine, based upon all the information available, including the applicant's record of prior convictions, if the applicant is unfit or unsuited to engage in the profession of opticianry*. Any plea of nolo contendere shall be considered a conviction for the purposes of this section. ~~The record of a conviction authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where the conviction occurred shall be forwarded to the board within 10 days of entry and shall be admissible as prima facie evidence of such conviction; or~~ *The licensee shall provide a certified copy of a final order, decree or case decision by a court or regulatory agency with the lawful authority to issue such order, decree or case decision, and such copy shall be admissible as prima facie evidence of such conviction. This record shall be forwarded by the licensee to the board within 10 days after all appeal rights have expired;*

7. Having been disciplined by another jurisdiction in the practice of opticianry. Documentary evidence of such discipline shall be submitted *by the licensee* to the board within 10 days ~~of entry.~~ *after all appeal rights have expired; or*

8. Allowing any person to engage in the practice of opticianry, except an optician apprentice or student enrolled in a course in a school of opticianry under the direct supervision of a licensed optician.

B. A finding of improper or dishonest conduct in the practice of the profession by a court of competent jurisdiction shall be cause for disciplinary action.

18 VAC 100-20-120. Accountability of licensee.

A licensee shall be responsible for his acts or omissions and for the acts of his agents or employees or his staff in the performance of opticianry services.

18 VAC 100-20-130. Approval of review courses.

A. Review courses set out in this chapter shall be approved by the board, except those provided by institutions, schools and universities approved by the State Council of Higher Education for Virginia, for which continuing education units are awarded. Training courses requiring board approval shall be approved by the board prior to commencing in accordance with subsection B of this section.

B. Training activities for which experience credit may be granted must be conducted in general conformance with the International Association for Continuing Education and Training's "Criteria and Guidelines for Quality Continuing Education and Training Programs: the CEU and Other Measurement Units," 1998. The board reserves the right to waive any of the requirements of the association's guidelines on a case-by-case basis. Only classroom, laboratory and field trip contact time will be used to compute training credits. No credit will be given for breaks, meals, or receptions.

1. Organization. The board will only approve training offered by a sponsor who is an identifiable organization with a mission statement outlining its functions, structure, process and philosophy, and that has a staff of one or more persons with the authority to administer training.

2. Training records. The board will only approve training offered by a sponsor who maintains training records for all participants for a minimum of five years, and who has a written policy on retention and release of training records.

3. Instructors. The board will only approve training conducted by personnel who have demonstrated competence in the subject being taught, an understanding of the learning objective, a knowledge of the learning process to be used, and a proven ability to communicate.

4. Objectives. The board will only approve courses that have a series of stated objectives that are consistent with

the job requirements of an optician. The training content must be consistent with those objectives.

5. Course completion requirements. For successful completion of a training program, participants must attend 90% or more of the class contact time and must demonstrate their learning through written examinations, completion of a project, self-assessment, oral examination, or other assessment technique.

C. The board shall consider the following information, to be submitted by the instructor, institution, school or university on forms provided by the board, at least 45 days prior to the scheduled training activity:

1. Course information.

a. Course title,

b. Planned audience,

c. Name of sponsor,

d. Name, address, phone number of contact person,

e. Schedule presentation dates,

f. Detailed course schedule, hour-by-hour,

g. List of planned breaks,

h. Scheduled presentation location(s), and

i. Relevancy of course to opticianry licensing.

2. Instructor qualifications.

a. Name of instructor,

b. Title of instructor, and

c. Summary of qualifications to teach this course.

3. Training materials.

a. Course objectives - A listing of the course objectives stated in terms of the skills, knowledge, or attitude the participant will be able to demonstrate as a result of the training,

b. Course outline - A detailed outline showing the planned activities that will occur during the training program, including major topics, planned presentation sequence, laboratory and field activities, audio-visual presentations, and other major activities,

c. Course reference materials - A list of the name, publisher and publication date for commercially available publications; for reference materials developed by the course sponsor or available exclusively through the course, a copy of the reference materials,

d. Audio-visual support materials - A listing of any commercially available audio-visual support material that will be used in the program; a brief description of any sponsor or instructor generated audio-visual material that will be used, and

e. Handouts - Identification of all commercially available handout material that will be used; copies of all other planned handouts.

4. Determination of successful completion. A description of the means that will be used to determine the successful completion of the training program by individual attendees, such as examinations, projects, personal evaluations by the instructor, or other recognized evaluation techniques.

C. Recurring training programs. If there are plans to present the same course of instruction routinely at multiple locations with only minor modifications and changes, the board may approve the overall program rather than individual presentations if so requested by the sponsor.

1. The board shall consider all of the information listed above except those items related to specific offerings of the course.

2. Board approval may be granted for a specific period of time or for an indefinite period.

3. Board approval will apply only to those specific offerings certified by the sponsoring organization as having been conducted by instructors meeting the established criteria and in accordance with the board-approved courses, outlines and objectives.

4. To maintain approval of the program, changes made to the program since initial approval must be submitted to the board for review and approval. Changes must be approved by the board prior to any training subsequent to the changes.

DOCUMENT INCORPORATED BY REFERENCE

Criteria and Guidelines for Quality Continuing Education and Training Programs: the CEU and Other Measurement Units, International Association for Continuing Education and Training, 1998.

VA.R. Doc. No. R00-30; Filed June 30, 2000, 11:16 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 4. CONSERVATION AND NATURAL RESOURCES

MARINE RESOURCES COMMISSION

REGISTRAR'S NOTICE: The following regulations filed by the Marine Resources Commission are exempt from the Administrative Process Act in accordance with § 9-6.14:4.1 F of the Code of Virginia; however, the commission is required to publish the full text of final regulations.

Title of Regulation: **4 VAC 20-700-10 et seq. Pertaining to Crab Pots (amending 4 VAC 20-700-20).**

Statutory Authority: § 28.2-201 of the Code of Virginia.

Effective Date: July 1, 2000.

Summary:

The amendment establishes that the 2-5/16 inches crab pot cull ring may be obstructed in crab pots set within the crab dredge areas or within Pocomoke or Tangier Sound.

Agency Contact: Copies of the regulation may be obtained from Deborah R. Cawthon, Marine Resources Commission, P.O. Box 756, Newport News, VA 23607, telephone (757) 247-2248.

4 VAC 20-700-20. Cull ring requirements.

A. It shall be unlawful for any person to place, set or fish any crab pot in Virginia's tidal waters which does not contain at least two unobstructed cull rings of size and location within the pot as hereinafter described, except as provided in subsections B and C of this section. One cull ring shall be at least 2-5/16 inches inside diameter, and the other cull ring shall be at least 2-3/16 inches inside diameter. These cull rings shall be located one each in opposite exterior side panels of the upper chamber of the pot.

B. The required 2-5/16 inches inside diameter cull ring may be obstructed in crab pots set on the seaside of Accomack and Northampton Counties *or within the crab dredge areas, as set forth in 4 VAC 20-90-10 et seq., or within Pocomoke or Tangier Sound*.

~~C. The required 2-5/16 inches inside diameter cull ring may be obstructed in crab pots set within the crab dredge areas, as set forth in 4 VAC 20-90-10 et seq., or within Pocomoke or Tangier Sounds, until July 1, 2000.~~

~~D.~~ *C.* Peeler pots with a mesh size less than 1-1/2 inches shall be exempt from the cull ring requirement.

VA.R. Doc. No. R00-220; Filed June 30, 2000, 2:22 p.m.

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Title of Regulation: **4 VAC 20-752-10 et seq. Pertaining to the Hampton Roads and Bayside Eastern Shore Blue Crab Management Areas (amending 4 VAC 20-752-20 and 4 VAC 20-752-30).**

Statutory Authority: § 28.2-201 of the Code of Virginia.

Summary:

The amendments establish the Virginia Baywide Blue Crab Spawning Sanctuary which incorporates the former Bayside Eastern Shore Blue Crab Management Area and makes it unlawful to conduct recreational crabbing, rather than just recreational crab potting, within the Virginia Baywide Blue Crab Spawning Sanctuary from June 1 through September 15.

Agency Contact: Copies of the regulation may be obtained from Deborah R. Cawthon, Marine Resources Commission, P.O. Box 756, Newport News, VA 23607, telephone (757) 247-2248.

4 VAC 20-752-20. Blue crab management areas.

The following management areas are established:

1. The Hampton Roads Blue Crab Management Area shall consist of all tidal waters inshore and upstream of a line formed by the extreme south and north ends of the westbound span of the Hampton Roads Bridge Tunnel.

2. ~~The Bayside Eastern Shore Blue Crab Management Area shall consist of all tidal waters within a line beginning at buoy R'14" on the eastern side of the Chesapeake Channel at the Chesapeake Bay Bridge Tunnel, thence continuing northwesterly along the eastern side of Chesapeake Channel following the buoy line to buoy R'30," thence continuing in an easterly direction to the northernmost point of the northern concrete ship at Kiptopeke, thence due east to the mean low waterline, thence continuing southerly following the mean low waterline to its intersection with the Chesapeake Bay Bridge Tunnel, thence following the north side of the Chesapeake Bay Bridge Tunnel to buoy R'14," the point of beginning.~~ *The Virginia Baywide Blue Crab Spawning Sanctuary shall consist of all tidal waters that are bounded by a line that begins at 37°05'40.03" and 75°59'42.03" near the north end of the old span of the Chesapeake Bay Bridge Tunnel; continuing southwest to 37°03'49.26" and76°05'21.88" in the Chesapeake Channel; thence continuing soutwest to 37°00'52.49" and 76°14'27.31" at Thimble Shoals Light; thence continuing in a northerly direction to 37°24'24.87" and 76°09'30.78" off of Wolf Trap Light; thence continuing northwest to 37°39'21.01" and 76°14'00.83", east of Fleets Bay; thence continuing north to 37°54'05.43" and 76°11'44.09" on the Virginia-Maryland*

state line; thence continuing east along the state line to 37°55'44.37" and 76°07'14.62"; thence continuing due south to 37°40'45.64" and 76°06'05.81"; thence continuing northeast to 37°44'59.39" and 76°01'35.53"; thence continuing southeast to 37°42'23.27" and 75°58'02.59"; thence continuing in a southerly direction to 37°16'25.90" and 76°04'37.50" off of Cape Charles; thence continuing southeast to 37°10'29.44 and 76°01'54.50"; thence continuing southeast back towards the north end of the old span of the Chesapeake Bay Bridge Tunnel to the point of beginning.

4 VAC 20-752-30. Harvest restrictions.

A. It shall be unlawful for any person to dredge for crabs within the Hampton Roads Blue Crab Management Area at any time.

B. It shall be unlawful for any person to conduct commercial *or recreational* crabbing ~~or recreational crab potting~~ within the ~~Bayside Eastern Shore Management Area~~ *Virginia Baywide Blue Crab Spawning Sanctuary* from June 1 through September 15.

VA.R. Doc. No. R00-219; Filed June 30, 2000, 2:26 p.m.

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Title of Regulation: **4 VAC 20-910-10 et seq. Pertaining to Scup (Porgy) (amending 4 VAC 20-910-45).**

Statutory Authority: § 28.2-201 of the Code of Virginia.

Effective Date: July 1, 2000.

Summary:

The amendment limits the commercial harvest and landing of scup to 2,149 pounds during the period of May 1 through October 31 of each year.

Agency Contact: Copies of the regulation may be obtained from Deborah R. Cawthon, Marine Resources Commission, P.O. Box 756, Newport News, VA 23607, telephone (757) 247-2248.

4 VAC 20-910-45. Possession limits and harvest quotas.

A. During the period January 1 through April 30 of each year, it shall be unlawful for any person to possess aboard any vessel or to land in Virginia more than 10,000 pounds of scup; except when it is projected and announced that 85% of the coastwide quota for this period has been landed, it shall be unlawful for any person to possess aboard any vessel or to land in Virginia more than 1,000 pounds of scup.

B. During the period November 1 through December 31 of each year, it shall be unlawful for any person to possess aboard any vessel or to land in Virginia more than 8,000 pounds of scup except when it is announced that the coastwide quota for this period has been reached.

C. During the period May 1 through October 31 of each year, the commercial harvest and landing of scup in Virginia shall be limited to ~~3,167~~ *2,149* pounds.

D. For each of the time periods set forth in this section, the Marine Resources Commission will give timely notice to the industry of calculated poundage possession limits and quotas and any adjustments thereto. It shall be unlawful for any person to possess or to land any scup for commercial purposes after any winter period coastwide quota or summer period Virginia quota has been attained and announced as such.

E. It shall be unlawful for any buyer of seafood to receive any scup after any commercial harvest or landing quota has been attained and announced as such.

F. It shall be unlawful for any person fishing with hook and line, rod and reel, spear, gig or other recreational gear to possess more than 50 scup. When fishing is from a boat or vessel where the entire catch is held in a common hold or container, the possession limit shall be for the boat or vessel and shall be equal to the number of persons on board legally eligible to fish multiplied by 50. The captain or operator of the boat or vessel shall be responsible for any boat or vessel possession limit. Any scup taken after the possession limit has been reached shall be returned to the water immediately.

VA.R. Doc. No. R00-221; Filed June 30, 2000, 2:23 p.m.

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TITLE 11. GAMING

VIRGINIA RACING COMMISSION

REGISTRAR'S NOTICE: The Virginia Racing Commission is claiming an exemption from the Administrative Process Act pursuant to § 9-6.14:4.1 B 23 of the Code of Virginia, which exempts regulatory action relating to the administration of medication or other substances foreign to the natural horse.

Title of Regulation: **11 VAC 10-180-10 et seq. Medication (amending 11 VAC 10-180-10 through 11 VAC 10-180-80).**

Statutory Authority: § 59.1-369 of the Code of Virginia.

Effective Date: July 10, 2000.

Summary:

The Virginia Racing Commission is incorporating amendments recommended by the Racing Safety and Medication Committee. Among these recommendations were three substantial changes adopted by the commission. The substantial changes (i) reduce the time of administration of furosemide from no less than four hours to no less than three hours prior to post time; (ii) allow the administration of furosemide to occur outside the enclosure of the racetrack, but the medication must be administered by a veterinarian who is a permit holder; and (iii) allow the permitted adjunct therapies be administered concurrently with the administration of furosemide.

Agency Contact: Copies of the regulation may be obtained from William H. Anderson, Virginia Racing Commission, 10700 Horsemen's Road, New Kent, VA 23124, telephone (804) 966-7404.

11 VAC 10-180-10. Definitions.

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

"Bleeder" means a horse which has been diagnosed as suffering from exercise-induced pulmonary hemorrhage based on external or endoscopic examination by the commission veterinarian, licensee's veterinarian or private practitioner who is a permit holder.

"Bleeder list" means a tabulation of all bleeders to be maintained by the stewards.

"Commission" means the Virginia Racing Commission.

"Controlled substance" means *a drug, substance or immediate precursor in Schedules I through VI of the Virginia Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) or* any substance included in the five classification schedules of the U.S. *Uniform* Controlled Substances Act ~~of 1970~~ (21 USC § ~~801~~ *301* et seq.).

"Injectable substance" means a liquid or solid substance, which may require the addition of a liquid via a needle and syringe to change it from a solid into a liquid, contained in a vial with a rubber top which can be accessed and administered only via a needle and syringe.

"Licensed veterinarian" means a veterinarian who holds a valid license to practice veterinary medicine and surgery under the applicable laws of the jurisdiction in which such person's practice is principally conducted.

"Permitted race day substances" means ~~nonperformance~~ *only substances that are not performance* altering and *are* administered ~~only~~ *solely* for the benefit and welfare of the horse.

"Prescription substance" means any substance which is administered or dispensed by or on the order of a ~~private practitioner, who is a permit holder,~~ *licensed veterinarian* for the purpose of medical treatment of an animal patient when a bona fide doctor-patient relationship has been established.

"Primary laboratory" means a facility designated by the commission for the testing of test samples.

"Prohibited substance" means any drug, medication or chemical foreign to the natural horse, whether natural or synthetic, or a metabolite or analog thereof, the use of which is not expressly permitted by the regulations of the commission.

"Race day" means the period between midnight before a race and post-time for the race in which the horse is entered to start.

"Reference laboratory" means a facility designated by the commission for the testing of split samples.

"Substance" means any drug, medication or chemical foreign to the natural horse or human being, whether natural or synthetic, or a metabolite or analog thereof.

"Test sample" means any sample of blood, urine, saliva or tissue obtained from a horse or person for the purpose of laboratory testing for the presence of substances.

"Tubing" means the administration to a horse of any substance via a naso-gastric tube.

11 VAC 10-180-20. Generally.

A. Race day prohibitions. No person shall administer any substance to a horse on race day other than those substances expressly permitted by the commission. Substances permitted by the commission shall be nonperformance altering and administered only for the benefit and welfare of the horse.

B. Tubing of horses prohibited. The tubing or dosing of any horse for any reason on race day is prohibited, unless administered for medical emergency purposes by a ~~private practitioner who is a permit holder,~~ *licensed veterinarian* in which case the horse shall be scratched. The practice of administration of any substance, via a tube or dose syringe, into a horse's stomach on race day is considered a violation of this chapter.

C. Possession of needles prohibited. No ~~permit holder~~ *person*, except a veterinarian *holding a valid veterinarian's permit* or an assistant under his immediate supervision, shall have in his possession within the enclosure any hypodermic syringe or needle or any instrument capable of being used for the injection of any substance.

D. Possession of injectables prohibited. No ~~permit holder~~ *person*, except a veterinarian *holding a valid veterinarian's permit* or an assistant under his immediate supervision, shall have in his possession within the enclosure any injectable substance.

E. Prescription substances for animal use. No ~~permit holder~~ *person*, except a veterinarian *holding a valid veterinarian's permit* or an assistant under his immediate supervision, shall have in his possession within the enclosure of a horse racing facility any prescription substance for animal use unless:

1. The ~~permit holder~~ *person* actually possesses, within the enclosure of the horse racing facility, documentary evidence that a prescription has been issued to him for the substance by a ~~private practitioner who is a permit holder~~ *licensed veterinarian*;

2. The prescription substance is labelled with a dosage for the horse or horses to be treated with the prescription substance; and

3. The horse or horses named in the prescription are then under the care and supervision of the permit holder and are then stabled within the enclosure of the horse racing facility.

F. Possession of substances. No veterinarian or permit holder shall possess or administer any substance to a horse stabled within the enclosure:

1. That has not been approved by the U.S. Food and Drug Administration, pursuant to the Federal Food, Drug and Cosmetic Act (21 USC § ~~30~~ *301* et seq.); or

2. That is on the U.S. Drug Enforcement Agency's Schedule I or Schedule II of controlled substances as prepared by the Attorney General of the United States pursuant to 21 USC §§ 811 and 812.

G. Human use of needles and substances. Notwithstanding these regulations, a permit holder or veterinarian may possess within the enclosure of a horse racing facility a substance for use on his person, providing the permit holder or veterinarian possesses documentary evidence that a valid medical prescription has been issued to the permit holder or veterinarian.

Notwithstanding these regulations, a permit holder or veterinarian may possess within the enclosure of a horse racing facility a hypodermic syringe or needle for the purpose of administering to himself a substance, provided that the permit holder has documentary evidence that the substance can only be administered by injection and that the substance to be administered by injection has been prescribed for him.

11 VAC 10-180-30. Bleeders.

A. Examination of bleeders. A horse which is alleged to have bled in Virginia must be physically examined by the commission veterinarian, licensee's veterinarian or private practitioner who is a permit holder in order to confirm the horse's inclusion on the bleeder list. The veterinarians may conclude a horse is a bleeder under the following circumstances:

1. If the examination takes place immediately following the race or exercise and before the horse leaves the racing surface, a veterinarian may conclude the horse is a bleeder and an endoscopic examination is not required for inclusion on the bleeder list; or

2. If the examination takes place after the horse leaves the racing surface but within 90 minutes following the finish of a race or exercise in which the horse participated, a veterinarian shall require an endoscopic examination for inclusion on the bleeder list.

B. Confirmation of a bleeder. The commission veterinarian, licensee's veterinarian or private practitioner who is a permit holder, shall decide, based upon his experience and professional training, whether the horse suffers from exercise-induced pulmonary hemorrhage and should be placed on the bleeder list. The confirmation of a bleeder shall be certified in writing by the commission veterinarian, licensee's veterinarian or private practitioner who is a permit holder, and the horse shall be placed on the bleeder list. The confirmation of a bleeder shall be filed with the commission within ~~10~~ *three* days of the confirmation. Upon request, a copy of the certification shall be provided to the owner of the horse or his agent.

C. Posting of bleeder list. The bleeder list shall be maintained by the stewards, with the assistance of the commission veterinarian, and shall be made available upon request. No horse shall be removed from the bleeder list without the approval of the stewards.

D. Recovery period. If it is determined that a horse has bled as determined by this chapter, the horse shall be placed on the bleeders list and may not be permitted to race for at least 10 days. If a horse is determined to have bled within 365 days of the first occurrence, the horse may not race for the following periods of time:

1. 30 days after the first reoccurrence;

2. 90 days after the second reoccurrence; and

3. The horse shall be barred from racing forever at race meetings licensed by the commission after the third reoccurrence.

For the purpose of counting the number of days a horse is not permitted to race in meetings licensed by the commission, the day the horse bled is the first day of the recovery period, and the horse shall be permitted to race in meetings licensed by the commission when the last day of the recovery period under this chapter has expired.

E. Bleeders from other jurisdictions. The commission veterinarian may designate a horse as a bleeder from another jurisdiction ~~upon receipt of documentation~~ *based upon information received from that jurisdiction* confirming that the horse is a bleeder~~, providing~~ *and* that the requirements for inclusion on the bleeder list in Virginia have been satisfied.

11 VAC 10-180-40. Collection of samples.

A. Test barn. All test samples shall be collected in the test barn under the supervision of the commission veterinarian *or his designee*. The commission veterinarian~~,~~ may*,* at his discretion, permit test samples to be collected in the horse's stall or any other location he deems appropriate. Under these circumstances, the commission veterinarian shall inform the stewards of his decision.

B. Horses to be tested. The stewards or commission veterinarian may, at any time, order the taking of test samples from any horse stabled within the enclosure of the horse racing facility, prior to racing or after racing*, including qualifying races and official timed workouts for the stewards or commission veterinarian*. However, the stewards shall designate at least one horse from each race for the collection of test samples.

C. Collection procedure.

1. The trainer ~~and groom of~~ *or a permit holder designated by the trainer shall accompany* a horse sent to the test barn ~~for the collection of test samples~~ *and witness the collection and splitting of the samples. The trainer or a permit holder designated by the trainer* shall cooperate with the commission veterinarian and the commission's veterinary technicians in the performance of their duties. *The trainer or a permit holder designated by the trainer must remain with the horse until the horse is released from the test barn.*

2. Horses, from which samples are to be collected, shall be escorted, following the race, directly to the test barn by the commission's veterinary technicians and the horses shall remain in the test barn until released by the commission veterinarian.

3. Stable equipment, other than that which is necessary for washing and cooling out of a horse, is prohibited in the test barn. A private practitioner may attend a horse in

the test barn only in the presence of the commission veterinarian or the commission's veterinary technicians.

4. During the collection of test samples, the owner, trainer or an assistant designated by the owner or trainer, shall be present and witness the collection of the test sample, the splitting of the sample and sealing of containers. In the case of a claimed horse, the owner or trainer, or an assistant designated by the owner or trainer in whose name the horse started, shall be present to witness the collection of the test samples.

5. The test and split samples collected from a horse shall have identification tags affixed. One portion of the tag, bearing a printed identification number, shall remain with the sealed test and split samples, and the other portion of the tag bearing the same printed identification numbers shall be detached in the presence of the witness. The ~~commission's veterinary technician~~ *commission veterinarian or his designee* shall on the detached portion of the tags identify the horse from which the test and split samples were collected, the race and date, and other information deemed appropriate. The detached portion of the tag shall be witnessed by the ~~owner or~~ trainer~~,~~ or ~~an assistant~~ *a permit holder* designated by the ~~owner or~~ trainer~~,~~ and shall be ~~delivered to the commission's general business office~~ *retained by the commission veterinarian for safe keeping*.

6. A horse's identity shall be confirmed by examining its lip-tattoo number*, or for a Standardbred, its freeze brand number*. A horse that has not been lip-tattooed*, or a Standardbred that has not been freeze branded* shall be reported immediately to the stewards.

7. If, after a horse remains for a reasonable time in the test barn, a test sample of urine cannot be collected from the horse, the commission veterinarian may, at his discretion, collect a test sample of blood or permit the horse to be returned to its barn where a test sample may be collected under the supervision of the commission veterinarian or the commission's veterinary technicians.

11 VAC 10-180-50. Laboratory findings and reports.

A. Primary testing laboratory. The commission shall designate a primary testing laboratory for the analysis of test samples collected under the supervision of the commission veterinarian. The commission shall designate a chief racing chemist within the primary testing laboratory who shall have the authority to report his findings to the executive secretary of the commission, the stewards and the commission veterinarian.

B. Reference laboratories. The commission shall designate one or more laboratories, other than the primary testing laboratory, as references laboratories. These laboratories will conduct confirmatory analysis of split samples ~~as shipped by the commission veterinarian~~. Any reference laboratory must be accredited by the Association of Racing Commissioners International and be willing to accept split samples for confirmatory testing. Any reference laboratory shall send results to both the person requesting the testing and the commission.

C. Chief racing chemist's responsibilities. The chief racing chemist shall be responsible for safeguarding and analyzing the test samples delivered to the primary testing laboratory. It shall be the chief racing chemist's responsibility to maintain proper equipment, adequate staffing and acceptable procedures to thoroughly and accurately analyze test samples submitted to the primary testing laboratory.

D. Reporting procedures. The chief racing chemist shall submit to the executive secretary of the commission, the stewards and the commission veterinarian a written report as to each test sample analyzed, indicating by identification tag number, whether the test sample was negative or there was a chemical identification.

E. Chemical identifications. If the chief racing chemist determines that there is present in the test sample a substance or metabolites of a substance foreign to the natural horse, except those specifically permitted by the regulations of the commission, he shall submit a report of chemical identification to the executive secretary of the commission, the stewards and the commission veterinarian. In a report of chemical identification, the chief racing chemist shall submit evidence acceptable in the scientific community and admissible in court in support of his determination.

F. Review of chemical identifications. Upon receipt of a report of a chemical identification from the chief racing chemist, the stewards shall conduct a review of the chemical identification which shall include but not be limited to the chief racing chemist~~,~~ *and* the commission veterinarian ~~and the commission's veterinary-pharmacological consultant~~. During the review, the following procedures shall apply:

1. All references to the report of a chemical identification shall be only by the identification tag number of the sample collected from the horse;

2. The chief racing chemist shall submit his written report of the chemical identification and the evidence supporting his finding;

3. The ~~commission's veterinary-pharmacological consultant~~ *commission veterinarian* shall submit a written statement to the stewards including but not limited to the classification of the substance~~,~~ *and* its probable effect on a racehorse~~, and the efficacy of the substance at the levels found in the test sample~~;

4. The stewards may ask questions at any time and request further documentation as they deem necessary;

5. If the chemical identification involves a Class 1 or Class 2 substance, as specified by this regulation, then the stewards shall determine that the chemical identification constitutes a violation of the regulations of the commission and it is deemed a positive test result;

6. If the chemical identification and quantification involves a Class 3, Class 4 or Class 5 substance, as specified by this regulation, then the stewards shall determine whether the chemical identification does or does not constitute a violation of the regulations of the commission and whether it should be deemed a positive test result;

7. In the event of a positive test result, the stewards shall notify the trainer of the horse~~, in writing,~~ of his right to send the split sample collected from the horse to one of the reference laboratories, designated by the commission, for confirmatory testing;

8. The stewards shall take no disciplinary action against any permit holder until the results of confirmatory testing are received, and the findings shall be a part of the record of any subsequent ~~informal fact-finding conference~~ *hearing*; and

9. The chief racing chemist's report of a chemical identification, the ~~commission's veterinary-pharmacological consultant's~~ *commission veterinarian's* written statement, the results of confirmatory testing and any other documentation submitted to the stewards shall become part of the record of any subsequent proceedings.

G. Barred from racing. No horse from which a positive test sample was collected shall be permitted to race until the stewards have made a final determination in the matter. Such a horse shall not be immune from resulting disciplinary action by the stewards or the commission.

H. Frozen samples. Unconsumed portions of all test samples tested by the primary testing laboratory will be maintained in a frozen state until ~~the last sample of the race meeting is~~ cleared by the chief racing chemist *and permission for their disposal is obtained from the Senior Commonwealth Steward*. ~~In the event of a positive test result involving a Class 1, Class 2 or Class 3 substance, the commission or stewards shall direct that the stored frozen samples collected from the horses raced by the trainer shall be tested for the presence of the identified substance. The results of this testing may be considered by the stewards or commission in assessing any disciplinary actions.~~

I. Split samples. The commission veterinarian *or his designee* shall determine a minimum test sample requirement for the primary testing laboratory. If the test sample collected is less than the minimum requirement, then the entire test sample shall be sent to the primary laboratory.

If the sample collected is greater than the minimum sample requirement but less than twice that amount, the portion of the test sample that is greater than the minimum test sample requirement shall be secured as the split sample.

If the test sample collected is greater than twice the minimum test sample requirement, a portion of the sample approximately equal to the test sample shipped to the primary testing laboratory shall be secured as the split sample.

J. Storage of split samples. Split samples shall be stored in secured location inside a locked freezer in accordance with the following procedures:

1. Split samples shall be secured in the test barn in the same manner as the portion of the test sample acquired for shipment to the primary laboratory until such time as test samples are packed and secured for shipment to the primary laboratory.

2. Upon shipment of the test samples to the primary laboratory, the split samples shall be transferred to the locked freezer by the commission veterinarian who shall be responsible for securing possession of the keys.

3. The freezer for storage of split samples shall be opened only for depositing or removing split samples, for inventory, or for checking the condition of split samples.

4. Whenever the freezer used for storage of split samples is opened, it shall be attended by the commission veterinarian or his designee and a representative of the horsemen *if the respective horsemen's association has provided a representative*. *In the case that the split samples from a race must be secured in the freezer and no horsemen's representative is present, the commission veterinarian or his designee shall be in attendance.*

5. A log shall be maintained each time the freezer used for storage of split samples is opened to specify each person in attendance, the purpose for opening the freezer, identification of split samples deposited or removed, the date and time the freezer was opened, and the time the freezer was locked.

6. Any evidence of a malfunction of the freezer used for storage of split samples or evidence that split samples are not in a frozen condition shall be documented in the log and immediately reported to the stewards.

K. Shipment of split samples. The trainer or owner of the horse shall have 48 hours from receipt of ~~the written~~ notice of a positive test result to request that the split sample be shipped to one of the reference laboratories designated by the commission and the split sample shall be shipped to the requested reference laboratory ~~within an additional 48 hours~~. The cost of shipment and additional testing shall be paid by the permit holder requesting the testing of the split sample.

L. Chain of custody form. The commission veterinarian, or his designee, shall be responsible for the completion of a chain of custody verification form that shall provide a place for recording the following information:

1. Date and time the split sample is removed from the freezer;

2. The test sample number;

3. The address of the reference laboratory;

4. The name and address where the split sample package is to be taken for shipment to the reference laboratory;

5. Verification of retrieval of the split sample from the freezer;

6. Verification that each specific step of the split sample packaging procedure is in accordance with the recommended procedure;

7. Verification of the address of the reference laboratory on the split sample package;

8. Verification of the condition of the split sample package immediately prior to the transfer of custody to the carrier for shipment to the reference laboratory;

9. The date and time custody of the split sample package was transferred to the carrier; and

10. The commission veterinarian, or his designee, and the trainer or owner of the horse, or his designee, shall witness, attest and sign the form, and a copy of the form shall be supplied to the trainer or owner.

11. In the event that the trainer or owner of the horse, or his designee, is not present, the commission veterinarian shall not remove the split sample from the freezer or ship the split sample to a reference laboratory.

M. Packaging the split sample. The following procedures shall apply to the packaging of the split sample:

1. The split sample shall be removed from the freezer by the commission veterinarian, or his designee, in the presence of the trainer or owner, or his designee.

2. The trainer or owner, or his designee, shall pack the split sample, in the presence of the commission veterinarian or his designee, in accordance with the instructions supplied by the reference laboratory.

3. The exterior of the package shall be secured and identified with initialed tape, evidence tape or other means to prevent tampering with the package.

4. The package containing the split sample shall be transported in the presence of the commission veterinarian, or his designee, and the trainer or owner, or his designee, to the location where custody is transferred to the delivery carrier for shipment to the reference laboratory.

5. The commission veterinarian, or his designee, and the trainer or owner, or his designee, shall inspect the package containing the split sample immediately prior to transfer to the delivery carrier to verify that the package is intact and has not been tampered with.

6. The commission veterinarian, or his designee, and the trainer or owner, or his designee, shall complete the chain of custody verification form.

11 VAC 10-180-60. Medications and substances.

A. Disciplinary actions. The stewards may, at their discretion, refer to the following guidelines in imposing a disciplinary action upon a permit holder for a positive test result for one of the five classifications listed in subsection B of this section. However, the stewards may, at their discretion and in consideration of the circumstances, impose a greater or lesser disciplinary action. The guidelines are:

1. Class 1. One to five years suspension and at least $5,000 fine and loss of purse.

2. Class 2. Six months to one year suspension and $1,500 to $2,500 fine and loss of purse.

3. Class 3. Sixty days to six months suspension and up to $1,500 fine and loss of purse.

4. Class 4. Fifteen to 60 days suspension and up to $1,000 fine and loss of purse.

5. Class 5. Zero to 15 days suspension with a possible loss of purse or fine or both.

6. For cimetidine, dicoumerol, griseofulvin, isoxsuprine, ranitidine, sulfa and tetramisole--first offense: $500 fine; second offense: 15-day suspension and disqualification.

7. For procaine, o-desmethyl pyrilamine--if the stewards determine that the drug was administered more than 48 hours before race day, first offense: $500 fine; second offense: 15-day suspension and disqualification.

8. For procaine, o-desmethyl pyrilamine--if the stewards determine that the drug was administered within 48 hours of race day, first offense: 15-day suspension and disqualification; second offense: more stringent disciplinary action.

9. For methylprednisolone--first offense, if found in urine only: $250 fine, or if found in urine and blood: 15-day suspension and disqualification; second offense: 15-day suspension and disqualification.

B. Classes of prohibited substances. The classes of prohibited substances are:

1. Class 1. Drugs found in this class are substances which are potent stimulants of the nervous system and included in this class are opiates, opium derivatives, synthetic opioids, psychoactive drugs, amphetamines and U.S. Drug Enforcement Agency (DEA) Scheduled I and II drugs. Drugs in this class have no generally accepted medical use in the racehorse and their pharmacological potential for altering the performance of a racehorse is very high.

2. Class 2. Drugs found in this class have a high potential for affecting the outcome of a race. Most drugs in this class are generally not accepted therapeutic agents in the racehorse. Many drugs in this class are products intended to alter consciousness or the psychic state of humans, and have no approved or indicated use in the horse. Some drugs in this class, such as injectable local anesthetics, have legitimate use in equine medicine, but should not be found in a racehorse. The following groups of drugs are in this class:

a. Opiate partial agonists, or agonist-antagonists;

b. Nonopiate psychotropic drugs, which may have stimulant, depressant, analgesic or neuroleptic effects;

c. Miscellaneous drugs which might have a stimulant effect on the central nervous system (CNS);

d. Drugs with prominent CNS depressant action;

e. Antidepressant and antipsychotic drugs, with or without prominent CNS stimulatory or depressant effects;

f. Muscle blocking drugs which have a direct neuromuscular blocking action;

g. Local anesthetics which have a reasonable potential for use as nerve blocking agents (except procaine); and

h. Snake venoms and other biological substances which may be used as nerve blocking agents.

3. Class 3. Drugs found in this class may or may not have an accepted therapeutic use in the horse. Many are drugs that affect the cardiovascular, pulmonary and autonomic nervous systems. They all have the potential of affecting the performance of a racehorse. The following groups of drugs are in this class:

a. Drugs affecting the autonomic nervous system which do not have prominent CNS effects, but which do have prominent cardiovascular or respiratory system effects (bronchodilators are included in this class);

b. A local anesthetic which has nerve blocking potential but also a high potential for producing urine residue levels from a method of use not related to the anesthetic effect of the drug (procaine);

c. Miscellaneous drugs with mild sedative action, such as the sleep inducing antihistamines;

d. Primary vasodilating/hypotensive agents; and

e. Potent diuretics affecting renal function and body fluid composition.

4. Class 4. This class of drugs is comprised primarily of therapeutic medications routinely used in racehorses. These drugs may influence performance but generally have a more limited ability to do so. The following groups of drugs are in this class:

a. Nonopiate drugs which have a mild central analgesic effect;

b. Drugs affecting the autonomic nervous system which do not have prominent CNS, cardiovascular or respiratory effects:

(1) Drugs used solely as topical vasconstrictors or decongestants;

(2) Drugs used as gastrointestinal antispasmodics;

(3) Drugs used to void the urinary bladder; and

(4) Drugs with a major effect on CNS vasculature or smooth muscle of visceral organs;

c. Antihistamines which do not have a significant CNS depressant effect (This does not include H1 blocking agents, which are listed in Class 5);

d. Mineralocorticoid drugs;

e. Skeletal muscle relaxants;

f. Anti-inflammatory drugs--those that may reduce pain as a consequence of their anti-inflammatory actions, which include:

(1) Nonsteroidal Anti-inflammatory Drugs (NASAIDs)--aspirin-like drugs;

(2) Corticosteroids (glucocorticoids); and

(3) Miscellaneous anti-inflammatory agents;

g. Anabolic or androgenic steroids, or both, and other drugs;

h. Less potent diuretics;

i. Cardiac glycosides and antiarrhythmics including:

(1) Cardiac glycosides;

(2) Antirryhthmic agents (exclusive of lidocaine, bretylium and propranolol);

(3) Miscellaneous cardiotonic drugs;

j. Topical anesthetics--agents not available in injectable formulations;

k. Antidiarrheal agents; and

l. Miscellaneous drugs including:

(1) Expectorants with little or no other pharmacologic action;

(2) Stomachics; and

(3) Mucolytic agents.

5. Class 5. Drugs found in this class are therapeutic medications for which concentration limits have been established as well as certain miscellaneous agents. Included specifically in this class of drugs are agents with very localized action only, such as anti-ulcer drugs and certain antiallergic drugs. The anticoagulant drugs are also included.

C. Permitted race day substances. The following substances have been determined to be nonperformance altering and administered only for the benefit and welfare of the horse. These substances may be administered to a horse on race day by a permit holder when administered under veterinary supervision within the limits of this chapter:

1. Intravenous commercially available electrolyte solutions including calcium and magnesium, but not including bicarbonate*, providing such administration is a minimum of three hours prior to the post time for that horse's race*.

2. Conjugated estrogens, not to exceed 25 milligrams*, providing the horse is on the bleeders list and administration is concurrent with furosemide administration*.

3. Aminocaproic acid, not to exceed 2.5 grams*, providing the horse is on the bleeders list and administration is concurrent with furosemide administration*.

4. Tranexamic acid, not to exceed 1 gram*, providing the horse is on the bleeders list and administration is concurrent with furosemide administration*.

11 VAC 10-180-70. Phenylbutazone.

A. Generally. By this regulation, the Virginia Racing Commission specifically permits the use of phenylbutazone in racehorses in the quantities provided for in this chapter.

B. Quantitative testing. Any horse to which phenylbutazone has been administered shall be subject to having test

samples taken at the direction of the commission veterinarian to determine the quantitative level of phenylbutazone or the presence of other substances which may be present.

C. Disciplinary actions. The stewards shall take the following disciplinary actions for reports of quantitative testing by the primary testing laboratory for levels of phenylbutazone quantified at levels above 2.0 micrograms per milliliter of plasma *in horses following races, qualifying races, and official timed workouts for the stewards or commission veterinarian*:

1. The stewards shall verbally warn a trainer of a horse with a post-race test above 2.0 to below 2.6 micrograms per milliliter of plasma;

2. The stewards shall fine a trainer $500, but not more than any purse, for the first offense with a post-race test above 2.6 micrograms per milliliter to below 5.0 micrograms per milliliter of plasma;

3. The stewards shall suspend a trainer for 15 days and disqualify the horse for a second offense with a post-race test from above 2.6 micrograms per milliliter of plasma and below 5.0 micrograms per milliliter of plasma; and

4. The stewards shall suspend a trainer for 15 days and disqualify the horse for a post-race test of 5.0 micrograms per milliliter of plasma or above.

5. The stewards, in their discretion, may impose other more stringent disciplinary actions against trainers or other permit holders who violate the provisions under which phenylbutazone is permitted by the commission.

11 VAC 10-180-80. Bleeder medications.

A. Generally. By this regulation, the Virginia Racing Commission specifically permits the use of furosemide in only those horses that have been placed on the bleeder list by the stewards.

B. Furosemide.

1. Procedures for usage. The use of furosemide shall be permitted by the commission only ~~on~~ *in* horses already on the bleeder list and under the following circumstances:

a. Furosemide shall be administered intravenously, ~~within the enclosure of the horse race facility~~ *by a private practitioner who is a permit holder*, no less than ~~four~~ *three* hours prior to *the scheduled* post time of the race in which the horse is entered to start.

b. The furosemide dosage administered shall not exceed 10 ml (500 mg) and shall not be less than 3 ml (150 mg). Dosage levels between each race shall not vary by more than 3 ml (150 mg).

c. The private practitioner, who is a permit holder, administering the furosemide shall deliver to the commission's office at the racetrack no later than ~~one hour~~ *two hours* prior to post time for the race in which the horse is entered a furosemide treatment form containing the following:

(1) The trainer's name, date, horse's name, and horse's identification number;

(2) The time furosemide was administered to the horse;

(3) The prior dosage level of furosemide administered to the horse and the dosage level administered for this race;

(4) The barn and stall number; and

(5) The signature of the private practitioner, who is a permit holder.

2. Furosemide quantification. Furosemide levels must not exceed 100 nanograms per milliliter (ng/ml) of plasma in horses administered furosemide and with urine specific gravity measuring 1.010 or lower. Furosemide must be present in the plasma of any horse racing in Virginia which has been designated in the program as being treated with the substance.

C. Disciplinary actions.

1. For the first violation of the regulation pertaining to furosemide quantification (subdivision B 2 of this section), the stewards shall issue a written reprimand to the trainer.

2. For the second violation of the regulation pertaining to furosemide quantification (subdivision B 2 of this section), the stewards shall fine the trainer an amount not to exceed $500;

3. For the third violation of the regulation pertaining to furosemide quantification (subdivision B 2 of this section) within a 12-month period, the stewards shall suspend or fine the trainer or both; and

4. The stewards, in their discretion, may impose other more stringent disciplinary actions against trainers or other permit holders who violate the provisions under which furosemide is permitted by the commission, regardless of whether or not the same horse is involved.

D. Program designation. The licensee shall be responsible for designating in the program those horses racing on furosemide. The designation shall also include those horses making their first ~~or second starts~~ *start* while racing on furosemide. In the event there is an error, the licensee shall be responsible for making an announcement to be made over the public address system and taking other means to correct the information published in the program.

E. Removal from the bleeder list. A trainer or owner may remove his horse from the bleeder list *only* with the permission of the stewards prior to entering the horse in a race.

NOTICE: The forms used in administering 11 VAC 10-180-10 et seq., Medication, are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS

Universal Bleeder Certificate--Examination for Exercise Induced Pulmonary Hemorrhage, 3/98.

Furosemide Administration Report, 3/98.

~~Split Sample Freezer Log, 3/98.~~

Chain of Custody Form, 3/98.

Test Barn Daily Log, 3/98.

Certification of Removal from the Lasix Program (eff. 7/00).

Schedule of Split Samples (Id) (eff. 7/00).

Test Barn Freezer Log (eff. 7/00).

COMMONWEALTH of VIRGINIA
Virginia Racing Commission
10700 Horsemen's Road
New Kent, Virginia 23124
(804) 966-7400; FAX (804) 966-7418

CERTIFICATION OF REMOVAL FROM THE LASIX PROGRAM

Name of Horse _____

Tattoo _____ Last Bleed Date_____ #Bleed_____

Owner or Trainer _____

Effective Date _____

I hereby request that the above named horse be removed from the Lasix Program. I understand that removal from the program prohibits the horse from racing on Lasix. To be reinstated on the Lasix Program the horse must be observed bleeding on the track by a commission veterinarian or be certified a bleeder by endoscopic examination by a private veterinarian. Subsequent bleeding will subject the horse to 10, 30 or 90 days restriction from racing.

_____
Signature of Owner or Trainer Date

_____
Signature of Steward

_____
Signature of Commission Veterinarian

VIRGINIA RACING COMMISSION
Schedule of Split Samples (Id)

Race Date _____

Samples Deposited

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Samples Removed

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Remarks: _____

_____

_____ _____
(Commission Veterinarian) **(Test Barn Supervisor)**

Page #

Virginia Racing Commission
Test Barn
Freezer Log

Date	Time Opened	Reason	Sample Id	Time Closed	Persons Present

VA.R. Doc. No. R00-222; Filed July 10, 2000, 3:32 p.m.

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TITLE 13. HOUSING

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

Change in Effective Date

EDITOR'S NOTE: This final regulatory action was published in 16:20 VA.R. 2467-2472 June 19, 2000, with an effective date of August 15, 2000. The agency has requested that the effective date be changed to September 15, 2000.

Title of Regulation: **13 VAC 5-21-10 et seq. Virginia Certification Standards (amending 13 VAC 5-21-10 and 13 VAC 5-21-20; adding 13 VAC 5-21-31, 13 VAC 5-21-41, 13 VAC 5-21-51, 13 VAC 5-21-61, and 13 VAC 5-21-71; repealing 13 VAC 5-21-30, 13 VAC 5-21-40, 13 VAC 5-21-50, and 13 VAC 5-21-60).**

Statutory Authority: § 36-137 of the Code of Virginia.

Effective Date: September 15, 2000.

Agency Contact: George W. Rickman, Jr., Department of Housing and Community Development, 501 North Second Street, Richmond, VA 23219-1321, telephone (804) 371-7150.

VA.R. Doc. No. R98-273; Filed July 14, 2000, 10:42 a.m.

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Reprint and Change in Effective Date

EDITOR'S NOTE: The final amendments to the following regulation were previously published in 16:20 VA.R. 2472-2487 June 19, 2000. However, 13 VAC 5-51-130 and 13 VAC 5-51-135 of the Virginia Statewide Fire Prevention Code are being reprinted because the Department of Housing and Community Development has determined that certain technical changes, as shown in brackets, are needed to accurately reflect the board's intent to require fire exit drills only at those state-regulated care facilities that are required to have a state license issued by the Virginia Departments of Social Services; Mental Health, Mental Retardation and Substance Abuse Services; Education or Juvenile Justice to operate. All sections affected by this regulatory action are listed following this notice; however, only those sections affected since publication of the final action in Volume 16, Issue 20 of the Virginia Register are published here. See 16:20 VA.R. 2472-2487 June 19, 2000, for the full text of the sections not printed below. Because of the additional changes, the effective date for all sections listed below will be September 15, 2000.

Title of Regulation: **13 VAC 5-51-10 et seq. Virginia Statewide Fire Prevention Code (amending 13 VAC 5-51-130, 13 VAC 5-51-150, and 13 VAC 5-51-170; adding 13 VAC 5-51-11 through 13 VAC 5-51-121 and 13 VAC 5-51-181 through 13 VAC 5-51-200; repealing 13 VAC 5-51-10 through 13 VAC 5-51-120).**

Statutory Authority: § 27-97 of the Code of Virginia.

Effective Date: September 15, 2000.

Summary:

The amendments shown in brackets require fire exit drills only at those state-regulated care facilities that are required to have a state license issued by the Virginia Department of Social Services; Mental Health, Mental Retardation and Substance Abuse Services; Education or Juvenile Justice to operate and to require the installation of fire extinguishers and smoke detectors in all state-regulated care facilities.

Agency Contact: Copies of the regulation may be obtained from George W. Rickman, Jr., Department of Housing and Community Development, 501 North Second Street, Richmond, VA 23219-1321, telephone (804) 371-7150.

13 VAC 5-51-130. BNFPC Section F-202.0. General definitions.

A. Add the following definitions:

Blaster, restricted: See Section F-3002.0.

Blaster, unrestricted: See Section F-3002.0.

DHCD: The Virginia Department of Housing and Community Development.

Local government, *local governing body or locality*: The governing body of any county, city, or town*, other political subdivision and state agency* in this Commonwealth *charged with the enforcement of the SFPC under state law*.

State Fire Marshal: The State Fire Marshal as provided for by § 36-139.2 of the Code of Virginia.

State Regulated Care Facility (SRCF): A building or part thereof occupied by persons in the care of others where program regulatory oversight is provided by the Virginia Department of Social Services; Virginia Department Mental Health, Mental Retardation and Substance Abuse Services; Virginia Department of Education or Virginia Department of Juvenile Justice (Use Groups R-2, R-3 and R-4 only) [~~*and a state license is required by any such agencies to operate*~~].

TRB: The Virginia State Building Code Technical Review Board.

USBC: The Virginia Uniform Statewide Building Code (13 VAC 5-61-10 et seq.)

B. Change the following definition to read:

Code official *or fire code official*: The officer or other designated authority charged with administration and enforcement of this code, or a duly authorized representative. For the purpose of this code, the term "code official" *or "fire code official*" shall have the same meaning as used in § 27-98.1 of the Code of Virginia.

13 VAC 5-51-135. BNFPC Section F-701.0. General.

Add subsection F-701.1.1 to read:

F-701.1.1. State Regulated Care Facilities: SRCF [, when a state license is required by the Virginia Department of Social Services; Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services; Virginia Department of Education; or Virginia Department of Juvenile Justice to operate,] shall comply with this section and the provisions of section F-704.0.

VA.R. Doc. No. R98-270; Filed July 14, 2000, 10:49 a.m.

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Reprint and Change in Effective Date

EDITOR'S NOTE: The final amendments to the following regulation were previously published in 16:20 VA.R. 2487-2522 June 19, 2000. However, 13 VAC 5-61-230 of the Virginia Uniform Statewide Building Code is being printed because the Department of Housing and Community Development has determined that certain technical changes, as shown in brackets, are needed to accurately reflect the board's intent to allow construction of aboveground tanks for the storage of motor fuels at public service stations when such tanks meet the requirements of certain standards of the National Fire Protection Association. 13 VAC 5-61-200 and 13 VAC 5-61-220 are being reprinted to make the technical corrections shown in brackets. All sections affected by this regulatory action are listed following this notice; however, only those sections affected since publication of the final action in Volume 16, Issue 20 of the Virginia Register are published here. See 16:20 VA.R. 2487-2522 June 19, 2000, for the full text of the sections not printed below. Because of the additional changes, the effective date for all sections listed below will be September 15, 2000.

Title of Regulation: **13 VAC 5-61-10 et seq. Virginia Uniform Statewide Building Code (amending 13 VAC 5-61-200, 13 VAC 5-61-220, [13 VAC 5-61-230,] 13 VAC 5-61-290, 13 VAC 5-61-310, 13 VAC 5-61-340, 13 VAC 5-61-360, 13 VAC 5-61-390, 13 VAC 5-61-400, 13 VAC 5-61-410, 13 VAC 5-61-430, 13 VAC 5-61-440, and 13 VAC 5-61-450; adding 13 VAC 5-61-11, 13 VAC 5-61-15, 13 VAC 5-61-21, 13 VAC 5-61-25, 13 VAC 5-61-31, 13 VAC 5-61-35, 13 VAC 5-61-41, 13 VAC 5-61-45, 13 VAC 5-61-51, 13 VAC 5-61-55, 13 VAC 5-61-61, 13 VAC 5-61-65, 13 VAC 5-61-71, 13 VAC 5-61-75, 13 VAC 5-61-81, 13 VAC 5-61-85, 13 VAC 5-61-91, 13 VAC 5-61-95, 13 VAC 5-61-101, 13 VAC 5-61-105, 13 VAC 5-61-111, 13 VAC 5-61-115, 13 VAC 5-61-121, 13 VAC 5-61-125, 13 VAC 5-61-131, 13 VAC 5-61-135, 13 VAC 5-61-141, 13 VAC 5-61-145, 13 VAC 5-61-151, 13 VAC 5-61-155, ~~13 VAC 5-61-161,~~ 13 VAC 5-61-165, 13 VAC 5-61-171, 13 VAC 5-61-225, 13 VAC 5-61-245, ~~13 VAC 5-61-255,~~ 13 VAC 5-61-315, 13 VAC 5-61-317, 13 VAC 5-61-345, 13 VAC 5-61-395, 13 VAC 5-61-415, 13 VAC 5-61-447, and 13 VAC 5-61-460; repealing 13 VAC 5-61-10 through 13 VAC 5-61-190).**

Statutory Authority: § 36-98 of the Code of Virginia.

Effective Date: September 15, 2000.

Summary:

The amendments shown in brackets allow construction of aboveground tanks for the storage of motor fuels at public service stations when such tanks meet the requirements of certain standards of the National Fire Protection Association. The final text as published in 16:20 VA.R. 2487-2522 June 19, 2000, did not comport with this intent because the amendments were made only to the Statewide Fire Prevention Code, which is for maintenance, and not to the Uniform Statewide Building Code, which is for construction. Clarifying amendments are also being made.

Agency Contact: Copies of the regulation may be obtained from George W. Rickman, Jr., Department of Housing and Community Development, 501 North Second Street, Richmond, VA 23219-1321, telephone (804) 371-7150.

13 VAC 5-61-200. BNBC Section 202.0 General definitions.

A. Change the following definitions to read:

Building: A combination of any materials, whether portable or fixed, having a roof to form a structure for the use or occupancy by persons~~,~~ or property~~; however, farm buildings not used for residential purposes and frequented generally by the owner, members of his family and farm employees shall be exempt from this code, but such buildings lying within a flood plain or in a mudslide-prone area shall be subject to flood proofing regulations or mudslide regulations, as applicable~~. The word "building" shall be construed as though followed by the words "or part or parts thereof" unless the context clearly requires a different meaning. For application of this code, each portion of a building which is completely separated from other portions by fire walls complying with Section 707.0 shall be considered as a separate building.

Jurisdiction: The governing body of any city, county or town or other political subdivision or state agency in this Commonwealth authorized to enforce the USBC under state law. See local governing body.

Owner: The owner or owners of the freehold of the premises or lesser estate therein, a mortgagee or vendee in possession, assignee of rents, receiver, executor, trustee or lessee in control of a building or structure.

Structure: An assembly of materials forming a construction for occupancy or use including stadiums, gospel and circus tents, reviewing stands, platforms, stagings, observation towers, radio towers, water tanks, storage tanks (underground and aboveground), trestles, piers, wharves, swimming pools, amusement devices, storage bins, and other structures of this general nature but excluding water wells. ~~Farm structures not used for residential purposes shall be exempt from the provisions of this code, but such structures lying within a flood plain or in a mudslide-prone area shall be subject to flood proofing regulations or mudslide regulations, as applicable.~~ The word "structure" shall be construed as though followed by the words "or part or parts thereof"

and "or equipment" unless the context clearly requires a different meaning.

B. Add the following definitions to read:

Breezeway: See Section 1002.0.

Building regulations: Any law, rule, resolution, regulation, ordinance or code, general or special, or compilation thereof, heretofore or hereafter enacted or adopted by the Commonwealth or any county or municipality, including departments, boards, bureaus, commissions, or other agencies thereof, relating to construction, reconstruction, alteration, conversion, repair, maintenance, or use of structures and buildings and installation of equipment therein. The term does not include zoning ordinances or other land use controls that do not affect the manner of construction or materials to be used in the erection, alteration or repair of a building or structure.

Code official:

Building code official: The officer or other designated authority charged with the administration and enforcement of the USBC or a duly authorized representative.

Building maintenance code official: The officer or other designated authority charged with the administration and enforcement of the maintenance provisions of the USBC for existing structures or a duly authorized representative.

Construction: The construction, reconstruction, alteration, repair, or conversion of buildings and structures.

Day-night average sound level (Ldn): See Section 1202.0.

DHCD: The Virginia Department of Housing and Community Development.

Equipment: Plumbing, heating, electrical, ventilating, air-conditioning and refrigeration equipment, elevators, dumbwaiters, escalators, and other mechanical additions or installations.

~~Farm structure: A structure located on a farm utilized for either the storage, handling or production of agricultural, horticultural or floricultural products or the sheltering, raising or processing of farm animals or farm animal products, which products or animals are normally intended for sale to domestic or foreign markets. The term shall include structures used for the maintenance, storage or use of farm equipment.~~

Industrialized building: A combination of one or more sections or modules, subject to state regulations and including the necessary electrical, plumbing, heating, ventilating and other service systems, manufactured off-site and transported to the point of use for installation or erection, with or without other specified components, to comprise a finished building. Manufactured homes shall not be considered industrialized buildings for the purpose of this code.

Local building department: The agency ~~or agencies~~ of any local governing body charged with the administration, supervision or enforcement of ~~this code~~ *the provisions of Part II (13 VAC 5-61-15 et seq.) of Chapter 1 of the USBC*, *including but not limited to* approval of plans, inspection of ~~buildings~~ *structures* or issuance of permits, licenses, certificates, or similar documents. For application of ~~this code~~ *the USBC,* the term "department of building inspection" shall mean the local building department.

Local enforcing agency: The local agency or agencies charged by the local governing body with the administration, supervision or enforcement of the provisions of Part III (13 VAC 5-61-121 et seq.) of Chapter 1 of the USBC. The local governing body is permitted to assign "local enforcing agency" responsibility to the "local building department."

Local governing body or locality: The governing body of any city, county or town or other political subdivision or state agency in this Commonwealth authorized to enforce the USBC under state law. See jurisdiction.

Manufactured home: A structure subject to federal regulation, which is transportable in one or more sections; is eight body feet or more in width and 40 body feet or more in length in the traveling mode, or is 320 or more square feet when erected on site; is built on a permanent chassis; is designed to be used as a single-family dwelling, with or without a permanent foundation, when connected to the required utilities; and includes the plumbing, heating, air-conditioning, and electrical systems contained in the structure.

Skirting: A weather-resistant material used to enclose the space from the bottom of the manufactured home to grade.

State-regulated care facility (SRCF): A building or part thereof occupied by persons in the care of others where program regulatory oversight is provided by the Virginia Department of Social Services; Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services; Virginia Department of Education; or Virginia Department of Juvenile Justice (Use groups R-2, R-3 and R-4 only) [~~*and a state license is required by any such agencies to operate*~~].

Sound transmission class (STC) rating: See Section 1202.0.

Technical assistant: Any person employed by, or under contract to, a local building department or local enforcing agency for enforcing the USBC, including but not limited to inspectors and plans reviewers.

TRB: The Virginia State Building Code Technical Review Board.

C. Delete the ~~definition~~ *following definitions:*

"Agricultural building."

"Approved rules."

"Structure, existing."

13 VAC 5-61-220. BNBC Section 310.0 Residential use groups.

A. Change subsection 310.1 to read:

310.1. General: All structures in which sleeping accommodations are provided, excluding those that are classified as institutional occupancies, shall be classified as Use Group R-1, R-2, R-3 or R-4. The term "Use Group R" shall include Use Groups R-1, R-2, and R-3. Family day homes licensed or certified by the Virginia Department of Social Services shall be permitted to accommodate the numbers of children permitted under the licensing restrictions and shall be classified as a residential use group.

B. Change subsection 310.6 to read:

310.6. Use Group R-4 structures: This use group shall include all detached one- or two-family dwellings and one-family townhouses not more than three stories in height, and the accessory structures as indicated in the CABO One- and Two-Family Dwelling Code listed in Chapter 35 of this code. All such structures shall be designed in accordance with the CABO One- and Two-Family Dwelling Code listed in Chapter 35 of this code or in accordance with the requirements of this code applicable to Use Group R-3.

~~Exceptions:~~

~~1. Structures classified as Use Group R-4 shall comply with applicable requirements of Section 3107.0 of this code.~~

~~2. Structures classified as Use Group R-4 shall comply with the requirements of Section 1214.4 of this code, when applicable.~~

C. Add subsection 310.6.1 to read:

310.6.1. Amendments to the CABO Code: The following changes shall be made to the CABO One- and Two-Family Dwelling Code listed in Chapter 35 of this code:

1. Delete the note in CABO subsection 114.1.

2. Change CABO subsection 115.1 to read:

115.1. General: Swimming pools, spas and hot tubs shall comply with the provisions in Appendix D.

3. Change CABO subsection 119.1 to read:

119.1. General: The provisions for energy conservation contained in Appendix E shall be part of this code.

4. ~~Add exception to~~ *Amend* CABO subsection 301.2 ~~to read~~ *as follows*:

a. Add exception to CABO subsection 301.2 to read:

Exception: Heating facilities shall be required in accordance with Section 303.6. The winter design temperature for heating facilities required or provided shall be established by the jurisdiction in accordance with this section.

b. Change Note 5 in Table [~~*301.2b*~~ *301.2a*] *to read:*

5. Following official action under Article 7 (§ 15.2-2280 et seq.) of Chapter 22 of Title 15.2 of the Code of Virginia by a locality in areas of high radon potential, as indicated by Zone 1 on the U.S. EPA Map of Radon Zones (Figure 301.2h), such locality shall fill in this part of the table with "yes."

Exemption: Buildings or portions thereof with crawl space foundations which are ventilated to the exterior, shall not be required to provide radon-resistant construction.

5. Add CABO subsection 301.7 to read:

301.7. Airport noise attenuation standards: Following official action by the local governing body under § 15.2-2295 of the Code of Virginia, all structures to be located in areas affected by above average noise levels from aircraft due to their proximity to flight operations at nearby airports as determined by the governing body having jurisdiction shall have acoustical treatment measures in accordance with the provisions of Section 3107.0 of the BNBC.

6. Add CABO subsection 301.8 to read:

301.8. Floodproofing: All structures to be located in areas prone to flooding as determined by the local governing body shall be floodproofed in accordance with the provisions of Section 3107.0 of the BNBC.

~~5.~~ *7.* Change CABO subsection 303.6 to read:

303.6. Required heating: Every dwelling unit or portion thereof which is to be rented, leased or let on terms either expressed or implied to furnish heat to the occupants thereof shall be provided with heating facilities capable of maintaining the room temperatures at 65°F (18°C) during the period from October ~~1~~ *15* to May ~~15~~ *1* during the hours between 6:30 a.m. and 10:30 p.m. of each day and not less than 60°F (16°C) during other hours when measured at a point three feet (914 mm) above the floor and three feet (914 mm) from the exterior walls. The capability of the heating system shall be based on the winter design temperature for heating facilities established by the jurisdiction.

~~6.~~ *8.* Add CABO subsection 303.7 to read:

303.7. Insect screens: Every door, window and other outside opening required for ventilation purposes shall be supplied with approved tightly fitted screens of not less than 16 mesh per inch and every swinging door shall have a self-closing device.

~~7.~~ *9.* Add CABO subsection 306.5 to read:

306.5. Approval: Water supply sources and sewage disposal systems are regulated and approved by the Virginia Department of Health.

~~*10. Change CABO subsection 310.2 to read:*~~

~~*310.2. Emergency egress required: Every sleeping room shall have at least one openable window or*~~

~~*exterior door approved for emergency egress or rescue. The units must be operable from the inside to a full clear opening, including an operable sash without the use of a key or tool. Where windows are provided as a means of egress or rescue, they shall have a sill height of not more than 44 inches (1118 mm) above the floor.*~~

~~8.~~ ~~*11.*~~ *10.* Change CABO subsection 310.4 to read:

310.4. Type of lock or latch: All egress doors shall be readily openable from the inside without the use of a key unless the key cannot be removed from the lock when the door is locked from the inside.

~~9.~~ ~~*12.*~~ *11.* Change CABO subsection 314.2 to read:

314.2. Treads and risers: The maximum riser height shall be ~~8~~ ~~*eight*~~ *8-1/4* inches (210 ~~*203*~~ mm) and the minimum tread depth shall be nine inches (229 mm). The riser height shall be measured vertically between leading edges of the adjacent treads. The tread depth shall be measured horizontally between the vertical planes of the foremost projection of adjacent treads and at a right angle to the tread's leading edge. The walking surface of treads and landings of a stairway shall be sloped no steeper than one unit vertical in 48 units horizontal (2.0% slope). The greatest riser height within any flight of stairs shall not exceed the smallest by more than 3/8 inch (9.5 mm). The greatest tread depth within any flight of stairs shall not exceed the smallest by more than 3/8 inch (9.5 mm).

~~10.~~ ~~*13.*~~ *12.* Change CABO subsection 314.4 to read:

314.4. Winders: Winders are permitted, provided that the width of the tread at a point not more than 12 inches (305 mm) from the side where the treads are narrower is not less than nine inches (229 mm) and the minimum width of any tread is not less than six inches (153 mm). The continuous handrail required by Section 314.1 shall be located on the side where the tread is narrower.

~~11.~~ ~~*14.*~~ *13.* Change CABO subsection 314.6 to read:

314.6. Circular stairways: Circular stairways shall have a minimum tread depth and a maximum riser height in accordance with Section 314.2 and the smaller radius shall not be less than twice the width of the stairway. The minimum tread depth of nine inches (229 mm) shall be measured from the narrower end.

~~12.~~ ~~*15.*~~ *14.* Change subsection 315.2 to read:

315.2. Handrail grip size: The handgrip portion of the handrails shall not be more than 2-5/8 inches (66.7 mm) in cross-sectional dimension, or the shape shall provide an equivalent gripping surface. The handgrip portion of handrails shall have a smooth surface with no sharp corners.

~~13.~~ ~~*16.*~~ *15.* Delete CABO subsection 316.1.1.

~~14. Delete CABO Section 324 Protection Against Radon.~~

~~15.~~ ~~*17.*~~ *16.* Change subsection 401.4 to read:

401.4. Soil tests: Localities having 20% and greater moderate and high shrink/swell potential of the jurisdictional land area shall implement an expansive soil test policy. Localities having less than 20% moderate and high shrink/swell potential of the jurisdictional land area may adopt a soil test policy. The policy shall establish minimum criteria to determine the circumstances which require testing for expansive soils and the minimum testing requirements. The policy shall be established in a manner selected by the local government having jurisdiction. All localities shall obtain and retain as a reference guide a copy of the applicable National Cooperative Soil Survey produced cooperatively by the Natural Resources Conservation Service and the Virginia Polytechnic Institute and State University, where this survey is available. Figures 401.4a and 401.4b shall be used to determine the percentage of jurisdictional land area which has moderate or high shrink/swell potential.

Exception: For additions to one- and two-family dwellings or slab-on-grade accessory structures and decks where there is no indication of a shrink-swell condition for the area.

~~*18.*~~ *17. Add CABO subsection 703.9 to read:*

703.9. Exterior insulation and finish systems (EIFS): Exterior insulation and finish systems (EIFS) shall comply with BNBC Section 1405.8.

~~*19.*~~ *18. Add CABO subsection 3903.1.1 to read:*

3903.1.1. Electrical service equipment: The code official shall give permission to energize the electrical service equipment of a one- or two-family dwelling unit when all of the following requirements have been approved:

1. The service wiring and equipment, including the meter socket enclosure, shall be installed and the service wiring terminated.

2. The grounding electrode system shall be installed and terminated.

3. Grounding and grounded conductors shall be terminated in the service equipment.

4. At least one receptacle outlet on a ground fault protected circuit shall be installed and the circuit wiring terminated.

5. Service equipment covers shall be installed.

6. The building roof covering shall be installed.

[13 VAC 5-61-230. BNBC Section 418.0 Use groups H-1, H-2 and H-3.

Change subsection 418.3.2 to read:

418.3.2. Flammable and combustible liquids: The storage, handling, processing, and transporting of flammable and combustible liquids shall be in accordance with the mechanical code and the fire prevention code listed in Chapter 35 of this code*, except*

that the fire prevention code shall not prohibit the installation of aboveground tanks utilized for the storage of motor fuels at automotive service stations to which the public does or does not have access, provided such tanks are installed in accordance with the requirements for fire-resistant tanks or tanks in vaults specified in NFPA 30A listed in Chapter 35 of this code. Regulations governing the installation, repair, upgrade, and closure of underground and aboveground storage tanks under the Virginia State Water Control Board regulations *9 VAC 25-91-10 et seq. and* 9 VAC 25-580-10 et seq.~~, 9 VAC 25-130-10 et seq. and 9 VAC 25-140-10 et seq.~~ are adopted and incorporated by reference to be an enforceable part of this code. Where differences occur between the provisions of this code and the incorporated provisions of the State Water Control Board regulations, the provisions of the State Water Control Board regulations shall apply. Where a Class I, II or IIIA flammable or combustible liquid is stored in tanks inside the building, the installation shall conform to Sections 418.3.2.1 through 418.3.2.10 and NFPA 30 listed in Chapter 35 of this code. The requirements shall only apply where tanks have an individual storage capacity that exceeds the exempt amounts specified in Tables 307.8(1) and 307.8(2). The fire area containing the tank or tanks shall be classified as Use Group H-2.]

VA.R. Doc. No. R98-274; Filed July 14, 2000, 10:42 a.m.

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TITLE 20. PUBLIC UTILITIES AND TELECOMMUNICATIONS

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.

The distribution list that is referenced as Attachment B in the following order is not being published. However, the list is available for public inspection at the State Corporation Commission, Document Control Center, Tyler Building, 1st Floor, 1300 East Main Street, Richmond, Virginia 23219, from 8:15 a.m. to 5 p.m., Monday through Friday; or it may be viewed at the Virginia Code Commission, General Assembly Building, 2nd Floor, 910 Capitol Street, Richmond, Virginia 23219, during regular office hours.

Title of Regulation: **20 VAC 5-203-10 et seq. Regulations Governing the Separation of Regulated and Unregulated Businesses of Utility Consumer Services Cooperatives and Utility Aggregation Cooperatives.**

Statutory Authority: §§ 12.1-13, 56-231.34:1 and 56-231.50:1 of the Code of Virginia.

Effective Date: July 1, 2000.

Summary:

The regulations address the conduct of cooperatives for the purpose of promoting effective and fair competition between such cooperatives' affiliates and other persons engaged in the same or similar businesses that are not regulated utility services. The regulations prohibit the following practices: cost-shifting and cross subsidies between a cooperative and its nonregulated affiliates, anticompetitive behavior or self-dealing between a cooperative and its nonregulated affiliates, and discriminatory behavior by a cooperative toward competing suppliers. Additionally, the regulations establish codes of conduct detailing permissible relationships between such cooperatives and their affiliates. Such codes address, among other things, the sharing of customer information between such cooperatives and affiliates; affiliate use of cooperative name, logo or trademarks; and sharing of vehicles, office space and employees by such cooperatives and affiliates.

Agency Contact: Susan Larsen, Deputy Director, Division of Public Utility Accounting, State Corporation Commission, P.O. Box 1197, Richmond, VA 23218, telephone (804) 371-9950 or e-mail Sdlarsen@scc.state.va.us. There is a copy charge of $1.00 for the first two pages and 50¢ for each additional page.

AT RICHMOND, JUNE 29, 2000

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. PUA000028

Ex Parte: In the Matter Concerning the Separation of Regulated and Unregulated Businesses of Utility Consumer Services Cooperatives and Utility Aggregation Cooperatives.

ORDER ADOPTING REGULATIONS

Sections 56-231.34:1 and 56-231.50:1 of the Code of Virginia direct the State Corporation Commission ("Commission") to promulgate rules and regulations governing the conduct of utility consumer services cooperatives and utility aggregation cooperatives for the purpose of promoting effective and fair competition between such cooperative's affiliates that are engaged in business activities that are not regulated utility services and other persons engaged in the same or similar unregulated businesses.

By Order Prescribing Notice and Inviting Comments entered April 18, 2000, the Commission established this proceeding for the promulgation of regulations in accordance with §§ 56-231.34:1 and 56-231.50:1. The Commission received comments from the following parties: the Virginia Cooperatives;[1] the Virginia Petroleum Marketers &

[1] Namely, A&N Electric Cooperative; BARC Electric Cooperative; Community Electric Cooperative; Craig-Botetourt Electric Cooperative; Mecklenburg

Convenience Store Association, Inc. ("VAPMACS"); the Virginia Propane Gas Association and the Consulting Engineers Council of Virginia, Inc. (collectively, "Trade Associations"); Roanoke Gas Company and Diversified Energy Company ("Roanoke Gas"); Washington Gas Light Company ("Washington Gas"); and The Potomac Edison Company, d/b/a Allegheny Power. VAPMACS requested a hearing on the proposed regulations.

By order of June 2, 2000, we scheduled a public hearing to receive evidence on the proposed regulations. The hearing was held on June 22, 2000. The Commission Staff, the Virginia Cooperatives, VAPMACS, the Trade Associations; Roanoke Gas; and Washington Gas participated at the hearing. The Commission received evidence from witnesses for the Staff and the parties, as well as from two public witnesses, and heard argument from counsel and VAPMACS.

NOW THE COMMISSION, upon consideration of the record developed in this proceeding and the applicable law, is of the opinion and finds that the regulations attached hereto should be adopted, effective July 1, 2000. The regulations we adopt herein contain certain modifications to those that were published pursuant to our order of April 18, 2000. These modifications have been made after our consideration of proposed revisions made by the Staff prior to the hearing and the additional changes suggested by the parties at the June 22 hearing, as well as all of the other testimony at the hearing.

We note that these regulations, like many rules, will be evolving. Some parties urged modifications for the regulations to more specifically address particular business activities. At this stage, however, we find that the regulations should be broad in scope as they are applicable to all cooperative affiliate relations.

The regulations adopted, as modified, also reflect our concern with the release of customer information. In the Commission's recently-adopted Interim Rules Governing Electric and Natural Gas Retail Access Pilot Programs in Case No. PUE980812, we permit the release of only addresses of eligible pilot customers absent affirmative authorization for the disclosure of additional customer information. In the regulations we adopt today, we will allow at this time disclosure of sales leads and customer information only if such disclosure is authorized by the person whose information is to be disclosed.

The regulations include, as required by §§ 56-231.34:1 and 56-231.50:1, provisions that: prohibit cost-shifting or cross-subsidies between a cooperative and its affiliates; prohibit anti-competitive behavior or self-dealing between a cooperative and its affiliates; prohibit a cooperative from engaging in discriminatory behavior towards nonaffiliated entities; and establish codes of conduct detailing permissible relations between a cooperative and its affiliates.

Electric Cooperative; Northern Neck Electric Cooperative, Inc.; Northern Virginia Electric Cooperative; Powell Valley Electric Cooperative; Prince George Electric Cooperative; Rappahannock Electric Cooperative; Shenandoah Valley Electric Cooperative; Southside Electric Cooperative, Inc.; Old Dominion Electric Cooperative; and the Virginia, Maryland & Delaware Association of Electric Cooperatives.

Accordingly, IT IS ORDERED THAT:

(1) Regulations governing the separation of regulated and unregulated businesses of utility consumer services cooperatives and utility aggregation cooperatives are hereby adopted, to be effective July 1, 2000, as shown in Attachment A to this Order.

(2) Any cooperative engaged in a contract or arrangement with a non-regulated affiliate as of July 1, 2000, shall file with the Commission the information required in 20 VAC 5-203-30 on or before October 2, 2000.

(3) There being nothing further to come before the Commission, this case shall be removed from the docket and the papers filed herein be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: all Virginia Electric Cooperatives as set out in Attachment B to this Order; Richard D. Gary, Esquire, Hunton & Williams, Riverfront Plaza, East Tower, 951 East Byrd Street, Richmond, Virginia 23219-4074; Eric M. Page, Esquire, and Robert A. Omberg, Esquire, LeClair Ryan, 4201 Dominion Boulevard, #200, Glen Allen, Virginia 23060; Donald R. Hayes, Senior Attorney, Washington Gas Light Company, 1100 H Street, N.W., Washington, D.C. 20080; John F. Dudley, Senior Assistant Attorney General, Division of Consumer Counsel, Office of Attorney General, 900 East Main Street, Second Floor, Richmond, Virginia 23219; Thomas B. Nicholson, Esquire, and Channing J. Martin, Esquire, Williams, Mullen, Clark & Dobbins, P.C., Two James Center, 1021 East Cary Street, P.O. Box 1320, Richmond, Virginia 23210; Philip J. Bray, Esquire, Allegheny Power, 10435 Downsville Pike, Hagerstown, Maryland 21740-1766; Frank C. Bedell, Virginia Petroleum Marketers & Convenience Store, 6716 Patterson Avenue, Richmond, Virginia 23226; David L. Bailey, Jr., David Bailey Associates, 1001 E. Broad Street, Suite 225, Richmond, Virginia 23219; Laurie Crigler, P.O. Box 418, Aroda, Virginia 22709; and to the Commission's Divisions of Energy Regulation, Economics and Finance, and Public Utility Accounting.

ATTACHMENT A

CHAPTER 203.
REGULATIONS GOVERNING THE SEPARATION OF REGULATED AND UNREGULATED BUSINESSES OF UTILITY CONSUMER SERVICES COOPERATIVES AND UTILITY AGGREGATION COOPERATIVES.

20 VAC 5-203-10. Applicability and scope.

These regulations are promulgated pursuant to the provisions of Chapter 9.1 (§ 56-231.15 et seq.) of Title 56 of the Code of Virginia, and [~~*they*~~] *apply to Utility Consumer Services Cooperatives and Utility Aggregation Cooperatives subject to the provisions thereof. Section 56-231.34:1, applicable to Utility Consumer Services Cooperatives, and § 56-231.50:1, applicable to Utility Aggregation Cooperatives, address relations between cooperatives* [*engaged in regulated utility services*] *and their affiliates that are engaged in businesses that are not regulated utility services.*

These statutory provisions direct the Virginia State Corporation Commission to promulgate regulations governing the conduct of cooperatives for the purpose of promoting effective and fair competition between such cooperatives' affiliates and other persons engaged in the same or similar businesses that are not regulated utility services. Additionally, these statutes direct the Virginia State Corporation Commission to establish codes of conduct detailing permissible relationships between such cooperatives and their affiliates. In establishing these codes, the commission is directed to address, among other things, the sharing of customer information between such cooperatives and affiliates; affiliate use of cooperative name, logo or trademarks; and sharing of vehicles, office space and employees by such cooperatives and affiliates.

[*These regulations are in addition to and do not limit the applicability of other provisions of the Code of Virginia and the Virginia Administrative Code, including, but not limited to, Chapter 4 (§ 56-76 et seq.) of Title 56 of the Code of Virginia, and Chapter 311 (20 VAC 5-311-10 et seq.) of Title 20 of the Virginia Administrative Code.*]

20 VAC 5-203-20. Definitions.

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

"Affiliate" shall have the meanings set forth in §§ 56-231.15 and 56-231.38 of the Code of Virginia.

"Commission" means the Virginia State Corporation Commission.

[*"Competing supplier" means any supplier of the same or similar types of goods or services that are offered, or intended to be offered, for sale by a nonregulated affiliate of a cooperative.*]

"Cooperative" shall have the meanings set forth in §§ 56-231.15 and 56-231.38 of the Code of Virginia.

"Nonregulated affiliate" means any affiliate of a cooperative engaged in businesses that are not regulated utility services.

"Regulated utility services" means utility services that are subject to regulation as to rates or service by the Virginia State Corporation Commission.

20 VAC 5-203-30. Relations between cooperatives and affiliates thereof not engaged in regulated utility services.

[*A. The following practices are prohibited:*

1. Cost shifting or cross subsidies between a cooperative and its nonregulated affiliates;

2. Anticompetitive behavior or self-dealing between a cooperative and its nonregulated affiliates; and

3. Discriminatory behavior by a cooperative toward competing suppliers.

B.] *A cooperative shall* [~~*file with the Director of the State Corporation Commission's Division of Public Utility Accounting*~~ *include with each application seeking approval of affiliate contracts or arrangements filed with the commission pursuant to Chapter 4 (§ 56-76 et seq.) of Title 56 of the Code of Virginia:*

1.] *A listing and description of internal controls* [~~*it has in place that are designed to prevent: (i) cost shifting or cross subsidies between any cooperative and its nonregulated affiliate; and (ii) anticompetitive behavior or self-dealing as between any cooperative and its nonregulated affiliate. Such information shall, in each instance, be filed at least 45 days before any cooperative and its nonregulated affiliate share any services*~~ *that prevent the practices enumerated in subsection A of this section; and*

2. A listing and description of internal controls effecting the Codes of Conduct set forth in 20 VAC 5-203-40.]

20 VAC 5-203-40. Codes of conduct governing cooperatives and affiliates thereof not engaged in regulated utility services.

Except as otherwise provided in any commission order or regulation, any cooperative subject to the provisions of this chapter shall be governed by the following codes of conduct when transacting business within this Commonwealth with a nonregulated affiliate.

1. A cooperative shall not give any preference related to the provision of its regulated electric service to a nonregulated affiliate over the interest of any [~~*nonaffiliated organization*~~ *competing supplier*].

2. A cooperative [~~*may provide*~~ *shall be prohibited from providing sales leads,*] *customer lists and other customer information to its nonregulated affiliate* [~~*only if such*~~ *unless:*

a. Such disclosure is authorized by the customer or other entity whose information is to be disclosed; and

b. Such] *information is made available to* [~~*third party competitors on equal*~~ *competing suppliers upon the same price,*] *terms and conditions.*

3. Joint [*promotions,*] *advertising and marketing* [*shall be prohibited*] *between a cooperative and its nonregulated affiliate* [~~*shall be permitted only if such advertising and marketing services are*~~ *unless*] *made available to* [~~*third party competitors on equal*~~ *competing suppliers upon the same price,*] *terms and conditions.*

4. A cooperative's name, logo or trademark may be used by a nonregulated affiliate provided such use is not misleading. A disclaimer that clearly and conspicuously discloses that the nonregulated affiliate [~~*operates independently of*~~ *is not the same company as*] *the cooperative shall accompany* [*any*] *such use. Such disclaimers shall not be required* [*, however,*] *on company vehicles, clothing, trinkets, writing instruments, or similar promotional materials.* [*Upon complaint of any competing supplier or other interested person, or upon motion of the Attorney General or the commission staff, or upon its own motion, the commission may, after notice and an opportunity for hearing, make a determination whether any such usage is misleading, and if so, take appropriate corrective actions.*]

5. Employees of the cooperative may provide services to nonregulated affiliates provided [*the provision of*] *such services* [~~*are*~~ *is*] *not anticompetitive or discriminatory.*

[*6. A cooperative shall document each occasion that one of its employees transfers to a nonregulated affiliate and each occasion that an employee of one of its nonregulated affiliates transfers to the cooperative. Upon staff's request, such information shall be filed with the commission that identifies each such occasion. Such information shall include a listing of each employee transferred and a brief description of each associated position and responsibility.]*

[~~*6.*~~ *7.*] *A* [~~*regulated*~~] *cooperative and its nonregulated affiliates may share the use of vehicles, equipment and office space provided* [~~*such sharing*~~ *the provision of such services*] *is not anticompetitive or discriminatory.*

[*8. A cooperative shall not condition the provision of any services on the purchase of any other service or product from any of its nonregulated affiliates.*

9. Neither a cooperative nor any of its nonregulated affiliates shall:

a. Suggest that the quality of regulated utility services provided to a customer by the cooperative will be any different if the customer purchases goods or services from the cooperative's nonregulated affiliates.

b. Suggest that the goods and services provided by any of the nonregulated affiliates are being provided by the cooperative rather than the nonregulated affiliates.

20 VAC 5-203-50. Requests for waiver.

Any request for a waiver of any of the provisions in this chapter shall be considered by the commission on a case-by-case basis and may be granted upon such terms and conditions as the commission may impose.]

VA.R. Doc. No. R00-164; Filed June 30, 2000, 11:41 a.m.

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TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulation: **Provider Reimbursement Appeals: 12 VAC 30-10-10 et seq. State Plan under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (adding 12 VAC 30-10-1000).**
12 VAC 30-20-10 et seq. Administration of Medical Assistance Services (adding 12 VAC 30-20-500 through 12 VAC 30-20-599).
12 VAC 30-70-10 et seq. Methods and Standards for Establishing Payment Rates; Inpatient Hospital Care (repealing 12 VAC 30-70-140 through 12 VAC 30-70-143).
12 VAC 30-90-10 et seq. Methods and Standards for Establishing Payment Rates for Long-Term Care (repealing 12 VAC 30-90-130 through 12 VAC 30-90-133).

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

Effective Dates: July 1, 2000, through June 30, 2001.

Summary:

REQUEST: The Governor is hereby requested to approve this agency's adoption of the emergency regulation entitled Provider Appeals. This regulation allows the Department to specify time frames for scheduling and conducting provider appeals so that the appeals can be processed within the statutory time frames required by Chapter 967.

RECOMMENDATION: Recommend approval of the Department's request to take an emergency adoption action regarding Provider Appeals Regulations. The Department intends to initiate the public notice and comment requirements contained in the Code of Virginia § 9-6.14:7.1.

BACKGROUND: The sections of the State Plan affected by this action are section 7.5 General Provider Appeals (12 VAC 30-10-1000) and Attachment 7.5 Provider Appeals (12 VAC 30-20-500). The existing regulation sections being repealed by this action are: Methods and Standards for Establishing Payment Rates-Inpatient Hospital Care, Attachment 4.19-A, Supplement 3, item VIII Refund of Overpayments (12 VAC 30-70-140 to 12 VAC 30-70-145); Methods and Standards for Establishing Payment Rates-Long Term Care, Attachment 4.19-D, Nursing Home Payment System Part XV, Refund of Overpayments (12 VAC 30-90-130 to 12 VAC 30-90-133 and 12 VAC 30-90-135).

Presently, the State Plan for Medical Assistance contains language addressing provider appeals of overpayments via the inpatient hospital reimbursement and the nursing facility reimbursement methodologies. These existing regulations have been superseded in intent and outcome by the passage of HB 892 and, therefore, are being repealed.

The 2000 General Assembly passed and the Governor enacted, on April 9, 2000, HB 892, which requires the processing of provider appeals within six months at the informal level and within six months at the formal level. If the Department does not meet its statutory time frames, then the decision is deemed to be in favor of the appealing provider, as provided in the new statute. The statute applies to all administrative appeals filed on or after July 1, 2000. In order to conduct these appeals to conclusion within the statutorily set time limits, DMAS must include the various time periods specified the State Plan for Medical Assistance.

In developing these emergency regulations, DMAS conferred with five provider organizations: the Virginia Health Care Association (VHCA), the Virginia Association of Non-Profit Homes for the Aging (VANHA), the Virginia Association for Home Care (VAHC), the Virginia Hospital and Healthcare Association (VHHA), and the Medical Society of Virginia. The VHCA commented and also transmitted comments from VANHA and VAHC. The VHCA also provided the draft regulations to two provider attorneys and two provider accountants. DMAS also met with the VHCA to discuss its comments.

AUTHORITY TO ACT: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:4.1(C)(5), for an agency's adoption of emergency regulations subject to the Governor's prior approval.

Subsequent to the emergency adoption action and filing with the Registrar of Regulations, this agency intends to initiate the public notice and comment process contained in Article 2 of the APA. Therefore, approval to file the required Notice of Intended Regulatory Action is also necessary and hereby being requested by this action.

Without an emergency regulation, this amendment to the State Plan cannot become effective until the publication and concurrent comment and review period requirements of the APA's Article 2 are met. Therefore, an emergency regulation is needed to meet the July 1, 2000, effective date specified by the statute. The statute requires the Department to promulgate emergency regulations to implement its provisions.

NEED FOR EMERGENCY ACTION: The Code § 9-6.14:4.1(C)(5) provides for regulations which an agency finds are necessitated by an emergency situation. To enable the Director, in lieu of the Board of Medical Assistance Services, to comply with Chapter 967, which amends Va. Code § 32.1-325.1, he is to promulgate regulations to implement the provisions of the statute. This issue qualifies as an emergency regulation as provided for in § 9-6.14:4.1(C)(5)(ii), because Virginia statutory law requires this regulation to be effective within 280 days from the enactment of the law. This law was enacted by the Governor on April 9, 2000. As such, this regulation may be adopted without public comment with the prior approval of the Governor and may become effective July 1, 2000.

Since this emergency regulation will be effective for no more than 12 months and the Director wishes to continue regulating the subject entities, the Department is also initiating the Administrative Process Act Article 2 procedures.

FISCAL/BUDGETARY IMPACT: The regulations have no fiscal/budgetary impact because the regulations only address time frames for processing provider appeals. Additionally, these types of general administrative provider appeals have been conducted for years by DMAS, so funding for them is already provided for in the base appropriation. There are no localities that are uniquely affected by these regulations as they apply statewide. Additionally, these regulations have no effect on local Departments of Social Services agencies.

FAMILY IMPACT: This regulatory action will not have any negative or positive effects on the institution of the family or family stability. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, nor the assumption of family responsibilities.

RECOMMENDATION: Recommend approval of this request to adopt this emergency regulation to become effective, once adopted and filed with the Registrar of Regulations, on July 1, 2000. From its effective date, this regulation is to remain in force for one full year or until superseded by permanent, final regulations. Without an effective emergency regulation, the Department would lack the authority to process provider appeals within the statutory timeframes.

APPROVAL SOUGHT FOR ADOPTION OF 12 VAC 30-10-1000, -20-500; REPEAL OF 12 VAC 30-70-140, -141, -142, -143, -144, -145; 90-130, -131, -132, -133, -135: Approval of the Governor is sought for an emergency modification of the Medicaid State Plan in accordance with § 9-6.14:4.1 C 5 of the Code of Virginia to adopt the following regulation:

/s/ Dennis G. Smith, Director
Department of Medical Assistance Services
Date: June 28, 2000

/s/ James S. Gilmore, III
Governor
Date: June 28, 2000

12 VAC 30-10-1000. Provider reimbursement appeals.

These provisions shall apply to all provider types for informal and formal administrative reimbursement appeals.

12 VAC 30-20-500 (Attachment 7.5) describes the process, procedures, and time frames for all provider informal and formal administrative reimbursement appeals.

PART I.
DEFINITIONS AND GENERAL PROVISIONS.

12 VAC 30-20-500. Definitions.

The following words, when used in these regulations, shall have the following meanings:

"Day" means a calendar day unless otherwise stated.

"DMAS" means the Virginia Department of Medical Assistance Services or its agents or contractors.

"Hearing officer" means an individual selected by the Executive Secretary of the Supreme Court of Virginia to conduct the formal appeal in an impartial manner pursuant to Va. Code §§ 9-6.14:12 and 32.1-325.1 and these regulations.

"Informal appeals agent" means a DMAS employee who conducts the informal appeal in an impartial manner pursuant to Va. Code §§ 9-6.14:11 and 32.1-325.1 and these regulations.

"Provider" means an individual or entity that has a contract with DMAS to provide covered services and that is not operated by the Commonwealth of Virginia.

12 VAC 30-20-510. Reserved.

12 VAC 30-20-520. General Provisions.

A. These regulations shall govern all DMAS informal and formal provider reimbursement appeals and shall supersede any other provider reimbursement appeals regulations.

B. A provider may appeal any DMAS reimbursement action that is subject to appeal under Va. Code § 9-6.14:1 et seq. (the Virginia Administrative Process Act), including DMAS' interpretation and application of payment methodologies. A provider may not appeal the actual payment methodologies.

C. DMAS shall mail all items to the last known address of the provider. It is presumed that DMAS mails items on the date noted on the item. It is presumed that providers receive items mailed to their last known address within 3 days after DMAS mails the item.

D. Whenever DMAS or a provider is required to file a document, the document shall be considered filed when it is date stamped by the DMAS Appeals Division in Richmond, Virginia.

E. Whenever the last day specified for the filing of any document or the performance of any other act falls on a day on which DMAS is officially closed, the time period shall be extended to the next day on which DMAS is officially open.

F. Conferences and hearings shall be conducted at DMAS' main office in Richmond, Virginia or at such other place as agreed to by the parties.

G. Whenever DMAS or a provider is required to attend a conference or hearing, failure by one of the parties to attend the conference or hearing shall result in dismissal of the appeal in favor of the other party.

H. DMAS shall reimburse a provider for reasonable and necessary attorneys' fees and costs associated with an informal or formal administrative appeal if the provider substantially prevails on the merits of the appeal and DMAS' position is not substantially justified, unless special circumstances would make an award unjust.

12 VAC 30-20-530. Reserved.

PART II.
INFORMAL APPEALS.

12 VAC 30-20-540. Informal appeals.

A. Providers appealing a DMAS reimbursement decision shall file a written notice of informal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the decision. Providers appealing adjustments to a cost report shall file a written notice of informal appeal with the DMAS Appeals Division within 90 days of the provider's receipt of the notice of program reimbursement. The notice of informal appeal shall identify the issues being appealed. Failure to file a written notice of informal appeal within 30 days of receipt of the decision or within 90 days of receipt of the notice of program reimbursement shall result in dismissal of the appeal.

B. DMAS shall file a written case summary with the DMAS Appeals Division within 30 days of the filing of the provider's notice of informal appeal. DMAS shall mail a complete copy of the case summary to the provider on the same day that the case summary is filed with the DMAS Appeals Division. The case summary shall address each adjustment, patient, service date, or other matter disputed and shall state DMAS' position for each adjustment, patient, service date, or other matter disputed. The case summary shall contain the factual basis for each adjustment, patient, service date, or other matter disputed and any other information, authority, or documentation DMAS relied upon in taking its action or making its decision. Failure to file a written case summary with the Appeals Division in the detail specified within 30 days of the filing of the provider's notice of informal appeal shall result in dismissal in favor of the provider on those issues not addressed in the detail specified.

C. The informal appeals agent shall conduct the conference within 90 days from the filing of the notice of informal appeal. If DMAS and the provider and the informal appeals agent agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the informal appeals agent shall specify the time within which the provider may file written submissions, not to exceed 90 days from the filing of the notice of informal appeal. Only written submissions filed within the time specified by the informal appeals agent shall be considered.

D. The conference may be recorded for the convenience of the informal appeals agent. Since the conference is not an adversarial or evidentiary proceeding, recordings shall not be made part of the administrative record and shall not be made available to anyone other than the informal appeals agent.

E. Upon completion of the conference, the informal appeals agent shall specify the time within which the provider may file additional documentation or information, if any, not to exceed 30 days. Only documentation or information filed within the time specified by the informal appeals agent shall be considered.

F. The informal appeal decision shall be issued within 180 days of receipt of the notice of informal appeal.

12 VAC 30-20-550. Reserved.

PART III.
FORMAL APPEALS.

12 VAC 30-20-560. Formal appeals.

A. Any provider appealing a DMAS informal appeal reimbursement decision shall file a written notice of formal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the informal appeal decision. The notice of formal appeal shall identify the issues being appealed. Failure to file a written notice of formal appeal within 30 days of receipt of the informal appeal decision shall result in dismissal of the appeal.

B. The hearing officer shall conduct the appeal and submit a recommended decision to the DMAS Director with a copy to the provider within 120 days of receipt of the formal appeal request. If the hearing officer does not submit a recommended decision within 120 days, then DMAS shall give written notice to the hearing officer and the Executive Secretary of the Supreme Court that a recommended decision is due.

C. In order to conduct the appeal and submit a recommended decision within 120 days, the following are suggested guidelines for hearing officers to use. DMAS and the provider should exchange and file with the hearing officer all documentary evidence on which DMAS or the provider relies within 21 days of the filing of the notice of formal appeal. Only documents filed within 21 days of the filing of the notice of formal appeal should be considered. DMAS and the provider should file any objections to the admissibility of documentary evidence within 7 days of the filing of the documentary evidence. Only objections filed within 7 days of the filing of the documentary evidence should be considered. The hearing officer should rule on any objections within 7 days of the filing of the objections. The hearing officer should conduct the hearing within 45 days from the filing of the notice of formal appeal. Upon completion of the hearing, DMAS and the provider should have 30 days to exchange and file with the hearing officer an opening brief. Only opening briefs filed within 30 days after the hearing should be considered. DMAS and the provider should have 10 days to exchange and file with the hearing officer a reply brief after the opening brief has been filed. Only reply briefs filed within 10 days after the opening brief has been filed should be considered.

D. Hearings shall be transcribed by a court reporter retained by DMAS.

E. Upon receipt of the hearing officer's recommended decision, the DMAS Director shall notify DMAS and the provider in writing that any written exceptions to the hearing officer's recommended decision shall be filed within 30 days of receipt of the DMAS Director's letter. Only exceptions filed within 30 days of receipt of the DMAS Director's letter shall be considered. The DMAS Director shall issue the final agency case decision within 60 days of receipt of the hearing officer's recommended decision.

12 VAC 30-20-561 through 12 VAC 30-20-599. Reserved.

12 VAC 30-70-140. ~~Right to appeal and initial agency decision.~~ *(REPEALED.)*

~~A. Right to appeal. Any hospital seeking to appeal its prospective payment rate for operating costs related to inpatient care or other allowable costs shall submit a written request to the Department of Medical Assistance Services within 30 days of the date of the letter notifying the hospital of its prospective rate unless permitted to do otherwise under 12VAC30-70-144 E. The written request for appeal must contain the information specified in subsection B of this section. The department shall respond to the hospital's request for additional reimbursement within 30 days or after receipt of any additional documentation requested by the department, whichever is later. Such agency response shall be considered the initial agency determination.~~

~~B. Required information. Any request to appeal the prospective payment rate must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) current and prospective cost containment efforts, if appropriate.~~

~~C. Nonappealable issues. The following issues will not be subject to appeal: (i) the organization of participating hospitals into peer groups according to location and bed size and the use of bed size and the urban/rural distinction as a generally adequate proxy for case mix and wage variations between hospitals in determining reimbursement for inpatient care; (ii) the use of Medicaid and applicable Medicare Principles of Reimbursement to determine reimbursement of costs other than operating costs relating to the provision of inpatient care; (iii) the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982; (iv) the use of the inflation factor identified in the State Plan as the prospective escalator; and (v) durational limitations set forth in the State Plan (the "twenty-one day rule").~~

~~D. The rate which may be appealed shall include costs which are for a single cost reporting period only.~~

~~E. The hospital shall bear the burden of proof throughout the administrative process.~~

12 VAC 30-70-141. ~~Administrative appeal of adverse initial agency determination.~~ *(REPEALED.)*

~~A. The administrative appeal of an adverse initial agency determination shall be made in accordance with the Virginia Administrative Process Act, §9-6.14:11 through §9-6.14:14 of the Code of Virginia, as set forth below.~~

~~B. The informal proceeding:~~

~~1. The hospital shall submit a written request to appeal an adverse initial agency determination in accordance with §9-6.14:11 of the Code of Virginia within 15 days of the date of the letter transmitting the initial agency determination.~~

~~2. The request for an informal conference in accordance with §9-6.14:11 of the Code of Virginia shall include the following information:~~

~~a. the adverse agency action appealed from;~~

~~b. a detailed description of the factual data, argument or information the hospital will rely on to challenge the adverse agency decision.~~

~~3. The agency shall afford the hospital an opportunity for an informal conference in accordance with §9-6.14:11 of the Code of Virginia.~~

~~4. The Director of the Appeals Division of the Department of Medical Assistance Services, or a designee, shall preside over the informal conference. As hearing officer, the director, or the designee, may request such additional documentation or information from the hospital or agency staff as may be necessary in order to render an opinion.~~

~~5. After the informal conference, the Director of the Appeals Division, having considered the criteria for relief set forth in 12VAC30-70-143 and 12VAC30-70-144, shall take any of the following actions:~~

~~a. Notify the provider that its request for relief is denied setting forth the reasons for such denial;~~

~~b. Notify the provider that its appeal has merit and advise it of the agency action which will be taken; or~~

~~c. Notify the provider that its request for relief will be granted in part and denied in part, setting forth the reasons for the denial in part and the agency action which will be taken to grant relief in part.~~

~~6. The decision of the informal hearing officer shall be rendered within 90 days of the conclusion of the informal conference.~~

12 VAC 30-70-142. ~~The formal administrative hearing: procedures.~~ *(REPEALED.)*

~~A. The hospital shall submit its written request for a formal administrative hearing under § 9-6.14:12 of the Code of Virginia within 15 days of the date of the letter transmitting the adverse informal agency decision.~~

~~B. At least 21 days prior to the date scheduled for the formal hearing, the hospital shall provide the agency with:~~

~~1. Identification of the adverse agency action appealed from, and~~

~~2. A summary of the factual data, argument and proof the provider will rely on in connection with its case.~~

~~C. The agency shall afford the provider an opportunity for a formal administrative hearing within 45 days of the receipt of the request.~~

~~D. The Director of the Department of Medical Assistance Services, or his designee, shall preside over the hearing. Where a designee presides, he shall make recommended findings and a recommended decision to the director. In such instance, the provider shall have an opportunity to file exceptions to the proposed findings and conclusions. In no case shall the designee presiding over the formal administrative hearing be the same individual who presided over the informal appeal.~~

E. The Director of the Department of Medical Assistance Services shall make the final administrative decision in each case.

F. The decision of the agency shall be rendered within 60 days of the conclusion of the administrative hearing.

12 VAC 30-70-143. The formal administrative hearing: necessary demonstration of proof. *(REPEALED.)*

A. The hospital shall bear the burden of proof in seeking relief from its prospective payment rate.

B. A hospital seeking additional reimbursement for operating costs relating to the provision of inpatient care shall demonstrate that its operating costs exceed the limitation on operating costs established for its peer group and set forth the reasons for such excess.

C. In determining whether to award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, the Director of the Department of Medical Assistance Services shall consider the following:

1. Whether the hospital has demonstrated that its operating costs are generated by factors generally not shared by other hospitals in its peer group. Such factors may include, but are not limited to, the addition of new and necessary services, changes in case mix, extraordinary circumstances beyond the control of the hospital, and improvements imposed by licensing or accrediting standards.

2. Whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis.

a. In making such a determination, the director or his designee may require that an appellant hospital provide quantitative data, which may be compared to similar data from other hospitals within that hospital's peer group or from other hospitals deemed by the director to be comparable. In making such comparisons, the director may develop operating or financial ratios which are indicators of performance quality in particular areas of hospital operation. A finding that the data or ratios or both of the appellant hospital fall within a range exhibited by the majority of comparable hospitals may be construed by the director to be evidence that the hospital has taken every reasonable action to contain costs in that particular area. Where applicable, the director may require the hospital to submit to the agency the data it has developed for the Virginia Department of Health (formerly Virginia Health Services Cost Review Council). The director may use other data, standards or operating screens acceptable to him. The appellant hospital shall be afforded an opportunity to rebut ratios, standards or comparisons utilized by the director or his designee in accordance with this section.

b. Factors to be considered in determining effective cost containment may include the following:

- Average daily occupancy

- Average hourly wage

- FTE's per adjusted occupied bed

- Nursing salaries per adjusted patient day

- Average length of stay

- Average cost per surgical case

- Cost (salary/nonsalary) per ancillary procedure

- Average cost (food/nonfood) per meal served

- Average cost per pound of laundry

- Cost (salary/nonsalary) per pharmacy prescription

- Housekeeping cost per square foot

- Maintenance cost per square foot

- Medical records cost per admission

- Current ratio (current assets to current liabilities)

- Age of receivables

- Bad debt percentage

- Inventory turnover

- Measures of case mix

c. In addition, the director may consider the presence or absence of the following systems and procedures in determining effective cost containment in the hospital's operation.

- Flexible budgeting system

- Case mix management systems

- Cost accounting systems

- Materials management system

- Participation in group purchasing arrangements

- Productivity management systems

- Cash management programs and procedures

- Strategic planning and marketing

- Medical records systems

- Utilization/Peer review systems

d. Nothing in this provision shall be construed to require a hospital to demonstrate every factor set forth above or to preclude a hospital from demonstrating effective cost containment by using other factors.

The director or his designee may require that an onsite operational review of the hospital be conducted by the department or its designee.

3. Whether the hospital has demonstrated that the Medicaid prospective payment rate it receives to cover operating costs related to inpatient care is insufficient to provide care and service that conforms to applicable state and federal laws, regulations and quality and safety standards.[1]

D. In no event shall the Director of the Department of Medical Assistance Services award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, unless the hospital demonstrates to the satisfaction of the director that the Medicaid rate it receives under the Medicaid prospective payment system is insufficient to ensure Medicaid recipients reasonable access to sufficient inpatient hospital services of adequate quality.[2]

In making such demonstration, the hospital shall show that:

1. The current Medicaid prospective payment rate jeopardizes the long-term financial viability of the hospital. Financial jeopardy is presumed to exist if, by providing care to Medicaid recipients at the current Medicaid rate, the hospital can demonstrate that it is, in the aggregate, incurring a marginal loss.[3]

For purposes of this section, marginal loss is the amount by which total variable costs for each patient day exceed the Medicaid payment rate. In calculating marginal loss, the hospital shall compute variable costs at 60% of total inpatient operating costs and fixed costs at 40% of total inpatient operating costs; however, the director may accept a different ratio of fixed and variable operating costs if a hospital is able to demonstrate that a different ratio is appropriate for its particular institution.

Financial jeopardy may also exist if the hospital is incurring a marginal gain but can demonstrate that it has unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospital's long-term financial viability.

2. The population served by the hospital seeking additional financial relief has no reasonable access to other inpatient hospitals. Reasonable access exists if most individuals served by the hospital seeking financial relief can receive inpatient hospital care within a 30-minute travel time at a total per diem rate which is less to Department of Medical Assistance Services than the costs which would be incurred by DMAS per patient day were the appellant hospital granted relief.[4]

E. In determining whether to award additional reimbursement to a hospital for reimbursable costs which are other than operating costs related to the provision of inpatient care, the director shall consider Medicaid and applicable Medicare rules of reimbursement.

[1]See 42 USC §1396a(a)(13)(A). This provision reflects the Commonwealth's concern that she reimburse only those excess operating costs which are incurred because they are needed to provide adequate care. The Commonwealth recognizes that hospitals may choose to provide more than "just adequate" care and, as a consequence, incur higher costs. In this regard, the Commonwealth notes that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services... that package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered --not "adequate health care."' Alexander v. Choate,--U.S.--decided January 9, 1985, 53 L.W., 4072, 4075.

[2]In Mary Washington Hospital v. Fisher, the court ruled that the Medicaid rate "must be adequate to ensure reasonable access." Mary Washington Hospital v. Fisher, at p. 18. The need to demonstrate that the Medicaid rate is inadequate to ensure recipients reasonable access derives directly from federal law and regulation. In its response to comments on the NPRM published September 30, 1981, HCFA points out Congressional intent regarding the access issue: The report on H.R. 3982 states the expectation that payment levels for inpatient services will be adequate to assure that a sufficient number of facilities providing a sufficient level of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to obtain quality inpatient services. This report further states that payments should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals in the state. 46 FR 47970.

[3]The Commonwealth believes that Congressional intent is threatened in situations in which a hospital is incrementally harmed for each additional day a Medicaid patient is treated --and therefore has good cause to consider withdrawal from the program --and where no alternative is readily available to the patient, should withdrawal occur. Otherwise, although the rate being paid a hospital may be less than that paid by other payors --indeed, less than average cost per day for all patients --it nonetheless equals or exceeds the variable cost per day, and therefore benefits the hospital by offsetting some amount of fixed costs, which it would incur even if the bed occupied by the Medicaid patient were left empty.

It should be emphasized that application of this marginal loss or "incremental harm" concept is a device to assess the potential harm to a hospital continuing to treat Medicaid recipients, and not a mechanism for determining the additional payment due to a successful appellant. As discussed below, once a threat to access has been demonstrated, the Commonwealth may participate in the full average costs associated with the circumstances underlying the appeal.

[4]With regard to the 30-minute travel standard, this requirement is consistent with general health planning criteria regarding acceptable travel time for hospital care.

12 VAC 30-90-130. ~~Dispute resolution for nonstate operated nursing facilities.~~ *(Repealed.)*

A. NF's have the right to appeal the DMAS's interpretation and application of state and federal Medicaid and applicable Medicare principles of reimbursement in accordance with the Administrative Process Act, §9-6.14:1 et seq. and §32.1-325.1 of the Code of Virginia.

B. Nonappealable issues are identified below:

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

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

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

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

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

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

7. The development of Service Intensity Indexes based on:

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

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

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

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

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

12 VAC 30-90-131. Conditions for appeal. *(Repealed.)*

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

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

2. Any and all moneys due to DMAS shall be paid in full, unless a repayment plan has been agreed to by DMAS.

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

12 VAC 30-90-132. Appeal procedure. *(Repealed.)*

A. There shall be two levels of administrative appeal.

B. Informal appeals shall be decided by the Director of the Appeals Division after an informal fact finding conference is held. The decision of the Director of the Appeals Division shall be sent in writing to the provider within 90 business days following conclusion of the informal fact finding conference.

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

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

E. The director shall notify the provider of his final decision within the time frames set for disposition of appeals in this subpart and the Administrative Process Act, § 9-6.14:1 et seq. of the Code of Virginia.

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

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

12 VAC 30-90-133. Appeals time frames. *(Repealed.)*

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

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

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

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

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

5. Disputes relating to the time lines established in 12VAC30-90-132 B or to the grant of extensions to the DMAS shall be resolved by application to the Director of the DMAS or his designee.

VA.R. Doc. No. R00-216; Filed June 29, 2000, 9:37 a.m.

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Title of Regulation: **Individual and Family Developmental Disabilities Support Waiver Services.**
12 VAC 30-50-10 et seq. Amount, Duration, and Scope of Medical and Remedial Care Services (adding 12 VAC 30-50-490).
12 VAC 30-120-10 et seq. Waivered Services (adding 12 VAC 30-120-700 through 12 VAC 30-120-799).

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

Effective Dates: July 1, 2000, through June 30, 2001.

SUMMARY

REQUEST: The Governor is hereby requested to approve this agency's adoption of the emergency regulation entitled Individual and Family Developmental Disabilities Waiver Services, permitting the implementation of another service delivery method as an option to long-term care community-based services, effective July 1, 2000.

RECOMMENDATION: Recommend approval of the Department's request to take an emergency adoption action regarding Individual and Family Developmental Disabilities Waiver Services. The Department intends to initiate the public notice and comment requirements contained in the Code of Virginia § 9-6.14:7.1.

DISCUSSION

BACKGROUND: The regulations added by this action are the Individual and Family Developmental Disabilities Waiver Services (12 VAC 30-50-490, 12 VAC 30-120-700 through 899).

The 1999 General Assembly, through Item 335.LL of the 1999 Appropriations Act, mandated that the Director of the

Department of Medical Assistance Services (DMAS) develop a Medicaid-funded home and community-based care waiver for persons with developmental disabilities, including persons with autism. The "Individual and Family Developmental Disabilities Support (IFDDS) Waiver" must offer a full array of appropriate, flexible individual- and family-driven control of services to meet their individualized needs.

Federal provisions governing home and community based services (HCBS) waivers are found in § 1915 (c) of the *Social Security Act*. Under this authority, states can waive the federal requirements for statewide service coverage, comparability of services (rules that require states to provide services on an equal basis to all recipients who are eligible for services under the State Plan), community income and resource rules. This waiver capability affords states the flexibility to design waivers selecting the mix of services that best meet the needs of the targeted waiver populations. HCBS waivers are approved for an initial three-year period and federally renewed every five years. The Commonwealth of Virginia currently has five HCBS Waivers: AIDS; Elderly and Disabled; Consumer-Directed Personal Attendant Services (CD-PAS); Mental Retardation (MR); and Technology Assisted.

In order to develop a waiver to specifically serve persons with developmental disabilities who do not have a diagnosis of mental retardation, there must be an alternative institutional placement. 42 CFR § 435.1009 specifies that the alternative institutional placement for individuals with developmental disabilities must be an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Although many individuals with developmental disabilities do not have mental retardation, many of the services offered in an ICF/MR are more appropriate for these individuals than standard services offered in nursing facilities. Currently, Virginia has very few institutional placements for individuals with developmental disabilities.

The 1999 Appropriations Act language directed DMAS to convene a workgroup composed of representatives from various state agencies, consumers, families, advocates, and public and private providers to assist with the development of the waiver proposal. The members of the workgroup represented the Brain Injury Association of Virginia; Centers for Independent Living; Consumer Representatives for Persons with Disabilities; Consumer Service Boards; the Department of Education; the Department of Medical Assistance Services; the Department of Mental Health/Mental Retardation, & Substance Abuse Services; the Department of Rehabilitative Services; the Department for the Rights of Virginians with Disabilities; the Department of Social Services; Disability Service Boards; the Epilepsy Association of Virginia; the Epilepsy Foundation of Virginia; family representatives for persons with disabilities; UCP of Washington & Northern Virginia; the Virginia Association for Home Care; the Autism Program of Virginia (TAP-VA); the Virginia Board for People with Disabilities; and the Virginia Network of Private Providers.

WAIVER ELIGIBILITY

"Developmentally disabled" is a term used to refer to individuals who have mental retardation, as well as a "related condition" to mental retardation. However, states distinguish between individuals with mental retardation and individuals with related conditions when developing waivers such as this one.

Since individuals up to age 6 with developmental disabilities and individuals with mental retardation are already being served through the Home and Community Based Services waiver (Mental Retardation), the IFDDS waiver will be available only to individuals age 6 and older who meet the "related conditions" requirements as defined in 42 CFR § 435.1009: "Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

(A) It is attributable to -

(1) Cerebral palsy, or epilepsy; or

(2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(B) It is manifested before the person reaches age 22.

(C) It is likely to continue indefinitely.

(D) It results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care.

(2) Understanding and use of language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living."

The 2000 Appropriations Act specifically required that persons with autism be included in the waiver proposal.

In addition to the above requirements, the individual cannot have, for purposes of this new waiver service, a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR). An individual must meet all of the following criteria:

1. The individual must meet the ICF/MR level of care, as established at 42 CFR §§ 435.217 and 435.1009. This will be determined through a screening process conducted by qualified individuals under contract with DMAS;

2. The individual's monthly income must not exceed 300% of the SSI income level. Currently this amount is $1,536 and increases in January of each year;

3. The income of parents would not be deemed to a child; and

4. No individual can be enrolled in more than one waiver at a time.

WAIVER SERVICES

All individuals determined eligible for the IFDDS waiver will have a case manager/support coordinator. Individuals will select a support coordinator who will assist them and their families with accessing needed medical, psychiatric, social, educational, vocational, and other services essential to meeting the individuals' needs. Support coordinator services will include: assessment and planning (including referrals) services; linking the individuals to services and supports specified in the Individualized Service Plan (ISP); assisting the individuals (or family) directly to develop or obtain needed resources, including crisis assistance supports; coordinating services and treatment planning with other agencies and providers; enhancing community integration; monitoring service delivery (including assessment and reassessment of program participant level of care, oversight of the cost-effectiveness of services, review of plans of care at designated intervals); and benefits counseling. Support coordination providers will not be permitted to be service delivery providers.

The medical care services that will be offered under the IFDDS waiver include adult companion care, assistive technology, personal emergency response systems, crisis intervention/stabilization, environmental modifications, in-home residential supports, skilled nursing services, supported employment, therapeutic consultation, family and caregiver training, day support, personal care, respite care, and consumer-directed personal services (attendant and consumer-directed respite care).

DMAS asked the workgroup to provide projections of the potential number of individuals who could be eligible for the IFDDS waiver. Because Virginia does not serve individuals with developmental disabilities without diagnoses of mental retardation in state funded ICF/MRs, there was no institutional population from which to determine potential numbers of eligible individuals.

In addition, many states have a waiting list for services for individuals with developmental disabilities. DMAS anticipates that there will be a demand for services that will exceed available funding within the first year of waiver operation and, therefore, has incorporated the use of a waiting list into its program design. Any time there are more qualifying individuals than there is funding for their needed services, these individuals will be maintained on the waiting list until additional waiver funding should become available. Individuals will be served from the waiting list on a first-come, first-served basis.

Because this waiver itself and the design of the service system are new, DMAS also believes that the mechanics of the program should be well established before expansion is sought. The long-term interests of the recipients of these services will be best served by a well-designed and functioning system. The health care system holds numerous examples of how poor planning or coordination can frustrate the intended beneficiaries and undermine confidence in the program. DMAS will work with consumers and providers to firmly establish this waiver program while maintaining cost effectiveness.

A method for initial acceptance into the waiver will include an initial application period of sixty days, beginning July 1, 2000, and ending August 31, 2000. This application period will be followed by an assessment of all applications based on established criteria. Applicants will be placed on the IFDDS waiver in accordance with available funding.

FAMILY IMPACT: This regulatory action will not have any negative affects on the institution of the family or family stability. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, nor the assumption of family responsibilities. The IFDDS Waiver will offer families the choice of keeping their loved ones home and in the community rather than living in an institutional setting. The IFDDS Waiver will also offer supportive services to families and caregivers, such as family and caregiver training, companion care, and respite care in an effort to ease their care-giving burdens and prevent or delay institutional placement of loved ones.

AUTHORITY TO ACT: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:4.1(C)(5), for an agency's adoption of emergency regulations subject to the Governor's prior approval.

Subsequent to the emergency adoption action and filing with the Registrar of Regulations, this agency intends to initiate the public notice and comment process contained in Article 2 of the APA. Therefore, approval to file the required Notice of Intended Regulatory Action is also necessary and hereby being requested by this action.

Without an emergency regulation, these regulations cannot become effective until the publication and concurrent comment and review period requirements of the APA's Article 2 are met. Therefore, an emergency regulation is needed to meet the July 1, 2000, effective date established by the General Assembly.

NEED FOR EMERGENCY ACTION: The Code § 9-6.14:4.1(C)(5) provides for regulations which an agency finds are necessitated by an emergency situation. To enable the Director, in lieu of the Board of Medical Assistance Services, to comply with the 1999 General Assembly through Item 335.LL of the 1999 Appropriations Act, he must develop a Medicaid-funded home and community-based care waiver for persons with developmental disabilities, including persons with autism. This issue qualifies as an emergency regulation as provided for in § 9-6.14:4.1(C)(5)(ii) of the *Code*, because Item 319(U) of the 2000 Appropriation Act requires this regulation to be effective within 280 days from the enactment of the law. As such, this regulation may be adopted without public comment with the prior approval of the Governor.

Although the emergency regulation process does not have a specified formal period of public comment, DMAS demonstrates its ongoing efforts to confer with all parties interested in this issue by its extensive collaboration with the identified work group. Since this emergency regulation will be effective for no more than 12 months and the Director wishes to continue regulating the subject entities, the Department is initiating the Administrative Process Act Article 2 procedures.

FISCAL/BUDGETARY IMPACT: The Medicaid-funded IFDDS program will be offered under a *Social Security Act* § 1915(c) home and community-based-care waiver which must be a cost-effective alternative to institutionalization. Including medical funding and administrative costs, the waiver is projected to cost $8 million ($3.8 million GF) in FY 2001 and $11 million ($5.3 million GF) in FY 2002. The Governor and General Assembly approved these amounts in the 2000 Appropriation Act. The appropriations for the waiver are sufficient to fund at least 300 positions in the waiver.

FEDERAL COST EFFECTIVENESS STANDARD

In order for HCFA to approve a HCBS waiver, it must be cost effective. A waiver can be cost effective in the aggregate or can be individually cost effective. Aggregate cost-effectiveness means that the average cost to Medicaid of individuals on the waiver cannot exceed the average cost to Medicaid of individuals in the alternative institutional placement. Individual cost effectiveness means that an individual's expected waiver costs cannot exceed those of an individual's institutional expected cost. Regardless of the method the state chooses to determine cost effectiveness, aggregate costs are reported to HCFA.

There are arguments for adopting either method of determining cost effectiveness. The work group felt very strongly that aggregate cost effectiveness should be used. However, without some cost controls built into the IFDDS Waiver, all funds could be used by a small number of high cost individuals, leaving families who need some or moderate support without services. This could thus increase the likelihood that these lower-cost family placements will fail and will increase the need for out-of-home (institutional) placements.

States are beginning to use other options in lieu of the "all or nothing" approach that has been the norm. The DMAS has secured HCFA approval of an approach geared to controlling costs while providing as much consumer choice as possible. DMAS believes that most individuals, given an array of services, will choose those that best meet their needs and are the most cost effective. The services chosen would have to be necessary to avoid institutionalization and the Consumer Service Plan (care plan) would need to be developed subject to approval by DMAS.

In order to assure cost effectiveness of this waiver, funds would be allocated between two “budget” levels to assure that, on the average, DMAS does not exceed cost effectiveness. For this waiver, DMAS will establish a threshold for waiver costs for recipients in “Level One” at approximately $25,000. Recipients whose care plans exceed $25,000 per year will be funded in “Level Two.” There would not be a budget threshold for “Level Two.” Regardless of the budget level an individual comes under, coverage of all individuals under this waiver program will be limited to available funding.

DMAS, upon the workgroup’s recommendation, has targeted 55 percent of waiver funds to level one and targeted 40 percent of waiver funds to level two. The remaining 5 percent of funds would be allocated for emergencies. While the primary purpose of this bi-level cost allocation is to assure that the waiver remains cost effective, with good support coordination and stewardship of funds, it may be possible to serve more than the projected number of individuals. If individuals who cost up to or more than the actual institutional cost are covered, the potential number of waiver recipients served would decrease. The unknown factors are the cost of non-waiver Medicaid covered services and the actual cost of recipients who would be eligible for services.

In compliance with HCFA requirements, the budget level chosen would fully fund the recipient’s plan of care after taking into account other community and family resources. Since family dynamics change frequently, sometimes rapidly, some funds will be set aside for emergency situations. These funds would be distributed according to emergency criteria that have been developed in conjunction with workgroup and are located at 12 VAC 30-120-850.

There are no localities that are uniquely affected by these regulations as they apply statewide.

RECOMMENDATION: Recommend approval of this request to adopt this emergency regulation to become effective July 1, 2000. From its effective date, these regulations are to remain in force for one full year or until superseded by final regulations, promulgated through the APA. Without an effective emergency regulation, the Department would lack the authority to implement the Medicaid-funded Individual and Family Developmental Disabilities Support Waiver on July 1, 2000, as mandated by the General Assembly.

APPROVAL SOUGHT FOR 12 VAC 30-120-700 through 12 VAC 30-120-899.

Approval of the Governor is sought for an emergency modification of the Medicaid State Plan in accordance with the Code of Virginia § 9-6.14:4.1(C)(5) to adopt the following regulation:

/s/ Dennis G. Smith, Director
Department of Medical Assistance Services
Date: June 29, 2000

/s/ James S. Gilmore, III
Governor
Date: June 28, 2000

12 VAC 30-50-490. Case management (support coordination) for individuals with developmental disabilities, including autism (12 VAC 30-50-490).

A. Target Group: Medicaid eligible recipients with related conditions who are six years of age and older and who are eligible to receive services under the IFDDS waiver.

B. Areas of State in which services will be provided:

☒ *Entire State*

☐ *Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:*

C. Comparability of Services

☐ *Services are provided in accordance with section 1902(a)(10)(B) of the Act.*

☒ *Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.*

D. Definition of Services: Support coordination services for recipients with related conditions who are participants in the home and community-based care IFDDS waiver. Support coordination services to be provided include:

1. Assessment and planning services, to include developing a consumer service plan (does not include performing medical and psychiatric assessment but does include referral for such assessments);

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

3. Assisting the recipient directly for the purpose of locating, developing, or obtaining needed services and resources;

4. Coordinating services with other agencies and providers involved with the recipient;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;

6. Making collateral contacts with the recipient's significant others to promote implementation of the service plan and community adjustment;

7. Following up and monitoring to assess ongoing progress and ensure services are delivered;

8. Education and counseling which guides the recipient and develops a supportive relationship that promotes the service plan; and

9. Benefits counseling.

E. Qualifications of Providers: In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications are:

1. To qualify as a provider of services through the DMAS for IFDDS waiver support coordination, the service provider must meet these criteria:

a. The provider must guarantee that recipients have access to emergency services on a 24- hour, 7-days a week basis;

b. The provider must have the administrative and financial management capacity to meet state and federal requirements;

c. The provider must have the ability to document and maintain recipient case records in accordance with state and federal requirements; and

d. The provider must be certified as an IFDDS support coordination agency by DMAS.

2. Providers may bill for Medicaid support coordination only when the services are provided by qualified support coordinators. The support coordinator must possess a combination of developmental disability work experience or relevant education, which indicates that the individual possesses the following knowledge, skills, and abilities, at the entry level. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

(1) The definition, causes, and program philosophy of developmental disabilities;

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills, training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

(3) Different types of assessments and their uses in program planning;

(4) Recipients' rights;

(5) Local service delivery systems, including support services;

(6) Types of mental retardation programs and services;

(7) Effective oral, written, and interpersonal communication principles and techniques;

(8) General principles of record documentation; and

(9) The service planning process and the major components of a service plan.

b. Skills in:

(1) Interviewing;

(2) Negotiating with recipients and service providers;

(3) Observing, recording, and reporting behaviors;

(4) Identifying and documenting a recipient's needs for resources, services, and other assistance;

(5) Identifying services within the established service system to meet the recipient's needs;

(6) Coordinating the provision of services by diverse public and private providers;

(7) Analyzing and planning for the service needs of developmentally disabled persons;

(8) Formulating, writing, and implementing recipient-specific individual service plans to promote goal

attainment for recipients with developmental disabilities; and

(9) Using assessment tools.

c. Abilities to:

(1) Demonstrate a positive regard for recipients and their families (e.g., treating recipients as individuals, allowing risk taking, avoiding stereotypes of developmentally disabled people, respecting recipients' and families' privacy, believing recipients can grow);

(2) Be persistent and remain objective;

(3) Work as team member, maintaining effective inter- and intra-agency working relationships;

(4) Work independently, performing positive duties under general supervision;

(5) Communicate effectively, verbally and in writing; and

(6) Establish and maintain ongoing supportive relationships.

F. The State assures that the provision of case management (support coordination) services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management (support coordination) services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

PART XI.
INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER

Subpart 1.

12 VAC 30-120-700 Definitions.

"60 day assessment" means the initial plan of care developed by providers prior to the initiation of services that establishes goals for the recipient in accordance with the recipient's Consumer Service Plan.

"Activities of daily living (ADL)" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. A recipient's degree of independence in performing these activities is a part of determining appropriate level of care and services.

"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances, specified in the plan of care but not available under the State Plan for Medical Assistance, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live or which are necessary to their proper functioning.

"Attendant care" means long-term maintenance or support services necessary to enable the mentally alert and competent recipient to remain at or return home rather than enter or remain in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The recipient will be responsible for hiring, training, supervising and firing the personal attendant. Recipients 18 years of age and older must be able to manage their own affairs without help, be mentally alert, have no cognitive impairments, and not have a legal guardian. If recipients receiving services are younger than 18 years of age, the legal guardians or parents will act on behalf of minor recipients.

"Community-based care waiver services or waiver services" means the range of community support services approved by the Health Care Financing Administration (HCFA) pursuant to §1915(c) of the Social Security Act to be offered to developmentally disabled recipients who would otherwise require the level of care provided in an ICF/MR.

"Companion services" means non-medical care, supervision and socialization, provided to a functionally impaired adult. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the individual service plan. This shall not be the sole service used to divert recipients from institutional care.

"Consumer-directed respite care" means services given to caretakers of eligible individuals who are unable to care for themselves that is provided on an episodic or routine basis because of the absence or need for relief of those persons residing with the recipient who normally provide the care. The recipient will be responsible for hiring, training, supervising, and firing the personal attendant. For recipients 18 years of age and older, they must be able to manage their own affairs without help, be mentally alert and have no cognitive impairments and not have a legal guardian. If recipients receiving services are under 18 years of age, the legal guardian or parent will act on behalf of the minor.

"Consumer service plan" or "CSP" means that document addressing all needs of recipients of home and community-based care developmental disability services, in all life areas. Plans of care (POC) developed by service providers are to be incorporated in the CSP by the support coordinator. Factors to be considered when these plans are developed may include, but are not limited to, recipients' ages and levels of functioning.

"Crisis stabilization" means direct intervention to persons with developmental disabilities who are experiencing serious psychiatric or behavioral problems, or both, that jeopardize their current community living situation. This service must provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out of home placement. This service shall be designed to stabilize recipients and strengthen the current living situations so that recipients can be maintained in the community during and beyond the crisis period.

"Current functional status" means recipients' degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means individuals who perform utilization review, recommendation of preauthorization for service type and intensity, and review of recipient level of care criteria.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services. The DRS currently operates the Personal Assistance Services Program, which is a state-funded program that provides a limited amount of personal care services to Virginians.

"DSS" means the Department of Social Services.

"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, services and support activities, and prevocational services aimed at preparing a recipient for paid or unpaid employment.

"Environmental modifications" means physical adaptations to a house, place of residence, vehicle or work site, when the modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure recipients' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to recipients.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines which prescribe specific preventive and treatment services for Medicaid-eligible children.

"Family and caregiver training" means training and counseling services provided to families of recipients receiving services in the IFDDS waiver.

"Fiscal agent" means an agency or organization contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of recipients who are receiving consumer-directed attendant and respite services.

"Guardian" means a person who has been legally invested with the authority and charged with the duty of taking care of, managing the property of, and protecting the rights of the recipient who has been declared by the circuit court to be incapacitated and incapable of administering his own affairs. The powers and duties of the guardian are defined by the court and are limited to matters within the areas where the recipient has been determined to be incapacitated.

"Home and community-based care" means a variety of in-home and community-based services reimbursed by the DMAS authorized under a § 1915(c) waiver designed to offer recipients an alternative to institutionalization. Recipients may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/MR placement.

"HCFA" means the Health Care Financing Administration as that unit of the federal Department of Health and Human Services, which administers the Medicare and Medicaid programs.

"IFDDS waiver" means the Individual and Family Developmental Disabilities Support Waiver.

"In-home residential support services" means support provided in the developmentally disabled recipient's home which includes training, assistance, and supervision in enabling the recipient to maintain or improve his health, assistance in performing recipient care tasks, training in activities of daily living, training and use of community resources, providing life skills training, and adapting behavior to community and home-like environments.

"Instrumental activities of daily living (IADL)" mean social tasks (i.e., meal preparation, shopping, housekeeping, laundry, money management). A recipient's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Mental retardation" means mental retardation as being substantially limited in present functioning as characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests itself before age 18. A diagnosis of mental retardation is made if the person's intellectual functioning level is approximately 70-75 or below, as diagnosed by a licensed clinical professional; and there are related limitations in two or more applicable adaptive skill areas; and the age of onset is 18 or below; and the person meets existing criteria for placement in an ICF/MR. If a valid IQ score is not possible, significantly subaverage intellectual capabilities means a level of performance that is less than that observed in the vast majority of persons of comparable background. In order to be valid, the assessment of the intellectual performance must be free of errors caused by motor, sensory, emotional, language, or cultural factors.

"Nursing services" means skilled nursing services listed in the plan of care which are ordered by a physician and required to prevent institutionalization, not available under the State Plan for Medical Assistance, are within the scope of the State's Nurse Practice Act, and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, who is licensed to practice in the state.

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

"Personal attendant" means, for purposes of this regulation and exemption from Worker's Compensation, a domestic

servant. Recipients shall be restricted from employing more than two personal attendants simultaneously at any given time.

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

"Personal care services" means long-term maintenance or support services necessary to enable recipients to remain at or return home rather than enter an Intermediate Care Facility for the Mentally Retarded. Personal care services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes and in the community.

"Personal emergency response system (PERS)" is an electronic device that enables certain recipients at high risk of institutionalization to secure help in an emergency. PERS services are limited to those recipients who live alone or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Plan of Care" or "POC" means the specific service plan developed by the recipient service provider related solely to the specific tasks required of that service provider. POCs help to comprise the overall CSP for the recipient.

"Qualified mental health professional" means a professional having (i) at least one year of documented experience working directly with recipients who have developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession.

"Related conditions" means those persons who have autism or who have a severe chronic disability that meets all of the following conditions identified in 42 CFR § 435.1009:

(1) It is attributable to:

a. Cerebral palsy or epilepsy; or

b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(2) It is manifested before the person reaches age 22.

(3) It is likely to continue indefinitely.

(4) It results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self-care.

b. Understanding and use of language.

c. Learning.

d. Mobility.

e. Self-direction.

f. Capacity for independent living.

"Respite care" means services given to caretakers of eligible recipients who are unable to care for themselves that is provided on an episodic or routine basis because of the absence of or need for relief of those persons residing with the recipient who normally provide the care.

"Respite care agency" means a participating provider, which renders services, designed to prevent or reduce inappropriate institutional care by providing respite care services to eligible recipients.

"Screening" means the process to: evaluate the medical, nursing, and social needs of recipients referred for screening, determine Medicaid eligibility for an ICF/MR level of care and authorize Medicaid-funded ICF/MR care or community-based care for those recipients who meet ICF/MR level of care and require that level of care.

"Screening team" means the entity contracted with the DMAS which is responsible for performing screening for the IFDDS Waiver.

"Service coordination provider" means the provider contracted by DMAS that is responsible for ensuring development and monitoring of the plan of care, management training, and review activities as required by DMAS for attendant care and consumer-directed respite care services are accomplished.

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

"Support coordination" means the assessment, planning, linking, and monitoring for recipients referred for the IFDDS community-based care waiver. Support coordination (i) ensures the development, coordination, implementation, monitoring, and modification of consumer service plans; (ii) links recipients with appropriate community resources and supports; (iii) coordinates service providers; and (iv) monitors quality of care.

"Supported employment" means training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable a recipient to maintain paid employment.

"Therapeutic consultation" means consultation provided by members of psychology, social work, behavioral analysis, speech therapy, occupational therapy, therapeutic recreation, physical therapy disciplines or behavior consultation to assist recipients, parents, family members, in-home residential support, day support and any other providers of support services in implementing a plan of care.

12 VAC 30-120-710. General Coverage and Requirements for all Home and Community-Based Care Waiver Services.

A. Waiver service populations. Home and community-based services shall be available through a § 1915(c) waiver.

Coverage shall be provided under the waiver for the following recipients who have been determined to require the level of care provided in an Intermediate Care Facility for the Mentally Retarded.

Recipients six years of age and older with related conditions as defined in 42 CFR § 435.1009, including autism. The individual must not also have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR).

1. The AAMR defines mental retardation as being substantially limited in present functioning that is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests itself before age 18.

2. A diagnosis of mental retardation is made if the person's intellectual functioning level is approximately 70-75 or below, as diagnosed by a licensed clinical professional; and there are related limitations in two or more applicable adaptive skill areas; and the age of onset is 18 or below; and the person meets existing criteria for placement in an ICF/MR. If a valid IQ score is not possible, significantly subaverage intellectual capabilities means a level of performance that is less than that observed in the vast majority of persons of comparable background. In order to be valid, the assessment of the intellectual performance must be free from errors caused by motor, sensory, emotional, language, or cultural factors.

B. Coverage statement.

1. Covered services shall include: in-home residential supports, day support, supported employment, personal care (agency-directed), attendant care (consumer-directed), respite care (both agency- and consumer-directed), assistive technology, environmental modifications, nursing services, therapeutic consultation, crisis stabilization, personal emergency response systems (PERS), family and caregiver training, and companion care.

2. These services shall be medically appropriate and necessary to maintain these recipients in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures in the aggregate for the level of care provided in Intermediate Care Facilities for the Mentally Retarded under the State Plan that would have been made had the waiver not been granted.

3. Under this § 1915(c) waiver, DMAS waives subsection (a)(10)(B) of § 1902 of the Social Security Act related to comparability.

C. Appeals. Recipient appeals shall be considered pursuant to 12 VAC 30-110-10 through 110-380. Provider appeals shall be considered pursuant to 12 VAC 30-10-1000 and 12 VAC 30-20-500 through 20-599.

12 VAC 30-120-720. Recipient qualification and eligibility requirements; intake process.

A. Recipients receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR §§ 435.121 and 435.217. The income level used for §§ 435.121 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person.

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

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

a. For recipients to whom § 1924(d) applies, and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% SSI; for an individual employed at least 8 but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5 percent of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with a spouse at home, the community spousal income allowance determined in accordance with § 1924(d) of the Social Security Act.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with § 1924(d) of the Social Security Act.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the Plan.

b. For individuals to whom § 1924(d) does not apply and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% SSI; for an individual employed at least 8 but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5 percent of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with a dependent child or children, an additional amount for the maintenance needs of the child or children which shall be equal to the medically needy income standard based on the number of dependent children.

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the state medical assistance plan.

B. Assessment and authorization of home and community-based care services.

1. To ensure that Virginia's home and community-based care waiver programs serve only recipients who would otherwise be placed in an ICF/MR, home and community-based care services shall be considered only for individuals who are eligible for admission to an ICF/MR, absent a diagnosis of mental retardation. Home and community-based care services shall be the critical service that enables the individual to remain at home rather than being placed in an ICF/MR.

2. The recipient's status as an individual in need of IFDDS home and community-based care services shall be determined by the IFDDS screening team after completion of a thorough assessment of the recipient's needs and available support. Screening and preauthorization of home and community-based care services by the IFDDS screening team or DMAS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care services.

3. The IFDDS screening team shall gather relevant medical, social, and psychological data and identify all services received by the recipient.

4. An essential part of the IFDDS screening team's assessment process is determining the level of care required by applying existing DMAS ICF/MR criteria (12 VAC 30-130-430 et seq.).

5. The team shall explore alternative settings and services to provide the care needed by the individual. If placement in an ICF/MR or a combination of other services are determined to be appropriate, the IFDDS screening team shall initiate a referral for service. If Medicaid-funded home and community-based care services are determined to be the critical service to delay or avoid placement in an ICF/MR or promote exiting from either an ICF/MR or nursing facility placement, the IFDDS screening team shall initiate a referral for service to a support coordinator of the recipient's choice.

6. Home and community-based care services shall not be provided to any individual who also resides in a nursing facility, an ICF/MR, a hospital, or an assisted living facility licensed by the DSS.

7. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by DMAS. Any Consumer Service Plan for home and community-based care services must be pre-approved by DMAS prior to Medicaid reimbursement for waiver services.

8. The following five criteria shall apply to all IFDDS waiver services:

a. Individuals qualifying for IFDDS Waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life activities. In order to be eligible, a person must have a related condition as defined in these regulations and cannot have a diagnosis of mental retardation, and who would, in the absence of waiver services, require the level of care provided in an ICF/MR facility, the cost of which would be reimbursed under the Plan;

b. The Consumer Service Plan and services which are delivered must be consistent with the Medicaid definition of each service;

c. Services must be approved by the support coordinator based on a current functional assessment

tool approved by DMAS or other DMAS approved assessment and demonstrated need for each specific service;

d. Individuals qualifying for IFDDS waiver services must meet the ICF/MR level of care criteria; and

e. The individual is Medicaid eligible as determined by the local office of DSS.

9. The IFDDS screening teams must submit the results of the comprehensive assessment and a recommendation to DMAS staff for final determination of ICF/MR level of care and authorization for community-based care services.

C. Screening for the IFDDS waiver.

1. To begin implementation of the waiver, individuals or the individuals' families will initially have the opportunity to request to be screened for waiver services from July 1, 2000, through August 31, 2000. This 60-day period is to allow for all interested individuals who wish to apply to do so. During this time, individuals or their families will request that the individual be screened for eligibility into the IFDDS waiver by the screening entity contracted by DMAS. Individuals will be screened with the Level of Functioning (LOF) Survey, which is the assessment instrument used to determine eligibility for ICF/MR level of care. Once the initial pool of applicants has been screened, applicants will be placed on the IFDDS waiver and in accordance with available funding. If more individuals are eligible to receive services than available funding allows, DMAS will randomly assign recipients a number (from 1 to the number of individuals eligible), and will begin serving individuals in numerical order (1, 2, 3, etc.). After the initial 60-day screening period, individuals requesting to receive IFDDS waiver services will be screened and will receive services on a first-come, first-served basis in accordance with available funding based on the date the recipients' applications are received. Individuals who meet at least one of the emergency criteria pursuant to 12 VAC 30-120-790 shall be eligible for immediate access to waiver services pending available funding.

2. To be eligible for IFDDS waiver services, the individual must:

a. Be determined to be eligible for the ICF/MR level of care;

b. Meet the related conditions definition as defined in 42 CFR § 435.1009 or be diagnosed with autism; and

c. Not have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR) as contained in 12 VAC 30-120-720.

D. Waiver Approval Process: Available funding.

1. In order to assure cost effectiveness of the IFDDS Waiver, the funding available for the waiver will be allocated between two "budget" levels. The "budget" will be the cost of waiver services only and will not include the costs of other Medicaid covered services. Other Medicaid services, however, must be counted toward cost-effectiveness of the IFDDS Waiver. All services available under the waiver would be available to both levels.

2. Level one will be for individuals whose comprehensive consumer service plan (CSP) is anticipated to cost less than $25,000 per fiscal year. Level two will be for individuals whose CSP is anticipated to cost equal to or more than $25,000. There will not be a threshold for budget level two; however, if the actual cost of waiver services exceeds the average annual cost of ICF/MR care, the recipient's care will be coordinated by DMAS staff.

3. Fifty-five percent of available waiver funds will be allocated to budget level one, and 40 percent of available waiver funds will be allocated to level two, in order to assure that the waiver will be cost-effective. The remaining 5 percent of available waiver funds will be allocated for emergencies as defined in 12 VAC 30-120-790. Recipients who have been placed in budget level one and who subsequently require additional services that would exceed $25,000 per fiscal year must meet the emergency criteria as defined in 12 VAC 30-120-790 to receive additional funding for services.

E. Waiver approval process: Accessing services.

1. Once the screening entity has determined an individual to be eligible for IFDDS waiver services and the individual has chosen this service, the screening entity will provide the individual with a list of available support coordinators. The individual will choose a support coordinator within five calendar days and the screening entity will forward the screening materials within five calendar days to the selected support coordinator.

2. The support coordinator will contact the recipient within five calendar days of receipt of screening materials. The support coordinator and the recipient or recipient's family will meet within 30 calendar days to discuss the recipient's needs, existing supports and to develop a comprehensive consumer service plan (CSP) which will identify services needed and will estimate the annual waiver cost of the recipient's CSP. If the recipient's annual waiver cost is expected to exceed the average annual cost of ICF/MR care, the recipient's support coordination will be managed by DMAS.

3. Once the CSP has been developed, the support coordinator will contact DMAS to receive prior authorization to enroll the recipient onto the IFDDS waiver. DMAS shall only authorize waiver services for the recipient if funding is available for the entire CSP. Once this authorization has been received, the support coordinator shall inform the recipient so that the recipient can begin choosing service providers for services listed in the CSP. If DMAS does not have the available funding for this recipient, the recipient will be held on the waiting list until such time as additional funds are available to cover the entire cost of the CSP.

4. Once the recipient has been authorized for the waiver, the recipient or support coordinator will contact service providers and shall initiate services within 60 days. If services are not initiated within 60 days, the support coordinator must submit information to DMAS demonstrating why more time is needed to initiate services. DMAS has the authority to approve or deny the request in 30-day extensions. The service providers will develop a Plan of Care (POC) for each service and will submit a copy of these plans to the support coordinator. The support coordinator will monitor the service providers' POCs to assure that all providers are working toward the identified goals of recipients. The support coordinator will review and sign off on the POCs and will contact DMAS for prior authorization of services and will notify the service providers when services are approved.

5. The support coordinator will contact the recipient at a minimum on a monthly basis and as needed to coordinate services and maintain the recipient's CSP. DMAS will conduct annual level of care reviews in which the recipient is assessed to ensure he continues to meet waiver criteria. DMAS will review recipients' CSPs and will review the services provided by support coordinators as well as service providers.

12 VAC 30-120-730. General Requirements for Home and Community-based Care Participating Providers.

A. General Requirements. Providers approved for participation shall, at a minimum, perform the following activities:

1. Immediately notify DMAS, in writing, of any change in the information which the provider previously submitted to DMAS.

2. Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid Program at the time the service or services were performed.

3. Assure the recipient's freedom to reject medical care and treatment.

4. Accept referrals for services only when staff is available to initiate services and perform such services on an ongoing basis.

5. Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 200d 4a), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (§§ 51.5-1 through 51.5-59 of the Code of Virginia), as amended; § 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 U.S.C. §§ 12101 through 12213), which provides comprehensive civil rights protections to recipients with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

6. Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.

7. Submit charges to DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public. The provider must accept as payment in full the amount established by DMAS payment methodology from the first day of eligibility.

8. Use program-designated billing forms for submission of charges.

9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the care provided.

a. In general, such records shall be retained for at least five years from the last date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia.

c. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and number of hours/units provided (including specific time frame).

10. The provider agrees to furnish information on request and in the form requested to DMAS, the Attorney General of Virginia or his authorized representatives, federal personnel, or the State Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement.

11. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid.

12. Hold confidential and use for DMAS authorized purposes only all medical assistance information regarding recipients served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the DMAS. DMAS shall not disclose medical information to the public.

13. Change of Ownership. When ownership of the provider agency changes, DMAS shall be notified at least 15 calendar days before the date of change.

14. All facilities covered by § 1616(e) of the Social Security Act in which home and community-based care services will be provided shall be in compliance with applicable standards that meet the requirements for board and care facilities. Health and safety standards shall be monitored through the DMHMRSAS' licensure standards, 12 VAC 35-102-10 et seq.

15. Suspected Abuse or Neglect. Pursuant to §§ 63.1-55.3 and 63.1-248.3, Code of Virginia, if a participating provider knows or suspects that a home and community-based care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local DSS adult or child protective services worker and to DMAS.

16. Adherence to provider contract and the DMAS provider service manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their recipient provider contracts and in the DMAS provider service manual.

12 VAC 30-120-740. Participation Standards for Home and Community-Based Care Participating Providers.

A. Requests for participation. Requests will be screened to determine whether the provider applicant meets the basic requirements for participation.

B. Provider participation standards. For DMAS to approve contracts with home and community based care providers, the following standards shall be met:

1. Licensure and certification requirements pursuant to 42 CFR § 441.352.

2. Disclosure of ownership pursuant to 42 CFR §§ 455.104 and 455.105.

C. Adherence to provider contract and special participation conditions. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their provider contracts.

D. Recipient choice of provider agencies. The recipient will have the option of selecting the provider agency of his choice.

E. Review of provider participation standards and renewal of contracts. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and recertify each provider for contract renewal with DMAS to provide home and community-based services. A provider's non-compliance with DMAS policies and procedures, as required in the provider's contract, may result in a written request from DMAS for a corrective action plan which details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies which have been cited.

F. Termination of provider participation. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification. DMAS shall be permitted to administratively terminate a provider from participation upon 30 days' written notification. DMAS may also cancel a contract immediately or may give notification in the event of a breach of the contract by the provider as specified in the DMAS contract. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice.

G. Reconsideration of adverse actions. A provider shall have the right to appeal adverse action taken by DMAS. Adverse action includes, but shall not be limited to, termination of the provider agreement by DMAS, and retraction of payments from the provider by DMAS for noncompliance with applicable law, regulation, policy, or procedure. All disputes regarding provider reimbursement or termination of the agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be conducted pursuant to the Virginia Administrative Process Act (§§ 9-6.14:1 through 9.6-14.25 of the Code of Virginia) ,the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia, and duly promulgated regulations. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

H. Termination of a provider contract upon conviction of a felony. Section 32.1-325(C), as amended, of the Code of Virginia, mandates that "any such [Medicaid] agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington D.C. must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. Reinstatement will be contingent upon provisions of state law. In addition, termination of a provider contract will occur as may be required for federal financial participation.

I. Support coordinator's responsibility for the Recipient Information Form (DMAS-122). It is the responsibility of the support coordinator to notify DMAS and DSS, in writing, when any of the following circumstances occur:

1. Home and community-based care services are implemented.

2. A recipient dies.

3. A recipient is discharged or terminated from services.

4. Any other circumstances (including hospitalization) which cause home and community-based care services to cease or be interrupted for more than 30 days.

J. Changes or termination of care. It is the DMAS staff's responsibility to authorize any changes to a recipient's Plan of Care components of the Consumer Service Plan based on

the recommendations of the support coordinator. Agencies providing direct service are responsible for modifying the POC if the recipient or parent/legal guardian agrees. The provider will submit the POC to the support coordinator any time there is a change in the recipient's condition or circumstances, which may warrant a change in the amount or type of service rendered. The support coordinator will review the need for a change and will sign the POC if he agrees to the changes. The support coordinator will submit the revised POC to the DMAS staff to receive approval for that change. The DMAS staff has the final authority to approve or deny the requested change to recipients' POCs.

1. Non-emergency termination of home and community-based care services by the participating provider. The participating provider shall give the recipient and family and support coordinator ten days written notification of the intent to terminate services. The letter shall provide the reasons for and effective date of the termination. The effective date of services termination shall be at least ten days from the date of the termination notification letter.

2. Emergency termination of home and community-based care services by the participating provider. In an emergency situation when the health and safety of the recipient or provider agency personnel is endangered, the support coordinator and DMAS must be notified prior to termination. The ten day written notification period shall not be required. If appropriate, the local DSS adult protective services or child protective services must be notified immediately.

3. The DMAS termination of eligibility to receive home and community-based care services. DMAS shall have the ultimate responsibility for assuring appropriate placement of the recipient in home and community-based care services and the authority to terminate such services to the recipient for the following reasons:

a. The home and community-based care service is not the critical alternative to prevent or delay institutional (ICF/MR) placement;

b. The recipient no longer meets the institutional level of care criteria;

c. The recipient's environment does not provide for his health, safety, and welfare; or

d. An appropriate and cost-effective plan of care cannot be developed.

Subpart 2.
Covered services and limitations and related provider requirements.

12 VAC 30-120-750. In-home residential support services.

A. Service Description. In-home residential support services shall be based in the recipient's apartment or home. The service shall be designed to enable recipients qualifying for the IFDDS waiver to be maintained in living arrangements in the community and shall include: (i) training in or reinforcement of functional skills and appropriate behavior related to a recipient's health and safety, personal care, activities of daily living and use of community resources; (ii) assistance with medication management and monitoring health, nutrition, and physical condition; (iii) life skills training; (iv) cognitive rehabilitation; and (v) assistance with personal care activities of daily living and use of community resources. Service providers shall be reimbursed only for the amount and type of in–home residential support services included in the recipient's approved plan of care. In–home residential support services shall not be authorized in the plan of care unless the recipient requires these services and these services exceed services provided by the family or other caregiver. Services will not be provided for a continuous 24-hour period.

1. This service must be provided on a recipient-specific basis according to the plan of care and service setting requirements.

2. This service may not be provided simultaneously to any recipient who receives personal care or attendant care services under the IFDDS waiver or other residential program that provides a comparable level of care.

3. Room and board and general supervision shall not be components of this service.

4. This service shall not be used solely to provide routine or emergency respite care for the parent or parents or other caregivers with whom the recipient lives.

B. Criteria.

1. All recipients must meet the following criteria in order for Medicaid to reimburse for in-home residential support services. The recipient must meet the eligibility requirements for this waiver service as herein defined. The recipient shall have a demonstrated need for supports to be provided by staff who are paid by the in-home residential support provider.

2. A functional assessment should be conducted to evaluate each recipient in his home environment and community settings.

3. Routine supervision/oversight of direct care staff. To provide additional assurance for the protection or preservation of a recipient's health and safety, there are specific requirements for the supervision and oversight of direct care staff providing residential support as outlined below.

a. For all in-home residential support services provided under a DMHMRSAS license:

(1) An employee of the agency, typically by position, must be formally designated as the supervisor of each direct care staff person who is providing in-home residential support services.

(2) The supervisor must have and document at least one supervisory contact per month with each staff person regarding service delivery and staff performance.

(3) The supervisor must observe each staff person delivering services at least quarterly. Staff performance and service delivery according to the CSP should be documented, along with evaluation

and evidence of recipient satisfaction with service delivery by staff.

(4) Providers of in-home residential supports must also have and document at least one monthly contact with the recipient regarding satisfaction with services delivered by each staff person. If the recipient has a caregiver, the caregiver should be contacted.

4. The in-home residential support POC must indicate the necessary amount and type of activities required by the recipient, the schedule of residential support services, the total number of hours per day and the total number of hours per week of residential support.

5. Medicaid reimbursement is available only for in-home residential support services provided when the recipient is present and when a qualified provider is providing the services.

C. Service units and service limitations. In-home residential supports shall be reimbursed on an hourly basis for time the in-home residential support staff is working directly with the recipient. Total monthly billing cannot exceed the total hours authorized in the POC. The provider must maintain documentation of the date, times, services that were provided, and specific circumstances which prevented provision of all of the scheduled services.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, in-home residential support service providers must be licensed by DMHMRSAS as a provider of residential services or supportive residential services. They must also have training in the characteristics of developmental disabilities and appropriate interventions, strategies, and support methods for persons with developmental disabilities and functional limitations.

1. For DMHMRSAS licensed programs, a POC and ongoing documentation must be consistent with licensing regulations.

2. During the period when a 60-day assessment is used, documentation must confirm attendance, the amount of time in services and provide specific information regarding the recipient's response to various settings and supports as agreed to in the POC objectives. Assessment results must be available in at least a daily note or a weekly summary. Data must be collected as described in the POC, analyzed, summarized, and then, clearly addressed in the regular POC.

3. The POC must be reviewed by the provider with the recipient, and this review submitted to the support coordinator, at least quarterly, with goals, objectives, and activities modified as appropriate.

4. Documentation must be maintained for routine supervision and oversight of all in-home residential support staff. All significant contacts as described in this section must be documented.

5. Documentation must be completed and signed by the staff person designated to perform the supervision and oversight and include:

a. Date of contact or observation.

b. Person or persons contacted or observed.

c. A note regarding staff performance and POC service delivery for monthly contact and quarterly home visits.

d. Quarterly observation documentation must also address recipient satisfaction with service provision.

e. Any action planned or taken to correct problems identified during supervision and oversight.

12 VAC 30-120-751. Reserved.

12 VAC 30-120-752. Day support services.

A. Service description. Day support services shall include a variety of training, support, and supervision offered in a setting (other than the home or recipient residence), which allows peer interactions and community integration. If prevocational services are offered, the plan of care must contain documentation regarding whether prevocational services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 730), or in special education services through the Individuals with Disabilities Education Act (20 U.S.C. §§ 1400 through 1487). When services are provided through these sources, the plan of care shall not authorize them as a waiver funded expenditure. Compensation for prevocational services can only be made when the recipient's productivity is less than 50% of the minimum wage. Service providers are reimbursed only for the amount and type of day support services included in the recipient's approved plan of care based on the setting, intensity, and duration of the service to be delivered.

B. Criteria. For day support services, recipients shall have demonstrated the need for functional training, assistance, and specialized training offered in settings other than the recipient's own residence which allow an opportunity for being productive and contributing members of communities. In addition, day support services will be available for recipients who cannot benefit from supported employment services and who need the services for: accessing in-home supported living services; or increasing levels of independent skills within current daily living situations; or sustaining skills necessary for continuing the level of independence in current daily living situations.

1. A functional assessment should be conducted by the provider to evaluate each recipient in his home environment and community settings.

2. Levels of day support. The amount and type of day support included in the recipient's plan of care is determined according to the services required for that recipient. There are two types of day support: center-based, which is provided partly or entirely in a segregated setting, or non-center-based, which is provided entirely in community settings. Both types of

day support may be provided at either intensive or regular levels. To be authorized at the intensive level, the recipient must have extensive disability-related difficulties and require additional, ongoing support to fully participate in programming and to accomplish his service goals; or the recipient requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

C. Service units and service limitations. Day support cannot be regularly or temporarily (e.g., due to inclement weather or recipient illness) provided in a recipient's home or other residential setting without written prior approval from DMAS. Non-center-based day support services must be separate and distinguishable from either in-home residential support services or personal assistance services. There must be separate POCs and separate documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The POC must provide an estimate of the amount of day support required by the recipient. The maximum is 780 units per calendar year. Transportation shall not be billable as a day support service.

1. One unit shall be 1 to 3.99 hours of service a day.

2. Two units are 4 to 6.99 hours of service a day.

3. Three units are 7 or more hours of service a day.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, day support providers need to meet additional requirements.

1. For DMHMRSAS licensed programs, a POC and ongoing documentation must be consistent with licensing regulations. For non-DMHMRSAS licensed programs, there must be a POC, which contains, at a minimum, the following elements:

a. The recipient's strengths, desired outcomes, required or desired supports and training needs;

b. The recipient's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

d. All individuals or organizations that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the recipient's goals and objectives;

f. The estimated duration of the recipient's needs for services; and

g. The individual or individuals responsible for the overall coordination and integration of the services specified in the plan.

2. During a period when a 60-day assessment is used, documentation must confirm the recipient's attendance and amount of time in services and provide specific information regarding the recipient's response to various settings and supports as agreed to in the POC objectives. Assessment results shall be available in at least a daily note or a weekly summary.

a. The POC must be reviewed by the provider with the recipient, and this review submitted to the support coordinator, at least quarterly, with goals, objectives, and activities modified as appropriate.

b. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and the number of hours and units provided (including specific time frame).

c. Documentation must indicate whether the services were center-based or non-center-based.

d. If high intensity day support services are requested, in order to verify which of these criteria the recipient met, documentation must be present in the recipient's record to indicate the specific supports and the reasons they are needed. For reauthorization of high intensity day support services, there must be clear documentation of the ongoing needs and associated staff supports.

12 VAC 30-120-753. Reserved.

12 VAC 30-120-754. Supported employment services.

A. Service description.

1. Supported employment services shall include training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized training to enable a recipient to maintain paid employment. Each POC must contain documentation regarding whether supported employment services are available in vocational rehabilitation agencies through the Rehabilitation Act of 1973 or in special education services through 20 U.S.C. § 1401 of the Individuals with Disabilities Education Act. Providers of these DRS and IDEA services cannot be reimbursed by Medicaid with the IFDDS waiver funds. Waiver service providers are reimbursed only for the amount and type of habilitation services included in the recipient's approved POC based on the intensity and duration of the service delivered. Reimbursement shall be limited to actual interventions by the provider of supported employment, not for the amount of time the recipient is in the supported employment environment.

2. Supported employment can be provided in one of two models. Recipient supported employment is defined as intermittent support, usually provided one on one by a job coach to a recipient in a supported employment position. Group supported employment is defined as continuous support provided by staff to eight or fewer recipients with disabilities in an enclave, work crew, or bench work/entrepreneurial model. The recipient's assessment and POC must clearly reflect the recipient's need for training and supports.

B. Criteria for receipt of services.

1. Only job development tasks that specifically include the recipient are allowable job search activities under the IFDDS waiver supported employment and only after determining this service is not available from DRS.

2. In order to qualify for these services, the recipient shall have a demonstrated need for training, specialized supervision, or assistance in paid employment and for whom competitive employment at or above the minimum wage is unlikely without this support and who, because of the disability, needs ongoing support, including supervision, training and transportation to perform in a work setting.

3. A functional assessment should be conducted to evaluate each recipient in his home environment and community settings.

4. The plan of care must provide the amount of supported employment required by the recipient. Service providers are reimbursed only for the amount and type of supported employment included in the recipient's POC.

C. Service units and service limitations.

1. Supported employment for recipient job placement will be billed on an hourly basis. Transportation shall not be billable as a supported employment service.

2. Group models of supported employment (enclaves, work crews and entrepreneurial model of supported employment) will be billed at the unit rate.

a. One unit is 1 to 3.99 hours of service a day.

b. Two units are 4 to 6.99 or more hours of service a day.

c. Three units are 7 or more hours of service a day.

3. For the recipient job placement model, reimbursement of supported employment will be limited to actual documented interventions or collateral contacts by the provider, not for the amount of time the recipient is in the supported employment situation.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications are:

1. Supported employment services shall be provided by agencies that are either licensed by the DMHMRSAS as a day support service or are vendors of extended employment services, long-term employment support services or supportive employment services for the DRS.

2. Recipient ineligibility for DRS or Special Education services must be documented in the recipient's record, as applicable. If the recipient is older than 22 years, and therefore not eligible for Special Education funding, documentation is required only for lack of DRS funding. Acceptable documentation would include a copy of a letter from DRS or the local school system or a record of a phone call (name, date, person contacted) documented in the support coordinator's case notes, Consumer Profile/Social assessment or on the annual supported employment POC. Unless the recipient's circumstances change, the original verification can be forwarded into the current record or repeated on the POC or revised Consumer Profile/Social Assessment on an annual basis.

3. A POC and ongoing documentation consistent with licensing regulations, if a DMHMRSAS licensed program.

4. For non-DMHMRSAS licensed support programs, there must be a POC that contains, at a minimum, the following elements:

a. The recipient's strengths, desired outcomes, required/desired supports and training needs;

b. The recipient's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

d. All individuals or organizations that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the recipient's goals and objectives.

f. The estimated duration of the recipient's needs for services;

g. Individuals responsible for the overall coordination and integration of the services specified in the plan.

5. During the 60-day assessment period, documentation must confirm attendance and provide specific information regarding the recipient's response to various settings and supports as agreed to in the POC objectives. Assessment results should be available in at least a daily note or weekly summary.

6. The POC must be reviewed by the provider with the recipient, and this review submitted to the support coordinator, at least quarterly, with goals, objectives and activities modified as appropriate.

12 VAC 30-120-755. Reserved.

12 VAC 30-120-756. Therapeutic consultation.

A. Service description. Therapeutic consultation is available under the waiver for Virginia licensed or certified practitioners in psychology, social work, occupational therapy, physical therapy, therapeutic recreation, rehabilitation engineering, and speech therapy. Behavior consultation performed by these individuals may also be a covered waiver service. These services may be provided, based on the recipient plan of care, for those recipients for whom specialized consultation is clinically necessary to enable their utilization of waiver services. Therapeutic consultation services, other than behavior consultation, may be provided in in-home residential or day support settings or in office settings in conjunction with another waiver service. Only behavior consultation may be offered in the absence of any other waiver service when the consultation provided to informal caregivers is determined to be necessary to prevent

institutionalization. Therapeutic consultation service providers are reimbursed according to the amount and type of service authorized in the POC based on an hourly fee for service.

B. Criteria. In order to qualify for these services, the recipient shall have a demonstrated need for consultation in any of these services. Documented need indicates that the Plan of Care could not be implemented effectively and efficiently without such consultation from this service.

1. The recipient's POC must clearly reflect the recipient's needs, as documented in the social assessment, for specialized consultation provided to caregivers in order to implement the plan of care effectively.

2. Therapeutic consultation services may not include direct therapy provided to waiver recipients, nor duplicate the activities of other services that are available to the recipient through the State Plan of Medical Assistance.

C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the POC. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, professionals rendering therapeutic consultation services, including behavior consultation services, shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation engineering shall be contracted with DRS.

1. POC for therapeutic consultation. The standard therapeutic consultation POC must be used for this purpose. The following information is required on the POC:

a. Identifying information; recipient's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for POC; and quarterly review dates, if applicable;

b. Targeted objectives/time frames/expected outcomes;

c. Specific consultation; and

d. The expected products.

2. Monthly and contact notes shall include:

a. Summary of consultative activities for the month;

b. Dates, locations, and times of service delivery;

c. POC objectives addressed;

d. Specific details of the activities conducted;

e. Services delivered as planned or modified; and

f. Effectiveness of the strategies and recipients' and caregivers' satisfaction with service.

3. Quarterly reviews are required by the service provider if consultation extends three months or longer and are to be forwarded to the support coordinator and include:

a. Activities related to the therapeutic consultation POC;

b. Recipient status and satisfaction with services; and

c. Consultation outcomes and effectiveness of support plan.

4. If consultation services extend less than 3 months, the provider must forward monthly/contact notes or a summary of them to the support coordinator for the quarterly review.

5. A written support plan, detailing the interventions and strategies for staff, family or caregivers to use to better support the recipient in the service.

6. A final disposition summary must be forwarded to the support coordinator within 30 days following end of this service and must include:

a. Strategies utilized;

b. Objectives met;

c. Unresolved issues; and

d. Consultant recommendations.

12 VAC 30-120-757. Reserved.

12 VAC 30-120-758. Environmental modifications.

A. Service description. Environmental modifications shall be available to recipients who are receiving at least one other waiver service. Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repairs, central air conditioning, etc. Adaptations which add to the total square footage of the home shall be excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Modifications can be made to a vehicle if it is the primary vehicle being used by the individual.

B. Criteria. In order to qualify for these services, the recipient shall have a demonstrated need for equipment or modifications of a remedial or medical benefit offered primarily in a recipient's home, vehicle, community activity setting, or day program to specifically improve the recipient's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical

Assistance or through another program (e.g., DRS or the Consumer Service Fund).

C. Service units and service limitations. A maximum limit of $5,000 may be reimbursed per calendar year. Costs for environmental modifications shall not be carried over from year to year.

D. Provider requirements. In addition to meeting the general conditions and requirements for HCBC participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, environmental modifications shall be provided in accordance with all applicable state or local building codes by contractors of DMAS or DRS who shall be reimbursed for the amount charged by said contractors.

12 VAC 30-120-759. Reserved.

12 VAC 30-120-760. Skilled nursing services.

A. Service Description. Skilled nursing services shall be provided for recipients with serious medical conditions and complex health care needs who require specific skilled nursing services that cannot be provided by non-nursing personnel. Skilled nursing may be provided in the recipient's home or other community setting on a regularly scheduled or intermittent need basis.

B. Criteria. In order to qualify for these services, the recipient shall have demonstrated complex health care needs, which require specific skilled nursing services which are ordered by a physician and which cannot be otherwise accessed under the Title XIX State Plan for Medical Assistance. The recipient's plan of care must stipulate that this service is necessary in order to prevent institutionalization.

C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in hourly units. Recipients may receive up to 250 hours of skilled nursing services per calendar year without prior authorization.

D. Provider requirements. Skilled nursing services shall be provided by either a DMAS certified private duty nursing or home health provider or by a licensed registered nurse or licensed practical nurse contracted or employed by a Community Services Board. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications to be approved for skilled nursing contracts include:

1. Being a home health agency certified by the VDH for Medicaid participation, with which DMAS has a contract for private duty nursing.

2. Demonstrating a prior successful health care delivery business or practice;

3. Operating from a business office;

4. Employing or subcontracting with and directly supervising a registered nurse (RN) or a licensed practical nurse (LPN) with a current and valid license issued by the Virginia State Board of Nursing. The RN or LPN shall have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, or nursing home.

12 VAC 30-120-761. Reserved.

12 VAC 30-120-762. Assistive technology.

A. Service description. Assistive technology is available to recipients who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting.

B. Criteria. In order to qualify for these services, the recipient shall have a demonstrated need for equipment or modification for remedial or medical benefit primarily in a recipient's home, vehicle, community activity setting, or day program to specifically serve to improve the recipient's personal functioning. This shall encompass those items not otherwise covered under the State Plan.

C. Service units and service limitations. A maximum limit of $5,000 may be reimbursed per calendar year. Costs for assistive technology shall not be carried over from year to year.

D. Provider requirements. In addition to meeting the general conditions and requirements for HCBC participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, assistive technology shall be provided by agencies under contract with the DMAS as durable medical equipment and supply providers.

12 VAC 30-120-763. Reserved.

12 VAC 30-120-764. Crisis stabilization services.

A. Service Description. Crisis stabilization services shall provide, as appropriate, neuropsychological, psychiatric, psychological and functional assessments and stabilization, medication management and behavior assessment and support, and intensive care coordination with other agencies and providers. These services shall be provided to:

1. Assist planning and delivery of services and supports to maintain community placement of the recipient;

2. Training of family members and other care givers and service providers in positive behavioral supports to maintain the recipient in the community;

3. Temporary crisis supervision to ensure the safety of the recipient and others; and

4. Crisis stabilization services shall not be used for continuous long-term care. Room and board and general supervision are not components of this service.

B. Criteria.

1. In order to receive crisis stabilization services, the recipient must meet at least one of the following criteria:

a. The recipient is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;

b. The recipient is experiencing extreme increase in emotional distress;

c. The recipient needs continuous intervention to maintain stability; or

d. The recipient is causing harm to self or others.

2. The recipient must be at risk of at least one of the following:

a. Psychiatric hospitalization;

b. Emergency ICF/MR placement;

c. Disruption of community status (living arrangement, day placement, or school); or

d. Causing harm to self or others.

C. Service units and service limitations. Crisis stabilization services must be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional.

1. The unit for each component of the service shall equal one hour. This service may be authorized for a maximum period of 15 days and no more than 60 days in a calendar year. The actual service units per episode shall be based on the documented clinical needs of the recipients being served. Extension of services, beyond the 15-day limit per authorization, must be authorized following a documented face-to-face reassessment conducted by a qualified professional.

2. Crisis stabilization services may be provided directly in, but shall not be limited to, the following settings:

a. The home of a recipient who lives with family or other primary caregiver or caregivers;

b. The home of a recipient who lives independently or semi-independently to augment any current services and support;

c. A community-based residential program to augment current services and supports;

d. A day program or setting to augment current services and supports; or

e. A respite care setting to augment current services and supports.

3. Crisis stabilization may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided face-to-face with the recipient.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications are:

1. Crisis stabilization services shall be provided by agencies licensed by DMHMRSAS as a provider of outpatient, residential, supportive residential services, or day support services. The provider agency must employ or utilize qualified licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and related activities to recipients with developmental disabilities who are experiencing serious behavioral problems.

2. A crisis stabilization POC must be developed (or revised, if requesting an extension) and submitted to the support coordinator for authorization within 72 hours of assessment or reassessment.

3. Documentation indicating the dates and times of crisis stabilization services and amount and type of service provided must be recorded in the recipient's record.

4. Documentation of qualifications of providers must be maintained for review by DMAS staff. This service shall be designed to stabilize the recipient and strengthen the current semi-independent living situation, or situation with family or other primary care givers so the recipient can be maintained during and beyond the crisis period.

12 VAC 30-120-765. Reserved.

12 VAC 30-120-766. Personal care services.

A. Service description. Personal care services may be offered to recipients in their homes and communities as an alternative to more costly institutional care. This service shall provide care to recipients with activities of daily living, medication or other medical needs or the monitoring of health status or physical condition.

B. Criteria. In order to qualify for these services, the individual shall have demonstrated a need for such personal care.

C. Service units and service limitations. Recipients can have personal care and in-home residential support services in their service plan but cannot receive in-home residential supports and personal care services at the same time. The recipient must have an emergency back-up plan in case the personal care aide does not show up for work as expected.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, personal care providers must meet additional provider requirements.

1. Personal care services shall be provided by a DMAS certified personal care provider or by a DMHMRSAS licensed residential support provider.

2 The personal care provider shall:

a. Demonstrate a prior successful health care delivery business.

b. Operate from a business office.

c. Employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all personal care aides.

(1) The supervising RN and LPN shall be currently licensed to practice in the Commonwealth and have at least 2 years of related clinical nursing experience which may include work in an acute care hospital,

public health clinic, home health agency, or nursing facility.

(2) The RN supervisor shall make an initial assessment home visit prior to the start of care for all new recipients admitted to personal care.

(3) The RN or LPN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services. A minimum frequency of these visits is every 30 - 90 days depending on recipient needs.

(4) The supervising RN or LPN summary shall note:

(a) Whether personal care services continue to be appropriate;

(b) Whether the plan is adequate to meet the need or changes are indicated in the plan;

(c) Any special tasks performed by the aide and the aide's qualifications to perform these tasks;

(d) Recipient's satisfaction with the service;

(e) Hospitalization or change in medical condition or functioning status;

(f) Other services received and their amount; and

(g) The presence or absence of the aide in the home during the RN's or LPN's visit.

(5) Employ and directly supervise personal care aides who will provide direct care to personal care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by the DMAS. Each aide:

(a) Shall be able to read and write;

(b) Shall complete 40 hours of training consistent with the DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards;

(c) Shall be physically able to do the work;

(d) Shall have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect or exploitation of aged or incapacitated adults and children; and

(e) Shall not be a member of the recipient's family (e.g., family is defined as parents, spouses, children, siblings, grandparents, legal guardian, and grandchildren).

3. Provider inability to render services and substitution of aides.

a. When a personal care aide is absent and the agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients. The agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient to another agency.

b. During temporary, short-term lapses in coverage not to exceed two weeks in duration, the following procedure shall apply:

(1) The personal care agency having recipient responsibility shall provide the RN or LPN supervision for the substitute aide.

(2) The agency providing the substitute aide shall send a copy of the aide's signed daily records signed by the recipient to the personal care agency having recipient care responsibility.

(3) The provider agency having recipient responsibility shall bill DMAS for services rendered by the substitute aide.

c. If a provider agency secures a substitute aide, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS' requirements.

4. Required documentation in recipients' records. The provider agency shall maintain all records of each personal care recipient. At a minimum these records shall contain:

a. The most recently updated Level of Functioning Survey (LOF) and addendum, the Screening Authorization, the recipient choice form, all provider agency plans of care, and all DMAS-122 forms;

b. All the DMAS utilization review forms and plans of care;

c. Initial assessment by the RN supervisory nurse completed prior to or on the date services are initiated;

d. Nurses notes recorded and dated during any contacts with the personal care aide and during supervisory visits to the recipient's home;

e. All correspondence to the recipient and to DMAS;

f. Reassessments made during the provision of services; and

g. Contacts made with family, physicians, DMAS, formal and informal service providers and all professionals concerning the recipient.

h. All personal care aide records. The personal care aide record shall contain:

(1) The specific services delivered to the recipient by the aide and the recipient's responses;

(2) The aide's arrival and departure times;

(3) The aide's weekly comments or observations about the recipient to include observations of the

recipient's physical and emotional condition, daily activities, and responses to services rendered;

(4) The aide's and recipient's weekly signatures to verify that personal care services during that week have been rendered, and

i. Signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

12 VAC 30-120-767. Reserved.

12 VAC 30-120-768. Respite care services.

A. Service description. Respite care means services specifically designed to provide a temporary but periodic or routine relief to the primary caregiver of a recipient who is incapacitated or dependent due to physical disability. Respite care services includes assistance with personal hygiene, nutritional support and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver. Persons can have respite care and in-home residential support services in their service plan but cannot receive in-home residential supports and respite care services simultaneously.

B. Criteria. Respite care may only be offered to recipients who have a primary caregiver living in the home who requires temporary relief to avoid institutionalization of the recipient. Respite care is designed to focus on the need of the caregiver for temporary relief and to help prevent the breakdown of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the dependent recipient.

C. Service units and service limitations. Respite care services are limited to a maximum of 30 days or 720 hours per year.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications include, but are not limited to:

1. Respite care services shall be provided by a DMAS certified personal care provider; a DMHMRSAS licensed supportive in-home residential support provider, respite care services provider (ICF/MR) or in-home respite care provider.

2. The respite care provider shall employ or subcontract with and directly supervise an RN and an LPN who will provide ongoing supervision of all respite care aides.

a. The RN and LPN shall be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.

b. Based on continuing evaluations of the aides' performance and recipients' needs, the RN and LPN supervisor shall identify any gaps in the aides' ability to function competently and shall provide training as indicated.

c. The RN supervisor shall make an initial assessment visit prior to the start of care for any recipient admitted to respite care.

d. The RN or LPN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of these supervisory visits shall be every 30 days.

(2) When respite care services are not received on a routine basis, but are episodic in nature, the RN or LPN shall not be required to conduct a supervisory visit every 30 days. Instead, the nurse supervisor shall conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period.

(3) When respite care services are routine in nature and offered in conjunction with personal care, the 30-day supervisory visit conducted for personal care may serve as the RN or LPN visit for respite care. However, the RN or LPN supervisor shall document supervision of respite care separately. For this purpose, the same recipient record can be used with a separate section for respite care documentation.

e. The RN or LPN shall document in a summary note:

(1) Whether respite care services continue to be appropriate.

(2) Whether the plan of care is adequate to meet the recipient's needs or if changes need to be made.

(3) The recipient's satisfaction with the service.

(4) Any hospitalization or change in medical condition or functioning status.

(5) Other services received and their amount.

(6) The presence or absence of the aide in the home during the visit.

3. Employ and directly supervise respite care aides who provide direct care to respite care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications. Each aide:

a. Shall be able to read and write;

b. Shall have completed 40 hours of training consistent with the DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with the DMAS standards;

c. Shall be evaluated in his job performance by the RN or LPN supervisor;

d. Shall have the physical ability to do the work;

e. Shall have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect or exploitation of aged or incapacitated adults or children; and

f. Shall not be a member of a recipient's family (family is defined as parents, spouses, siblings, legal guardian, grandparents, and grandchildren).

4. Inability to provide services and substitution of aides. When a respite care aide is absent and the respite care provider agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients.

a. If a provider agency cannot supply a respite care aide to render authorized services, the agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient's care to another agency.

b. If no other provider agency is available who can supply an aide, the provider agency shall notify the recipient or family so that they may contact the support coordinator to request a screening if ICF/MR placement is desired.

c. During temporary, short-term lapses in coverage, not to exceed two weeks in duration, a substitute aide may be secured from another respite care provider agency or other home care agency. Under these circumstances, the following requirements shall apply:

(1) The respite care agency having recipient responsibility shall be responsible for providing the RN or LPN supervision for the substitute aide.

(2) The respite care agency having recipient care responsibility shall obtain a copy of the aide's daily records signed by the recipient and the substitute aide from the respite care agency providing the substitute aide. All documentation of services rendered by the substitute aide shall be in the recipient's record. The documentation of the substitute aide's qualifications shall also be obtained and recorded in the personnel files of the agency having recipient care responsibility. The two agencies involved shall negotiate the financial arrangements of paying the substitute aide.

(3) The provider agency having recipient responsibility shall bill the DMAS for services rendered by the substitute aide.

d. Substitute aides obtained from other agencies may be used only in cases where no other arrangements can be made for recipient respite care services coverage and may be used only on a temporary basis. If a substitute aide is needed for more than two weeks, the case shall be transferred to another respite care provider agency that has the aide capability to serve the recipient or recipients.

5. Required documentation for recipients' records. The provider agency shall maintain all records of each respite care recipient. These records shall be separated from those of other non-home and community-based care services, such as companion services or home health. These records shall be reviewed periodically by the DMAS staff. At a minimum these records shall contain:

(a) DMAS service authorization form, all respite care assessment and Plans of Care, and all DMAS-122s;

(b) All DMAS utilization review forms and Plans of Care;

(c) Initial assessment by the RN or LPN supervisory nurse completed prior to or on the date services are initiated;

(d) Nurse's notes recorded and dated during significant contacts with the respite care aide and during supervisory visits to the recipient's home;

(e) All correspondence to the recipient and to the DMAS;

(f) Reassessments made during the provision of services;

(g) Significant contacts made with family, physicians, the DMAS, and all professionals concerning the recipient;

6. Respite care aide record of services rendered and recipient's responses. The aide record shall contain:

(a) The specific services delivered to the recipient by the respite care aide and the recipient's response.

(b) The arrival and departure time of the aide for respite care services only.

(c) Comments or observations recorded weekly about the recipient. Aide comments shall include but not be limited to observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to services rendered.

(d) The signature of the aide and the recipient once each week to verify that respite care services have been rendered.

(e) Signature, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

7. Copies of all aide records shall be subject to review by State and federal Medicaid representatives.

12 VAC 30-120-769. Reserved.

12 VAC 30-120-770. Consumer-directed services: Attendant care and consumer-directed respite care.

A. Service definition.

1. Attendant services include hands-on care specific to the needs of a medically stable, physically disabled recipient. Attendant care includes assistance with ADLs, bowel/bladder programs, range of motion exercises, routine wound care which does not include sterile technique, and external catheter care. Supportive

services are those, which substitute for the absence, loss, diminution, or impairment of a physical function. When specified, supportive services may include assistance with instrumental activities of daily living (IADLs) which are incidental to the care furnished, or which are essential to the health and welfare of the recipient. Attendant care shall not include either practical or professional nursing services or those practices as regulated in Chapters 30 and 34 of Subtitle III of Title 54.1 of the Code of Virginia, as appropriate. Recipients can have attendant care and in-home residential support services in their service plan but cannot simultaneously receive these two services.

2. Consumer-directed respite care means services specifically designed to provide a temporary but periodic or routine relief to the primary caregiver of a recipient who is incapacitated or dependent due to frailty or physical disability. Respite care services includes assistance with personal hygiene, nutritional support, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver.

3. DMAS shall contract for the services of a fiscal agent for attendant care and consumer-directed respite care services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the recipient/employer who is receiving attendant care or consumer-directed respite care. The fiscal agent will handle responsibilities for the recipient for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

B. Criteria.

1. In order to qualify for these services, the recipient shall have demonstrated a need for personal care in activities of daily living, medication, or other medical needs, or monitoring health status or physical condition.

2. Respite care may only be offered to recipients who have a primary caregiver living in the home who requires temporary relief to avoid institutionalization of the recipient and is designed to focus on the need of the caregiver for temporary relief.

3. Attendant care and consumer-directed respite services shall be available to recipients who must be mentally alert and have no cognitive impairments who would otherwise require the level of care provided in an ICF/MR. If 18 years of age or older, recipients must be able to manage their own affairs without help and not have a legal guardian. If recipients receiving services are under 18 years of age, the legal guardian or parent will act on behalf of the minor. Recipients (and their parent or legal guardian, if minors) who are eligible for attendant care and consumer-directed respite care must have the capability to hire and train their own personal attendants and supervise the attendant's performance.

4. Responsibilities as employer. The recipient is the employer in this service, and is responsible for hiring, training, supervising, and firing personal attendants. If the recipient is a minor, the recipient's parent or legal guardian will serve on behalf of the recipient and monitor the recipient's care. Specific duties include checking references of personal attendants, determining that personal attendants meet basic qualifications, training personal attendants, supervising the personal attendant's performance, and submitting timesheets to the service coordinator and fiscal agent on a consistent and timely basis. The recipient must have an emergency back-up plan in case the personal attendant does not show up for work as expected or terminates employment without prior notice.

C. Service units and service limitations.

1. Respite care services are limited to a maximum of 30 days or 720 hours per calendar year.

2. Recipients can have consumer-directed personal care and attendant care and in-home residential support services in their service plans but cannot simultaneously receive these services.

3. For attendant care and consumer-directed respite care services, recipients will hire their own personal attendants and manage and supervise the attendants' performance.

a. The attendant must the following requirements:

(1) Be 18 years of age or older;

(2) Have the required skills to perform attendant care services as specified in the recipient's POC;

(3) Possess basic math, reading, and writing skills;

(4) Possess a valid Social Security number;

(5) Submit to a criminal records check and, if the recipient is a minor, the child protective services registry. The personal attendant will not be compensated for services provided to the recipient if the records check verifies the personal attendant has been convicted of crimes described in the Code of Virginia § 32.1-162.9:1 or if the personal attendant has a complaint confirmed by the DSS child protective services registry.

(6) Be willing to attend training at the recipient's or family's request;

(7) Understand and agree to comply with the DMAS IFDDS waiver requirements; and

(8) Be willing to register in a personal attendant registry which will be maintained by the service coordinator chosen by the recipient or recipient's parent/guardian.

4. Restrictions. Attendants shall not be members of the recipients' family. Family is defined as a parent or stepparent, spouse, children or stepchildren, legal guardian, siblings or stepsiblings, grandparents or stepgrandparents, grandchildren, or stepgrandchildren.

5. Retention, hiring, and substitution of attendants. Upon the recipient's request, the service coordination

provider shall provide the recipient with a list of persons on the personal attendant registry who can provide temporary assistance until the attendant returns or the recipient or recipient's parent/legal guardian is able to select and hire a new personal attendant. If a recipient or recipient's parent/legal guardian is consistently unable to hire and retain the employment of an attendant to provide attendant or consumer-directed respite services, the service coordination provider must contact the support coordinator and DMAS to transfer the recipient, at the recipient's choice, to a provider which provides Medicaid-funded agency-directed personal care or respite care services. The service coordination provider will make arrangements with the support coordinator to have the recipient transferred.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications are:

1. To be enrolled as a Medicaid service coordination provider and maintain provider status, the service coordination provider shall operate from a business office and have sufficient qualified staff who will function as service coordinators to perform the needed plans of care development and monitoring, reassessments, service coordination, and support activities as required. It is preferred that the employee of the service coordination provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the recipient have two years of satisfactory experience in the human services field working with persons with severe physical disabilities or the elderly. The recipient shall possess a combination of work experience and relevant education, which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented on the application form, found in supporting documentation. or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities shall include:

a. Knowledge of:

(1) Types of functional limitations and health problems that are common to different disability types and the aging process as well as strategies to reduce limitations and health problems;

(2) Physical assistance typically required by people with severe physical disabilities or elderly persons, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications commonly used and required by people with physical disabilities or elderly persons which reduces the need for human help and improves safety;

(4) Various long-term care program requirements, including nursing home and adult care residence placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance services;

(5) IFDDS waiver requirements, as well as the administrative duties for which the recipient will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;

(7) Interviewing techniques;

(8) The recipient's right to make decisions about, direct the provisions of, and control his attendant care and consumer-directed respite care services, including hiring, training, managing, approving time sheets, and firing an attendant;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with recipients and service providers;

(2) Observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to persons with developmental disabilities; and

(4) Identifying services within the established services system to meet the recipient's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for persons who have visual impairments;

(2) Demonstrate a positive regard for recipients and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, verbally and in writing; and

(6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds.

2. If the service coordination staff employed by the service coordination provider is not an RN, the service coordination provider must have RN consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. The RN consultant is to be available as needed to consult with recipients/service coordination providers on issues related to the health needs of the recipient.

3. Initiation of services and service monitoring.

a. Attendant care services. The service coordination provider must make an initial, comprehensive home

visit to develop the POC with the recipient and provide management training. After the initial visit, two routine onsite visits must occur in the recipient's home within 60 days of the initiation of care or the initial visit to monitor the POC. The service coordination provider will continue to monitor the POC on an as needed basis, not to exceed a maximum of one routine onsite visit every 30 days but no less than the minimum of one routine onsite visit every 90 days per recipient. The initial comprehensive visit is done only once upon the recipient's entry into the service. If a waiver recipient changes service coordination agencies, the new service coordination provider shall bill for a reassessment in lieu of a comprehensive visit.

b. Consumer-directed respite services. The service coordination provider must make an initial, comprehensive home visit to develop the POC with the recipient or parent/legal guardian and will provide management training. After the initial visit, the service coordinator will periodically review the utilization of services at a minimum of every six months or upon the use of 300 respite care hours. The initial comprehensive visit is done only once upon the recipient's entry into the service. If a waiver recipient changes service coordination agencies, the new service coordination provider shall bill for a reassessment in lieu of a comprehensive visit.

4. Service coordinator reassessments for consumer-directed respite and attendant care. A reassessment of the recipient's level of care will occur six months after initial entry into the program, and subsequent reevaluations will occur at a minimum of every six months. During visits to the recipient's home, the service coordination provider shall observe, evaluate, and document the adequacy and appropriateness of personal attendant services with regard to the recipient's current functioning and cognitive status, medical, and social needs. The service coordination provider's summary shall include, but not necessarily be limited to:

a. Whether attendant care or consumer-directed respite care services continue to be appropriate and medically necessary to prevent institutionalization;

b. Whether the plan of care is adequate to meet the recipient's needs;

c. Any special tasks performed by the attendant and the attendant's qualifications to perform these tasks;

d. Recipient's satisfaction with the service;

e. Hospitalization or change in medical condition, functioning, or cognitive status;

f. Other services received and their amount; and

g. The presence or absence of the attendant in the home during the service coordinator's visit.

5. The service coordination provider shall be available to the recipient by telephone.

6. The service coordination provider will submit a criminal record check pertaining to the personal attendant on behalf of the recipient and report findings of the criminal record check to the recipient or the recipient's legal guardian/parent and the program's fiscal agent. Personal attendants will not be reimbursed for services provided to the recipient effective with the date the criminal record check confirms a personal attendant has been found to have been convicted of a crime as described in the § 32.1-162.9:1 of the Code of Virginia. If the recipient is a minor, the personal attendant must also be screened through the DSS child protective services registry.

7. The service coordination provider shall verify bi-weekly timesheets signed by the recipient or the legal guardian/parent and the personal attendant to ensure that the number of POC approved hours are not exceeded. If discrepancies are identified, the service coordination provider will contact the recipient to resolve discrepancies and will notify the fiscal agent. If a recipient is consistently being identified as having discrepancies in his timesheets, the service coordination provider will contact the support coordinator to resolve the situation. The service coordination provider shall not verify timesheets for personal attendants who have been convicted of crimes described in the § 32.1-162.9:1 of the Code of Virginia and will notify the fiscal agent.

8. Personal attendant registry. The service coordination provider shall maintain a personal attendant registry.

9. Required documentation in recipients' records. The service coordination provider shall maintain all records of each recipient. At a minimum these records shall contain:

a. All copies of the Level of Functioning (LOF) Survey and its addendum, the screening authorization form (DMAS-96), the recipient choice form, all plans of care, and all DMAS-122 forms.

b. All DMAS utilization review forms.

c. Service coordination provider's notes contemporaneously recorded and dated during any contacts with the recipient and during visits to the recipient's home.

d. All correspondence to the recipient and to DMAS.

e. Reassessments made during the provision of services.

f. Records of contacts made with family, physicians, DMAS, formal and informal service providers, and all professionals concerning the recipient.

g. All training provided to the personal attendant or attendants on behalf of the recipient.

h. All management training provided to the recipients, including the recipient's responsibility for the accuracy of the timesheets.

i. All documents signed by the recipient or the recipient's parent or legal guardian which acknowledge the responsibilities of the services.

12 VAC 30-120-771. Reserved.

12 VAC 30-120-772. Family and caregiver training.

A. Service Description. Family and caregiver training shall be the provision of identified training and education related to disabilities, community integration, family dynamics, stress management, behavior interventions and mental health to a parent, other family members or primary caregiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver recipient, and may include a parent, spouse, children, relatives, a legal guardian, foster family, or in-laws. "Family" does not include individuals who are employed to care for the recipient. All family training must be included in the recipient's written POC.

B. Criteria. The need for the training and the content of the training in order to assist family or caregivers with maintaining the recipient at home must be documented in the recipient's POC. The training must be necessary in order to improve the family or caregiver's ability to give care.

C Service units and service limitations. Services will be billed hourly and must be prior authorized for services billed beyond 40 hours per calendar year.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications include:

1. Family and caregiver training shall be provided on an individual basis, in small groups or through seminars and conferences provided by Medicaid certified family and caregiver training providers. Such training may only be billed as it is rendered, for example, billed as individual training when rendered to an individual, or billed as a group when rendered to a group of individuals.

2. Family and caregiver training must also be provided by practitioners or individuals with expertise who work for an agency with experience in or demonstrated knowledge of the training topic and who work for an agency or organization that has a provider agreement with DMAS to provide these services.

12 VAC 30-120-773. Reserved.

12 VAC 30-120-774. Personal Emergency Response System (PERS).

A. Service Description. PERS is a service which electronically monitors recipient safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line.

B. Criteria. PERS can be authorized when no one else is in the home that is competent and continuously available to call for help in an emergency. If the recipient's caregiver has a business in the home, such as a day care center, PERS will only be approved if the recipient is evaluated as being dependent in orientation and behavior pattern.

C. Service units and service limitations.

1. A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, and monitoring of the PERS. A unit of service is one-month rental price set by DMAS. The one time installation of the unit shall include installation, account activation, recipient and caregiver instruction, and removal of equipment.

2. PERS services shall be capable of being activated by a remote wireless device and be connected to the recipient's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device shall be waterproof, shall automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and shall be able to be worn by the recipient.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications include, but are not limited to:

1. A PERS provider shall be a certified home health or personal care agency, a durable medical equipment provider, a hospital or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e. installation, equipment maintenance and service calls), and PERS monitoring.

2. The PERS provider must provide an emergency response center staff with fully trained operators that are capable of receiving signals for help from a recipient's PERS equipment 24-hours a day, 365, or 366 as appropriate, days per year; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS recipient needs emergency help.

3. A PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

4. The PERS provider shall have the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the recipient's notification of a malfunction of the console unit, activating devices or medication-monitoring unit while the original equipment is being repaired.

5. The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

6. The PERS installation shall include local seize line circuitry, which guarantees the unit to have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

7. A PERS provider must maintain all installed PERS equipment in proper working order.

8. A PERS provider must maintain a data record for each PERS recipient at no additional cost to DMAS. The record shall document all of the following:

a. Delivery date and installation date of the PERS;

b. Enrollee/caregiver signature verifying receipt of PERS device;

c. Verification by a test that the PERS device is operational, monthly or more frequently as needed;

d. Updated and current recipient responder and contact information, as provided by the recipient or the recipient's care provider; and

e. A case log documenting recipient system utilization and recipient or responder contacts/communications.

9. The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

10. Standards for PERS Equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.

11. A PERS provider shall furnish education, data, and ongoing assistance to DMAS to familiarize staff with the service, allow for ongoing evaluation and refinement of the program and shall instruct the recipient, caregiver, and responders in the use of the PERS service.

12. The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the recipient's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the recipient resetting the system in the event it cannot get its signal accepted at the response center.

13. Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to assure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from recipients' PERS equipment. The monitoring agency's equipment must include the following:

a. A primary receiver and a back-up receiver, which must be independent and interchangeable;

b. A back-up information retrieval system;

c. A clock printer, which must print out the time and date of the emergency signal, the PERS recipient's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

d. A back-up power supply;

e. A separate telephone service;

f. A toll free number to be used by the PERS equipment in order to contact the primary or back-up response center; and

g. A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

14. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

15. The PERS provider shall document and furnish a written report to the support coordinator each emergency signal which results in action being taken on behalf of the recipient. This shall exclude test signals or activations made in error.

12 VAC 30-120-775. Reserved.

12 VAC 30-120-776. Companion Care.

A. Service Description. Companion care is a covered service when its purpose is to supervise or monitor those individuals who require the physical presence of an aide to insure their safety during times when no other supportive individuals are available. Companion services will include, as appropriate, psychiatric, neuropsychiatric, and psychological assessment and other functional assessments and stabilization techniques; medication management and monitoring; behavior assessment and positive behavioral support; intensive care coordination with other agencies and providers to assist planning and delivery of services and supports to maintain community placement of the recipient; training of family members, other caregivers, and service providers in positive behavioral supports to maintain the recipient in the community; and temporary crisis supervision to ensure the safety of the recipient and others.

B. Criteria.

1. The inclusion of companion care in the plan of care is appropriate only when the recipient cannot be left alone at any time due to mental or severe physical incapacitation. This includes recipients who cannot use a phone to call for help due to a physical or neurological disability. Recipients can only receive companion care due to their inability to call for help if PERS is not appropriate for them.

2. Recipients who have a current, uncontrolled medical condition which would make them unable to call for help during a rapid deterioration can be approved for companion care if there is documentation that the recipient has had recurring attacks during the two-month period prior to the authorization of companion care. Companion care shall not be covered if required only because the recipient does not have a telephone in the home or because the recipient does not speak English.

3. There must be a clear and present danger to the recipient as a result of being left unsupervised. Companion care cannot be authorized for persons whose only need for companion care is for assistance exiting the home in the event of an emergency.

C. Service units and service limitations.

1. The amount of companion care time included in the plan of care must be no more than is necessary to prevent the physical deterioration or injury to the recipient. In no event may the amount of time relegated solely to companion care on the plan of care exceed eight hours per day.

2. A personal/respite care aide cannot provide supervision to recipients who are on ventilators, continuous tube feedings, or those who require suctioning of their airways.

3. Companion care will be authorized for family members to sleep either during the day or during the night when the recipient cannot be left alone at any time, due to the recipient's severe agitation and physically wandering behavior. Companion aide services must be required to insure the recipient's safety secondary to a clear and present danger to the recipient as a result of being left unsupervised.

4. Companion care can be authorized when no one else is in the home who is competent to call for help in an emergency. If the recipient's caregiver has his business in the home, such as a day care center, companion care will only be considered if the recipient is dependent in orientation and behavior pattern.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications include:

1. Companion aide qualifications. Agencies must employ individuals to provide companion care who meet the following requirements:

a. Be at least 18 years of age;

b. Possess basic reading, writing, and math skills;

c. Be capable of following a plan of care with minimal supervision;

d. Submit to a criminal history record check. The companion will not be compensated for services provided to the recipient if the records check verifies the companion has been convicted of crimes described in § 32.1-162.9:1 of the Code of Virginia;

e. Possess a valid Social Security number; and

f. Be capable of aiding in the activities of daily living or instrumental activities of daily living.

2. Companions will be employees of agencies that will contract with DMAS to provide companion services. Agencies will be required to have a companion care supervisor to monitor companion care services. The supervisor must be a certified Home Health Aide, an LPN, or an RN and must have a current license or certification to practice in the Commonwealth.

3. The provider agency will conduct an initial home visit within the first three days of initiating companion care services to document the efficacy and appropriateness of services and to establish an individual service plan for the recipient. The agency will provide follow-up home visits to monitor the provision of services every four months or as often as needed. The recipient will be reassessed for services every six months.

12 VAC 30-120-777 through 12 VAC 30-120-779. Reserved.

12 VAC 30-120-780. Reevaluation of service need and utilization review.

A. The Consumer Service Plan (CSP).

1. The CSP shall be developed by the support coordinator mutually with other service providers, the recipient, the recipient's parents or legal guardians for minors, consultants, and other interested parties based on relevant, current assessment data. The plan of care process determines the services to be rendered to recipients, the frequency of services, the type of service provider, and a description of the services to be offered. All CSPs developed by the support coordinators are subject to approval by DMAS. DMAS is the single state authority responsible for the supervision of the administration of the community-based care waiver.

2. The support coordinator is responsible for continuous monitoring of the appropriateness of the recipient's plan of care and revisions to the CSP as indicated by the changing needs of the recipient. At a minimum, the case support coordinator shall review the plan of care every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

3. The DMAS staff shall review the Consumer Service Plan every 12 months or more frequently as required to

assure proper utilization of services. Any modification to the amount or type of services in the CSP must be authorized by DMAS.

B. Review of level of care.

1. The DMAS shall complete an annual comprehensive reassessment, in coordination with the recipient, family, and service providers. If warranted, the DMAS shall coordinate a medical examination and a psychological evaluation for every waiver recipient. The reassessment shall include an update of the assessment instrument and any other appropriate assessment data.

2. A medical examination shall be completed for adults based on need identified by the provider, recipient, support coordinator, or DMAS staff. Medical examinations for children shall be completed according to the recommended frequency and periodicity of the EPSDT program.

3. A psychological evaluation or standardized developmental assessment for children over six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities. A new psychological evaluation shall be required whenever the recipient's functioning has undergone significant change and is no longer reflective of the past psychological evaluation.

C. Documentation required.

1. The support coordination agency must maintain the following documentation for review by the DMAS staff for each waiver recipient:

a. All assessment summaries and all CSPs completed for the recipient and maintained for a period of not less than five years from recipients' start of care.

b. All individual providers' POCs from any provider rendering waiver services to the recipient.

c. All supporting documentation related to any change in the plan of care.

d. All related communication with the providers, recipient, consultants, DMHMRSAS, DMAS, DSS, DRS or other related parties.

e. An ongoing log which documents all contacts made by the support coordinator related to the waiver recipient.

2. The recipient service providers must maintain the following documentation for review by the DMAS staff for each waiver recipient:

a. All POC's developed for that recipient and maintained for a period of not less than five years from the date of the recipient's entry to waiver services.

b. An attendance log which documents the date services were rendered and the amount and type of services rendered.

c. Appropriate progress notes reflecting recipient's status and, as appropriate, progress toward the goals on the POC.

12 VAC 30-120-790. Eligibility criteria for emergency access to the waiver.

A. Subject to available funding, individuals must meet at least one of the emergency criteria to be eligible for immediate access to waiver services without consideration to the length of time an individual has been waiting to access services. In the absence of waiver services, the individual would not be able to remain in his home.

B. The criteria are:

1. The primary caregiver has a serious illness, has been hospitalized, or has died;

2. The individual has been determined by the DSS to have been abused or neglected and is in need of immediate Waiver services;

3. The individual has behaviors which present risk to personal or public safety; or

4. The individual presents extreme physical, emotional, or financial burden at home and the family or caregiver is unable to continue to provide care.

12 VAC 30-120-800. Reserved.

VA.R. Doc. No. R00-217; Filed June 29, 2000, 11:12 a.m.

* * * * * * * *

Title of Regulation: **Nursing Home Payment System: 12 VAC 30-90-10 et seq. Methods and Standards for Establishing Payment Rates for Long-Term Care (amending 12 VAC 30-90-20, 12 VAC 30-90-34, 12 VAC 30-90-40, 12 VAC 30-90-41, 12 VAC 30-90-50, 12 VAC 30-90-51, 12 VAC 30-90-60, 12 VAC 30-90-65, 12 VAC 30-90-160, and 12 VAC 30-90-264; adding 12 VAC 30-90-35, 12 VAC 30-90-36, 12 VAC 30-90-37, and 12 VAC 30-90-136; repealing 12 VAC 30-90-30, 12 VAC 30-90-31, 12 VAC 30-90-32, 12 VAC 30-90-33, 12 VAC 30-90-42, 12 VAC 30-90-43, 12 VAC 30-90-53, 12 VAC 30-90-54, 12 VAC 30-90-220, 12 VAC 30-90-221, 12 VAC 30-90-222, 12 VAC 30-90-260, and 12 VAC 30-90-280).**

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

Effective Dates: July 1, 2000, through June 30, 2001.

SUMMARY

REQUEST: The Governor is hereby requested to approve this agency's adoption of the emergency regulation entitled Nursing Home Payment System Revisions. This regulation implements the changes directed by the Appropriations Act of the 2000 Session of the General Assembly.

RECOMMENDATION: Recommend approval of the department's request to take an emergency adoption action regarding Nursing Home Payment System. The department intends to initiate the public notice and comment requirements contained in the Code of Virginia § 9-6.14:7.1.

DISCUSSION

BACKGROUND: The sections of the State Plan affected by this action are Methods and Standards for Establishing Payment Rates-Long-Term Care Services (Attachment 4.19-D, Supplement Nursing Home Payment System (12 VAC 30-90-20 through 12 VAC 30-90-260)).

The existing nursing home payment system relies on direct and indirect cost ceilings that have not been updated except for inflation since 1991. Nursing home costs have increased faster than inflation and the 2000 – 2002 Appropriations Act (Chapter 1073) provided that:

1. Direct care ceilings are to be recalculated effective July 1, 2000, and set at 112% of the median of base year cost per day.

2. The use of a direct care efficiency incentive payment is to be eliminated.

3. The department is to recalculate new ceilings, both direct and indirect, using a new base year at least every two years.

4. The department is to adjust rates to restore funding for the negative impact of case mix adjustment on aggregate payments.

5. The department is to adjust rates to incorporate the $21,700,000 (adjusted for inflation) provided by the 1999 Appropriations Act.

6. Direct care rates are to be set without application of an occupancy standard.

7. Indirect and capital rates are to be set with an occupancy standard of 90%.

8. The department is to implement a revised capital payment policy.

The Appropriations Act provided approximately $28 million per year (total funds), in addition to the $21.7 million per year (total funds) appropriated in 1999, to fund the implementation of these changes.

In addition, HB 2004 of the 1999 Session of the General Assembly provided that effective July 1, 2000, the recapture of depreciation expense payments by the Medicaid program is to be eliminated.

AUTHORITY TO ACT: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of board action pursuant to the board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:4.1(C)(5), for an agency's adoption of emergency regulations subject to the Governor's prior approval.

Subsequent to the emergency adoption action and filing with the Registrar of Regulations, this agency intends to initiate the public notice and comment process contained in Article 2 of the APA. Therefore, approval to file the required Notice of Intended Regulatory Action is also necessary and hereby being requested by this action.

42 CFR Part 447 Subpart C provides for the methods and standards of reimbursement for long-term care services.

Without an emergency regulation, these amendments to the regulations cannot become effective until the publication and concurrent comment and review period requirements of the APA's Article 2 are met. Therefore, an emergency regulation is needed to meet the July 1, 2000, effective date established by the General Assembly.

NEED FOR EMERGENCY ACTION: The Code § 9-6.14:4.1(C)(5) provides for regulations which an agency finds are necessitated by an emergency situation. To enable the director, in lieu of the Board of Medical Assistance Services, to comply with the 2000 General Assembly's mandates, he must adopt this emergency regulation. This issue qualifies as an emergency regulation as provided for in § 9-6.14:4.1(C)(5)(ii), because the Appropriation Act requires this regulation to be effective within 280 days from the enactment of the law or regulation. As such, this regulation may be adopted without public comment with the prior approval of the Governor.

Since this emergency regulation will be effective for no more than 12 months and the director wishes to continue regulating the subject entities, the department is initiating the Administrative Process Act Article 2 procedures.

FISCAL/BUDGETARY IMPACT: Under this regulation (as provided in the Appropriations Act) nursing home providers will receive approximately $28 million total funds ($13.5 million GF) more in SFY2001 than they would have under existing regulations. There are no localities that are uniquely affected by these regulations as they apply statewide.

RECOMMENDATION: Recommend approval of this request to adopt this emergency regulation to become effective July 1, 2000. From its effective date, this regulation is to remain in force for one full year or until superseded by final regulations, promulgated through the APA. Without an effective emergency regulation, the department would lack the authority to revise the nursing home rate methodology as directed by the Appropriations Act.

APPROVAL SOUGHT FOR 12 VAC 30-90-20 through 12 VAC 30-90-264, and 12 VAC 30-90-280. Approval of the Governor is sought for an emergency modification of the Medicaid State Plan in accordance with the Code of Virginia § 9-6.14:4.1(C)(5) to adopt the following regulation:

/s/ Dennis G. Smith, Director
Department of Medical Assistance Services
Date: June 28, 2000

/s/ James S. Gilmore, III
Governor
Date: June 28, 2000

12 VAC 30-90-20. Nursing home payment system; generally.

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

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

C. *Effective July 1, 2000,* in determining the ceiling limitations, there shall be direct patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA MSA, ~~and~~ *for NFs with less than 61 beds in the rest of the state, and for NFs with more than 60 beds* in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A nursing facility located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

D. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in *12 VAC 30-90-35,* 12 VAC 30-90-40, 12 VAC 30-90-60, and 12 VAC 30-90-80, as are mental retardation facilities. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare ~~and Medicaid~~ principles of reimbursement *and Medicaid principles of reimbursement in effect on June 30, 2000*, except that those that are defined as skilled nursing facilities (SNFs) and are operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall not be subject to the routine cost limits that are normally required and applicable under Medicare principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

E. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see 12 VAC 30-90-270) and must be identifiable and verified by contemporaneous documentation.

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

12 VAC 30-90-30. ~~Plant cost.~~ *(Repealed.)*

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

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

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

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

12 VAC 30-90-31. ~~New nursing facilities and bed additions.~~ *(Repealed.)*

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

~~All bids must be obtained in an open competitive market manner, and subject to disclosure to DMAS prior to initial rate setting. (Related parties see 12 VAC 30-90-51.)~~

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

additions shall be calculated by multiplying the square footage of the project by the applicable components of the construction cost in the R.S. Means Square Foot Costs, not to exceed the total per bed cost for a new NF. Reasonable limits for renovations shall be determined by the appropriate costs in the R.S. Means Repair and Remodeling Cost Data, not to exceed the total R.S. Means Building Construction Cost Data 3/4 square foot costs for nursing homes.

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

D. However in no case shall allowable reimbursed costs exceed 110% of the amounts approved in the original COPN, or 100% of the amounts approved in the original COPN as modified by any "significant change" COPN, where a provider has satisfied the requirements of the State Department of Health with respect to obtaining prior written approval for a "significant change" to a COPN which has previously been issued (see 12 VAC 5-220-10 et seq.).

12 VAC 30-90-32. Major capital expenditures. ***(Repealed.)***

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

B. Providers (including related organizations as defined in 12 VAC 30-90-51) shall be required to obtain three competitive bids and if applicable, a Certificate of Public Need before initiating any major capital expenditures. All bids must be obtained in an open competitive manner, and subject to disclosure to the DMAS prior to initial rate setting. (Related parties see 12 VAC 30-90-51.)

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

D. Major capital additions, modernization, renovations, and costs associated with upgrading the NF to new standards shall be subject to cost limitations based upon the applicable components of the construction cost limits determined in accordance with 12 VAC 30-90-31 B.

12 VAC 30-90-33. Financing. ***(Repealed.)***

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

1. Refinancing incentive. Effective July 1, 1991, for mortgages refinanced on or after that date, the DMAS will pay a refinancing incentive to encourage nursing facilities to refinance fixed-rate, fixed-term mortgage debt when such arrangements would benefit both the Commonwealth and the providers. The refinancing incentive payments will be made for the 10-year period following an allowable refinancing action, or through the end of the refinancing period should the loan be less than 10 years, subject to a savings being realized by application of the refinancing calculation for each of these years. The refinancing incentive payment shall be computed on the net savings from such refinancing applicable to each provider cost reporting period. Interest expense and amortization of loan costs on mortgage debt applicable to the cost report period for mortgage debt which is refinanced shall be compared to the interest expense and amortization of loan costs on the new mortgage debt for the cost reporting period.

2. Calculation of refinancing incentive. The incentive shall be computed by calculating two index numbers, the old debt financing index and the new debt financing index. The old debt financing index shall be computed by multiplying the term (months) which would have been remaining on the old debt at the end of the provider's cost report period by the interest rate for the old debt. The new debt index shall be computed by multiplying the remaining term (months) of the new debt at the end of the cost reporting period by the new interest rate. The new debt index shall be divided by the old debt index to achieve a savings ratio for the period. The savings ratio shall be subtracted from a factor of 1 to determine the refinancing incentive factor.

3. Calculation of net savings. The gross savings for the period shall be computed by subtracting the allowable new debt interest for the period from the allowable old debt interest for the period. The net savings for the period shall be computed by subtracting allowable new loan costs for the period from allowable gross savings applicable to the period. Any remaining unamortized old loan costs may be recovered in full to the extent of net savings produced for the period.

4. Calculation of incentive amount. The net savings for the period, after deduction of any unamortized old loan and debt cancellation costs, shall be multiplied by the refinancing incentive factor to determine the refinancing incentive amount. The result shall be the incentive payment for the cost reporting period, which shall be included in the cost report settlement, subject to per diem computations under 12 VAC 30-90-30 B and C, and 12 VAC 30-90-55 A.

5. Where a savings is produced by a provider refinancing his old mortgage for a longer time period, the DMAS shall calculate the refinancing incentive and payment in accordance with subdivisions A 1 through A 4 of this section for the incentive period. Should the calculation produce both positive and negative incentives, the provider's total incentive payments shall not exceed any net positive amount for the entire incentive period. Where

a savings is produced by refinancing with either a principal balloon payment at the end of the refinancing period, or a variable interest rate, no incentive payment will be made, since the true savings to the Commonwealth cannot be accurately computed.

6. All refinancings must be supported by adequate and verifiable documentation and allowable under DMAS regulations to receive the refinancing savings incentive.

7. Balloon loan reimbursement. This subdivision applies to the construction and acquisition of nursing facilities (as defined in 12 VAC 30-90-31 and 12 VAC 30-90-34) and major capital expenditures (as defined in 12 VAC 30-90-32) that are financed with balloon loans. A balloon loan requires periodic payments to be made that do not fully amortize the principal balance over the term of the loan; the remaining balance must be repaid at the end of a specified time period. Demand notes and loans with call provisions shall not be deemed to be balloon loans.

a. Incurred interest. Reimbursement for interest of a balloon loan and subsequent refinancings shall be considered a variable interest rate loan under subsection B of this section.

(1) A standard amortization period of 27 years, from the inception date of the original balloon loan, must be computed by the provider and submitted to DMAS and used as the amortization period for loans for renovation, construction, or purchase of a nursing facility.

(2) A standard amortization period of 15 years, from the inception of the original balloon loan, must be used as the amortization period for loans on furniture, fixtures, and equipment.

(3) A loan which is used partially for the acquisition of buildings, land, and land improvements and partially for the purchase of furniture, fixtures, and equipment must be prorated for the purpose of determining the amortization period.

b. The allowable interest rate shall be limited to the interest rate upper limit in effect on the date of the original balloon loan, unless another rate is allowable under subsection B of this section.

c. Financing costs. The limitations on financing costs set forth in subsection B of this section shall apply to balloon loans. Financing costs exceeding the limitations set forth in these sections shall be allowed to the extent that such excess financing costs may be offset by any available interest savings.

(1) A 27-year amortization period must be used for deferred financing costs associated with the construction or purchase of a nursing facility.

(2) A 15-year amortization period must be used for deferred financing costs associated with financing of furniture, fixtures, and movable equipment.

(3) Financing costs associated with a loan used partially for the acquisition of buildings, land, and land improvements and partially for the purchase of furniture, fixtures, and equipment must be prorated for determination of the amortization period.

d. Cumulative credit computation. The computation of allowable interest and financing costs for balloon loans shall be calculated using the following procedures:

(1) A standard amortization schedule of allowable costs based upon the upper limits for interest and financing costs shall be computed by the provider and submitted to DMAS for the applicable 27-year or 15-year periods on the original balloon loan.

(2) For each cost reporting period, the provider shall be allowed the lesser of loan costs (interest and financing costs) computed in accordance with subdivision 7 a of this subsection, or the actual loan costs incurred during the period.

(3) To the extent that there is a "credit" created by the actual loan costs being less than the loan costs computed on the amortization schedule in some periods, the provider may recover any otherwise allowable costs which result from the refinancing, extension, or renewal of the balloon loan, and any loan costs which have been disallowed because the loan costs are over the limitation for some periods. However, the cumulative actual loan cost reimbursement may not exceed the cumulative allowable loan cost as computed on the amortization schedule to that date.

(4) In refinancing or refinancings of the original balloon loan which involve additional borrowings in excess of the balance due on the original balloon loan, the excess over the balance due on the balloon loan shall be treated as new debt subject to the DMAS financing policies and regulations. Any interest and financing costs incurred on the refinancing shall be allocated pro rata between the refinancing of the balloon loan and the new debt.

(5) In the event of a sale of the facility, any unused balance of cumulative credit or cumulative provider excess costs would follow the balloon loan or the refinancing of the balloon loan if the balloon loan or its refinancing is paid by the buyer under the same terms as previously paid by the seller. Examples of this are (i) the buyer assumes the existing instrument containing the same rates and terms by the purchaser; or (ii) the balance of the balloon loan or its refinancings is financed by the seller to the buyer under the same rates and terms of the existing loan as part of the sale of the facility. If the loan is otherwise paid in full at any time and the facility is sold before the full 27-year or 15-year amortization period has expired, the balance of unused cumulative credit or cumulative provider excess costs shall expire and not be considered an allowable cost.

e. In accordance with subdivision A 5 of this section, no refinancing incentive shall be available for refinancings, extensions, or renewals of balloon loans.

f. The balloon loan and refinancing of the balloon loan shall be subject to all requirements for allowable borrowing, except as otherwise provided by this subsection.

B. Interest rate upper limit. Financing for all NFs and expansions which require a COPN and all renovations and purchases shall be subject to the following limitations:

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

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

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

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

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

3. Variable interest rate upper limit.

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

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

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

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

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

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

a. Examination Fees

b. Guarantee Fees

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

d. Underwriters Discounts

e. Loan Points

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

a. Legal Fees

b. Cost Certification Fees

c. Title and Recording Costs

d. Printing and Engraving Costs

e. Rating Agency Fees

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

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

12 VAC 30-90-34. Purchases of nursing facilities (NF).

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

reimbursement as a provider *and notify DMAS of the sale within 30 days of the date legal title passed to the purchaser*.

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

~~1. The allowable cost of a bona fide sale of a facility (whether or not the parties to the sale were, are, or will be providers of Medicaid services) shall be the lowest of the sales price, the replacement cost value determined by independent appraisal, or the limitations of Subpart XVI - Revaluation of Assets (12 VAC 30-90-260 et seq.). Revaluation of assets shall be permitted only when a bona fide sale of assets occurs.~~

~~2. Notwithstanding the provisions of 12 VAC 30-90-51, where there is a sale between related parties (whether or not they were, are or will be providers of Medicaid services), the buyer's allowable cost basis for the nursing facility shall be the seller's allowable depreciated historical cost (net book value), as determined for Medicaid reimbursement.~~

~~3. For purposes of Medicaid reimbursement, a "bona fide" sale shall mean a transfer of title and possession for consideration between parties which are not related. Parties shall be deemed to be "related" if they are related by reasons of common ownership or control. If the parties are members of an immediate family, the sale shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control." See 12 VAC 30-90-51 C for definitions of "common ownership," "control," "immediate family," and "significant ownership or control."~~

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

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

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

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

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

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

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

~~E. Depreciation recapture.~~

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

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

~~F. Reimbursable depreciation.~~

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

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

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

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

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

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

~~d. Whether or not there is a debt owing to the Commonwealth for the amount of depreciation charges previously allowed and reimbursed as a reasonable~~

~~cost to the transferor under the Virginia Medical Assistance Program.~~

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

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

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

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

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

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

12 VAC 30-90-35. ~~[Reserved.]~~ *Nursing Facility Capital Payment Methodology.*

Definitions. The terms used in this article shall be defined as follows:

"Date of acquisition" means the date legal title passed to the buyer. If a legal titling date is not determinable for a nursing facility building, date of acquisition shall be considered to be the date a certificate of occupancy was issued by the appropriate licensing or building inspection agency of the locality where the nursing facility is located.

"Facility average age" means for a facility the weighted average of the ages of all capitalized assets of the facility, with the weights equal to the expenditures for those assets. The calculation of average age shall take into account land improvements, building and fixed equipment, and major movable equipment. The basis for the calculation of average age shall be the schedule of assets submitted annually to the department in accordance with the provisions of this section.

"Facility imputed gross square feet" means a number that is determined by multiplying the facility's number of licensed beds by the imputed number of gross square feet per bed. The imputed number of gross square feet per bed shall be 405 for facilities of 90 or fewer beds, and 385 for facilities of more than 90 beds. Number of licensed beds shall be the number on the last day of the provider's most recent fiscal year end.

"Factor for land and soft costs" means a factor equaling 1.299 which adjusts the construction cost amount to recognize land and capitalized costs associated with construction of a facility, that are not part of the RSMeans construction cost amount.

"Fixed capital replacement value" means an amount equal to the RSMeans 75th percentile nursing home construction cost per square foot, times the applicable RSMeans historical cost index factor, times the factor for land and soft costs, times the applicable RSMeans location factor, times facility imputed gross square feet.

"FRV depreciation rate" means a depreciation rate equal to 1.5%.

"Movable capital replacement value" means a value equal to $3,475.00 in SFY2001, and shall be increased each July 1st by the same RSMeans historical cost index factor that is used to calculate the fixed capital replacement value.

"RSMeans 75th percentile nursing construction cost per square foot" means the 75th percentile value published in the most recent available edition of Building Construction Cost Data. In the 2000 edition of the RSMeans publication this value is $110, which is reported as a January 2000 value.

"RSMeans historical cost index factor" means the ratio of the two most recent RSMeans Historical Cost Indexes published in the most recent available edition of Building Construction Cost Data. In the 1999 edition of this RSMeans publication these two values are 117.6 (for 1999) and 115.1 (for 1998). The ratio of these values, and therefore the factor to be used would be 1.022. This factor would be used to adjust the January 2000 value for the one year of change from January 2000 to January 2001, the mid-point of the prospective rate year (SFY2001). The resulting cost value that would be used in SFY2001 is $112.42. The indexes used in this calculation do not match the time period for which a factor is needed. They relate to 1998 and 1999, while 2000 and 2001 would be ideal. However, RSMeans does not publish index forecasts, so the most recent available indexes shall be used.

"RSMeans location factors" means those published in the most recent available edition of Square Foot Costs. The 2000 location factors are shown in the following table. They will be updated annually and distributed to providers based upon the most recent available data.

TABLE 1

RSMEANS COMMERCIAL CONSTRUCTION COST LOCATION FACTORS (2000)

Zip Code	Principal City	Location Factor
220-221	Fairfax	0.90
222	Arlington	0.90
223	Alexandria	0.91
224-225	Fredericksburg	0.85
226	Winchester	0.80
227	Culpeper	0.80
228	Harrisonburg	0.77
229	Charlottesville	0.82
230-232	Richmond	0.85
233-235	Norfolk	0.82
236	Newport News	0.82
237	Portsmouth	0.81
238	Petersburg	0.84
239	Farmville	0.74
240-241	Roanoke	0.77
242	Bristol	0.75
243	Pulaski	0.70
244	Staunton	0.76
245	Lynchburg	0.77
246	Grundy	0.70

"Rental rate" means for a prospective year a rate equal to two percentage points plus the yield on US Treasury Bonds with maturity over 10 years, averaged over the most recent three calendar years for which data are available, as published by the Federal Reserve. Rental rates may not fall below 9% or exceed 11% and will be updated annually on or about July 1st each year. The rate will be published and distributed to providers annually. Changes in the rental rate shall be effective for the providers' fiscal year beginning on or after July 1st.

"Required occupancy percentage" means an occupancy percentage of 90%.

A. Fair Rental Value Payment for Capital. Effective for dates of service on or after July 1, 2000, the state agency shall pay nursing facility capital related costs under a Fair Rental Value (FRV) methodology. The payment made under this methodology shall be the only payment for capital related costs, and no separate payment shall be made for depreciation or interest expense, lease costs, property taxes, insurance, or any other capital related cost. This payment is considered to cover costs related to land, buildings and fixed equipment, major movable equipment, and any other capital related item. This shall be the case regardless of whether the property is owned or leased by the operator.

B. FRV Rate Year. The FRV payment rate shall be a per-diem rate determined each year for each facility, using the most recent available data from settled cost reports, or from other verified sources as specified herein. The per-diem rate shall be determined prospectively and shall apply for the entire fiscal year. Each provider shall receive a new capital per diem rate each year effective at the start of the provider's fiscal year. Data elements that are provider specific shall be revised at that time and shall rely on the filed cost report and schedule of assets of the previous year. Data elements that are not provider specific, including those published by RSMeans and the rental rate, shall be determined annually on or about July 1st, and shall apply to provider fiscal years beginning on or after July 1st. That is, each July 1st DMAS shall determine the RSMeans values and the rental rate, and these shall apply to all provider fiscal years beginning on or after July 1st.

C. Transition Policy. Nursing facilities enrolled in the Medicaid program prior to July 1, 2000 shall be paid for capital related costs under a transition policy from July 1, 2000 through June 30, 2005. Facilities and beds paid under the transition policy shall receive payments as follows:

1. During SFY2001, each facility's capital per diem shall be the facility's capital per diem on June 30, 2000. The methodology under which this per diem is determined is the plant cost reimbursement methodology in effect as of June 30, 2000.

2. During SFY2002 through SFY2005, each facility shall have a capital per diem that is a percentage of the per diem of June 30, 2000, plus a percentage of the modified FRV per diem. The percentage associated with the June 30, 2000 per diem shall be 75% for services provided in SFY2002, 50% for services provided in SFY2003, 25% for services provided in SFY2004, and 0% for services provided in SFY2005. The percentage associated with the modified FRV per diem shall be one minus the percentage associated with the June 30, 2000 per diem. The modified FRV per diem shall be equal to the FRV per diem described in this section, except that it can be no greater than the June 30, 2000 per diem plus $1, and no less than the June 30, 2000 per diem minus $3. If savings are identified due to facilities being fully subject to the FRV per diem, the upper limit of the modified FRV per diem shall be increased prospectively in the following state fiscal year, by an amount estimated to expend the savings as provided in subsection F of this section.

3. Prior to July 1, 2004, the department shall evaluate the June 30, 2000 per diem in comparison with actual capital expenses at the time and shall consider the feasibility of transitioning from the modified FRV per diem to the FRV per diem, as well as other possible modifications to the methodology.

D. Beds Excluded from the Transition Policy. Effective July 1, 2000, newly constructed facilities and newly constructed and replacement beds of previously enrolled facilities shall be paid entirely under the FRV methodology without application of the transition policy or the modified FRV per diem. However, facilities and beds with COPN applications submitted as of June 30, 2000, shall be subject to the transition policy and shall have their non-FRV rates calculated under the capital payment methodology in effect as

of June 30, 2000. Facilities changing ownership after June 30, 2000, shall be paid the lesser of the full FRV per diem or the transition policy payment of the previous owner. For purposes of this provision, change of ownership shall be defined to include all sales or transfers of stock or assets whether the transactions are between related or unrelated parties.

E. Adjustment for Renovations During the Transition Period. For services during state fiscal year 2001, the capital per-diem applicable to June 30, 2000, shall be the final basis of capital reimbursement. No adjustment to this amount shall be made for renovations completed in State Fiscal Year 2001. For services during State Fiscal Years 2002 through 2005, transition period payments shall be adjusted for renovations according to a methodology that DMAS shall adopt by means of regulations effective July 1, 2001.

F. Adjustment for FRV Savings During the Transition.

1. After the end of each state fiscal year from 2001 through 2005, the department shall determine the number of Medicaid resident days in the fiscal year that were paid entirely under the FRV method rather than the transition policy. The department shall multiply the number of these days by the difference between $25 and the applicable FRV per diem. The product is the estimated saving from excluding certain facilities and beds from the transition policy. This amount shall be used to calculate an estimated increase to the modified FRV per diem by revising the limit on increases above the June 30, 2000 per diem. Savings shall be identified for a state fiscal year after the end of the fiscal year, and shall be used to adjust facility rates effective during the state fiscal year immediately following the one for which the savings were identified. That is, if savings are identified for SFY 2001, all facilities modified FRV per diem rates will be adjusted to reflect those savings effective July 1,2001 through June 30, 2002. The amount of $25 is the estimated capital per diem of a new facility under the methodology in effect on June 30, 2000. This amount shall be reevaluated annually based on the most recent settled cost report data available, and revised if appropriate.

2. The department shall determine the savings for facilities sold or transferred after July 1, 2000. Savings shall be equal to the difference between the amount of reimbursement the new owner would have received under the reimbursement method in effect on June 30, 2000, and the amount of reimbursement under the FRV method. In the first years after the sale, this amount shall be reduced by the amount of depreciation recapture the seller would have paid based on the reimbursement method in effect on June 30, 2000. This reduction of savings shall continue until the cumulative savings from the FRV method equals the depreciation recapture amount. The amount of estimated net savings shall be used to increase the limits above the June 30, 2000, per diem.

12 VAC 30-90-36. Calculation of FRV Per Diem Rate for Capital. Calculation of FRV Rental Amount. Change of Ownership.

A. Calculation of FRV Per Diem Rate for Capital. The facility FRV per diem rate shall be equal to the sum of the facility FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by the greater of actual patient days or the product of: 1) the facility's number of licensed beds at the end of the provider's fiscal year immediately prior to the effective date of the rate to be calculated, 2) the required occupancy percentage, and 3) 365 days or 366 days if applicable.

B. Calculation of FRV Rental Amount. The facility FRV rental amount shall be equal to the facility prospective year total value times the rental rate.

1. The facility prospective year total value shall be equal to the facility prospective year replacement value minus FRV depreciation. FRV depreciation equals the prospective year replacement value multiplied by the product of facility average age and the depreciation rate. FRV depreciation cannot exceed 60% of the prospective year replacement value.

2. The facility prospective year replacement value shall be equal to the fixed capital replacement value plus the movable equipment replacement value.

C. Change of Ownership. As provided in connection with Schedule of Assets reporting, the sale of nursing facility assets after June 30, 2000 shall not result in a change to the Schedule of Assets or to the calculation of average age for purposes of reimbursement under the FRV methodology. Therefore any sale or transfer of assets after this date shall not affect the FRV per-diem rate. Changes of ownership for purposes of determining the FRV payment shall occur if there is a sale of stock, assets, or sales between related or unrelated parties.

12 VAC 30-90-37. Schedule of Assets Reporting.

A. For the calculation of facility average age the department shall use a "schedule of assets" that lists, by year of acquisition, the allowable acquisition cost of facilities' assets, including land improvements, buildings and fixed equipment, and major movable equipment. Asset allowable costs shall be as determined under rules in effect at the date of acquisition. This schedule shall be submitted annually by the provider on forms to be provided by the department, and shall be audited by the department. The principles of reimbursement for plant cost in effect on June 30, 2000, shall be used to determine allowable cost.

B. The schedule of assets used in the calculation of average age shall be submitted with the provider's cost report.

C. Facilities failing to submit the schedule of assets timely shall have their nursing facility per diem rate set to zero when the schedule is 150 days past due.

D. Capital expenditures are to be included on the schedule of assets. These do not include land purchases, but do include land improvements, renovations, additions, upgrading

to new standards, and equipment purchases. Capital expenditures shall be capital related expenditures costing $25,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a twelve-month period.

E. Items reportable on the schedule of assets may be removed only when fully depreciated (following the straight-line method of depreciation) and disposed of. Depreciation shall be according to the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (AHA). If an item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

F. Acquisition costs related to any sale or change in the ownership of a nursing facility or the assets of a nursing facility shall not be included in the Schedule of Assets if the transaction occurred after June 30, 2000. Whether such a transaction is the result of a sale of assets, acquisition of capital stock, merger, or any other type of change in ownership, related costs shall not be reported on the Schedule of Assets.

G. Audits of NF allowable capital costs, in addition to verifying the Schedule of Assets, shall continue to audit actual capital allowable expenses as defined under regulations effective June 30, 2000.

12 VAC 30-90-40. Operating cost.

A. *Effective July 1, 2000,* operating cost shall be the total allowable inpatient cost less ~~plant~~ *capital* cost and NATCEPs costs. See Part VII for rate determination procedures for NATCEPs costs. ~~To calculate the reimbursement rate, operating cost shall be converted to a per diem amount by dividing it by the greater of actual patient days, or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.~~ *Effective July 1, 2000, operating cost shall be made up of direct patient care operating cost and indirect patient care operating cost. Direct patient care operating cost is defined in Appendix I. Indirect patient care operating cost includes all operating costs not defined as direct patient care operating costs or NATCEPS costs in Appendix I. For purposes of calculating the reimbursement rate, the direct patient care operating cost per day shall be the Medicaid portion of the direct patient care operating cost divided by the nursing facility's number of Medicaid patient days in the cost reporting period. The indirect patient care operating cost per day shall be the Medicaid portion of the indirect patient care operating cost divided by the greater of the actual number of Medicaid patient days in the cost reporting period, or 90 percent of the potential patient days if all licensed beds were occupied throughout the cost reporting period times the Medicaid utilization percentage.*

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

12 VAC 30-90-41. Nursing facility reimbursement formula.

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

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

2. Direct and indirect group ceilings *and rates*.

a. In accordance with 12 VAC 30-90-20 C, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in 12 VAC 30-90-270.

b. *Effective July 1, 2000,* indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA*, for the rest of the state for facilities with less than 61 licensed beds,* and for the rest of the state *for facilities with more than 60 licensed beds*. Indirect patient care operating costs shall include all other operating costs, not defined in 12 VAC 30-90-270 as direct patient care operating costs and NATCEPs costs.

~~c. Effective July 1, 1995, existing indirect peer group ceilings of nursing facilities shall be adjusted according to the schedule below. These adjustments shall be added to the ceiling in effect for each facility on July 1, 1995, and shall apply from that day until the end of the facility's fiscal year in progress at that time. Peer group ceilings for the subsequent fiscal year shall be calculated by adding the adjustments below to the existing interim ceiling. The resulting adjusted interim ceiling shall be increased by 100% of historical inflation to the beginning of the facility's next fiscal year to obtain the new "interim" ceiling, and by 50% of the forecast inflation to the end of the facility's next fiscal year. This action increases the number of indirect patient care operating cost peer groups to a total of eight, four peer groups for the area within the Washington DC-MD-VA MSA, and four for the rest of the state.~~

~~Licensed Bed Size~~	~~Ceiling Adjustment~~
~~1 to 30~~	~~add $1.89~~
~~31 to 60~~	~~add $1.28~~
~~61 to 90~~	~~add $0.62~~
~~Over 90~~	~~add $0.00~~

3. Each NF's Service Intensity Index (SII) shall be calculated for each semiannual period of a NF's fiscal

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

See 2 VAC 30-90-300 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NF's facility score and the methodology of computing the NF's semiannual SIIs.

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

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

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

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

d. See 12 VAC 30-90-300 for an illustration of how the SII is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.

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

~~a. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during fiscal year 1991 under the prospective payment system in effect through September 30, 1990, as modified to incorporate the estimated additional NF reimbursement mandated by the provisions of § 1902(a)(13)(A) of the Social Security Act as amended by § 4211(b)(1) of the Omnibus Budget Reconciliation Act of 1987.~~

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

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

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

5. Effective for services on and after July 1, 2000, the following change shall be made to the direct and indirect payment methods.

a. The direct patient care-operating ceiling shall be set at 112% of the median of facility specific SII-normalized direct cost per day. The calculation of the median shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in calendar year 1998. The median used to set the direct ceiling shall be revised every two years using more recent data. In addition, for ceilings effective during July 1, 2000, through June 30, 2002, the ceiling calculated as described herein shall be increased by two per diem amounts. The first per diem amount shall equal $21,716,649, increased for inflation from SFY2000 to SFY 2001, divided by Medicaid days in SFY 2000. The second per diem amount shall equal $1,400,000 divided by Medicaid days in SFY2000. When this ceiling calculation is completed for services after June 30, 2002, the per diem amount related to the amount of $21,716,649 shall not be added.

b. Facility specific direct cost per day amounts used to calculate direct reimbursement rates for dates of service on and after July 1, 2000, shall be increased by the two per diem amounts described in subitem a above. However, the per diem related to the amount of $21,716,649 shall be included only in proportion to the number of calendar days in the provider fiscal year the data are taken from that do not fall after July 1, 1999. That is, for a cost report from a provider fiscal year ending December 31, 1999, the specified increase would apply to about half of the year.

c. The indirect patient care operating ceiling which shall be set at 106.9% of the median of facility specific indirect cost per day. The calculation of the median shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in calendar year 1998.

B. The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NF's most

recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:

1. ~~The initial peer group ceilings established under subsection A of this section shall be the final peer group ceilings for a NF's first full or partial fiscal year under PIRS and shall be considered as the initial "interim ceilings" for calculating the subsequent fiscal year's peer group ceilings. Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the initial "interim" ceilings by a "percentage factor" which shall eliminate any allowances for inflation after September 30, 1990, calculated in both subdivisions A 5 a and A 5 c of this section. The adjusted initial "interim" ceilings shall be considered as the final "interim ceiling." Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the final "interim" ceiling, as determined above, by 100% of historical inflation from October 1, 1990, to the beginning of the NFs next fiscal year to obtain new "interim" ceilings, and 50% of the forecasted inflation to the end of the NFs next fiscal year.~~ *The initial peer group ceilings established under 12 VAC 30-90-41 shall be the final peer group ceilings for a NF's first or partial cost reporting fiscal year under PIRS. Peer group ceilings for subsequent fiscal years shall be calculated by use of the adjusted medians determined at June 30, 2000, for direct and indirect cost. These adjusted medians shall be considered the 'final' interim ceilings for subsequent fiscal years. The 'final' interim ceilings determined above shall be adjusted by adding 100% of historical inflation from June 30, 2000, to the beginning of the NF's next fiscal year to obtain the new 'interim' ceilings, and 50% of the forecasted inflation to the end of the NF's next fiscal year.*

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

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

D. Nonoperating costs. Allowable plant costs shall be reimbursed in accordance with this article. Plant costs shall not include the component of cost related to making or producing a supply or service.

NATCEPs cost shall be reimbursed in accordance with 12 VAC 30-90-170.

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

F. *Effective July 1, 2000,* for those NFs whose *indirect* operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable *indirect* operating cost rates and the *indirect* peer group ceilings ~~under the PIRS~~.

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

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

2. ~~Separate~~ Efficiency incentives shall be calculated *only* for ~~both~~ the ~~direct and~~ indirect patient care operating ceilings and costs. *Effective July 1, 2000, a direct care efficiency incentive shall no longer be paid.*

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

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

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

12 VAC 30-90-42. ~~Phase-in period.~~ *(Repealed.)*

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

~~B. From October 1, 1990, through June 30, 1991, a NF's prospective operating cost rate shall be a blended rate calculated at 33% of the PIRS operating cost rates determined by 12 VAC 30-90-41 and 67% of the "current" operating rate determined by subsection D below.~~

~~C. From July 1, 1991, through June 30, 1992, a NF's prospective operating cost rate shall be a blended rate calculated at 67% of the PIRS operating cost rates determined by 12 VAC 30-90-41 and 33% of the "current" operating rate determined by subsection D below.~~

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

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

2. The base "current" operating rate established above shall be the "current" operating rate for the NF's first partial fiscal year under PIRS. The base "current" operating rate shall be adjusted by appropriate allowance for historical inflation and 50% of the forecasted inflation based on the methodology contained in 12 VAC 30-90-41 B at the beginning of each of the NF's fiscal years which starts during the phase-in period, October 1, 1990, through June 30, 1992, to determine the NF's prospective "current" operating rate. See 12 VAC 30-90-300 for example calculations.

12 VAC 30-90-43. Nursing facility rate change. *(Repealed.)*

For the period beginning July 1, 1991, and ending June 30, 1992, the per diem operating rate for each NF shall be adjusted. This shall be accomplished by applying a uniform adjustment factor to the rate of each NF.

12 VAC 30-90-50. Allowable costs.

A. Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see 12 VAC 30-90-270).

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

C. Operating costs.

1. Direct patient care operating costs shall be defined in 12 VAC 30-90-270.

2. Allowable direct patient care operating costs shall exclude (i) personal physician fees, and (ii) pharmacy services and prescribed legend and nonlegend drugs provided by nursing facilities which operate licensed in-house pharmacies. These services shall be billed directly to DMAS through separate provider agreements and DMAS shall pay directly in accordance with 12 VAC 30-80-10 et seq.

3. Indirect patient care operating costs include all other operating costs, not identified as direct patient care operating costs and NATCEPs costs in 12 VAC 30-90-270, which are allowable under the Medicare principles of reimbursement, except as specifically modified herein and as may be subject to individual cost or ceiling limitations.

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

E. Cost of protecting employees from blood borne pathogens. Effective July 1, 1994, reimbursement of allowable costs shall be adjusted in the following way to recognize the costs of complying with requirements of the Occupational Safety and Health Administration (OSHA) for protecting employees against exposure to blood borne pathogens.

1. Hepatitis B immunization. The statewide median of the reasonable acquisition cost per unit of immunization times the number of immunizations provided to eligible employees during facility fiscal years ending during SFY 1994, divided by Medicaid days in the same fiscal period, shall be added to the indirect peer group ceiling effective July 1, 1994. This increase to the ceilings shall not exceed $.09 per day for SFY 1995.

2. Other OSHA compliance costs. The indirect peer group ceilings shall be increased by $.07, effective July 1, 1994, to recognize continuing OSHA compliance costs other than immunization.

3. Data submission by nursing facilities. Nursing facilities shall provide for fiscal years ending during SFY 1994, on forms provided by DMAS, (i) the names, job titles and social security numbers of individuals immunized, the number of immunizations provided to each and the dates of immunization; and (ii) the acquisition cost of immunization.

12 VAC 30-90-51. Purchases/related organizations.

A. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization, provided that such costs do not exceed the price of comparable services, facilities or supplies. Purchases of existing NFs by related parties shall be governed by the provisions of 12 VAC 30-90-34 B 2.

Allowable cost applicable to management services furnished to the provider by organizations related to the provider by common ownership or control shall be lesser of the cost to the related organization or the per patient day ceiling limitation established for management services cost. (See 12 VAC 30-90-290.)

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

C. Common ownership exists when an individual or individuals or entity or entities possess significant ownership or equity in the parties to the transaction. Control exists where an individual or individuals or entity or entities have the power, directly or indirectly, significantly to influence or direct the actions or policies of the parties to the transaction. Significant ownership or control shall be deemed to exist where an individual is a "person with an ownership or control interest" within the meaning of 42 CFR 455.101. If the parties to the transaction are members of an immediate family, as defined below, the transaction shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control," as set forth above. Immediate family shall be defined to include, but not be limited to, the following: (i) husband and wife, (ii) natural parent, child and sibling, (iii) adopted child and adoptive parent, (iv) step-parent, step-child, step-sister, and

step-brother, (v) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, and (vi) grandparent and grandchild.

D. Exception to the related organization principle.

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

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

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

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

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

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

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

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

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

~~E. Three competitive bids shall not be required for the building and fixed equipment components of a construction project outlined in 12 VAC 30-90-31. Reimbursement shall be in accordance with subsection A of this section with the limitations stated in 12 VAC 30-90-31 B.~~

12 VAC 30-90-53. ~~Depreciation.~~ *(Repealed.)*

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

12 VAC 30-90-54. ~~Rent/Leases.~~ *(Repealed.)*

~~Rent or lease expenses shall be limited by the provisions of 12 VAC 30-90-280.~~

12 VAC 30-90-60. Interim rate.

A. *Effective July 1, 2000,* for all new or expanded NFs the ~~95%~~ *90%* occupancy requirement *for indirect and plant costs* shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed 12 months from the date of the NF's certification.

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

C. The ~~95%~~ *90%* occupancy requirement *for indirect and plant costs* shall be applied to the first and subsequent cost reporting periods' actual *indirect and plant* costs for establishing such NF's second and future cost reporting periods' prospective reimbursement rates. The ~~95%~~ *90%* occupancy requirement shall be considered as having been satisfied if the new NF achieved a ~~95%~~ *90%* occupancy at any point in time during the first cost reporting period.

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

E. *Effective July 1, 2000,* on the first day of its second cost reporting period, a new nursing facility's interim plant rate shall be converted to a per diem amount by dividing it by the number of patient days computed as ~~95%~~ *90%* of the daily licensed bed complement during the first cost reporting period.

~~F. Any NF receiving reimbursement under new NF status shall not be eligible to receive the blended phase-in period rate under 12 VAC 30-90-42.~~

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

12 VAC 30-90-65. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in 12 VAC 30-90-60 A, C, E, and F.

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

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable *indirect* operating cost and the peer group ceiling used to set the interim rate. (Refer to 12 VAC 30-90-41 F.)

12 VAC 30-90-136. ~~[Reserved.]~~ *Elements of the capital payment methodology that shall not be subject to appeal shall be:*

1. The definitions provided in this section, and the application of those definitions to the FRV rate calculation.

2. The transition policy described in this section.

3. The formula for determining the FRV per diem rate described in this section.

4. The calculation of the FRV rental amount described in this section.

5. The exclusion of certain beds from the transition policy, as provided in this section.

6. The adjustment for FRV savings during the transition.

12 VAC 30-90-160. Stock acquisition; merger of unrelated and related parties.

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

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

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

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

12 VAC 30-90-220. ~~Start-up costs.~~ *(Repealed.)*

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

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

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

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

12 VAC 30-90-221. ~~Time frames.~~ *(Repealed.)*

~~A. Start-up cost time frames.~~

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

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

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

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

~~B. Depreciation time frames.~~

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

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

12 VAC 30-90-222. Organizational costs. *(Repealed.)*

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

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

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

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

12 VAC 30-90-260. Change of ownership. *(Repealed.)*

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

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

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

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

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

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

C. Change of ownership is deemed to have occurred only when there has been a bona fide sale of assets of a NF (See 12 VAC 30-90-34 B 3 for the definition of "bona fide" sale).

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

1. The amounts computed in subsection B above;

2. Appraised replacement cost value; or

3. Purchase price.

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

12 VAC 30-90-264. Specialized care services.

Specialized care services provided in conformance with 12 VAC 30-60-40 E and H, 12 VAC 30-60-320 and 12 VAC 30-60-340 shall be reimbursed under the following methodology. The nursing facilities that provide adult specialized care for the categories of Ventilator Dependent Care, Comprehensive Rehabilitation Care, and Complex Health Care will be placed in one group for rate determination. The nursing facilities that provide pediatric specialized care in a dedicated pediatric unit of eight beds or more will be placed in a second group for rate determination.

1. Routine operating cost. Routine operating cost shall be defined as in 12 VAC 30-90-271 and 12 VAC 30-90-272. To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days.

2. Allowable cost identification and cost reimbursement limitations. The provisions of Article 3 (12 VAC 30-90-50 et seq.) of Part II of this chapter and of Appendix III (12

VAC 30-90-290) of Part III of this chapter shall apply to specialized care cost and reimbursement.

3. Routine operating cost rates. Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in 12 VAC 30-90-41.

4. Facility-specific prospective routine operating ceiling. Each nursing facility's prospective routine operating ceiling shall be calculated as:

a. Statewide ceiling. The statewide routine operating ceiling shall be the weighted average (weighted by 1994 days) of specialized care rates in effect on July 1, 1996, reduced by statewide weighted average ancillary and capital cost per day amounts based on audited 1994 cost data from the 12 facilities whose 1994 FY specialized care costs were audited during 1996. This routine operating ceiling amount shall be adjusted for inflation by the percentage of change in the moving average of the Virginia specific Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by DRI/McGraw-Hill, using the second quarter 1996 DRI table. The respective statewide operating ceilings will be adjusted each quarter in which the provider's most recent fiscal year ends, by adjusting the most recent interim ceiling by 100% of historical inflation and 50% of forecasted inflation to the end of the provider's next fiscal year.

b. The portion of the statewide routine operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for skilled nursing facilities, divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the Health Care Financing Administration (HCFA) publishes wage indices for skilled nursing facilities. Updated normalization shall be effective for fiscal years starting on and after the January 1 for which the normalization is calculated.

c. The percentage of the statewide routine operating ceiling relating to the nursing labor and nonlabor costs (as determined by the 1994 audited cost report data or 71.05%) will be adjusted by the nursing facility's specialized care average Resource Utilization Groups, Version III (RUG-III) Nursing-Only Normalized Case Mix Index (NCMI). The NCMI for each nursing facility will be based on all specialized care patient days rendered during the six-month period prior to that in which the ceiling applies (see subdivision 6 below).

5. Normalized case mix index (NCMI). Case mix shall be measured by RUG-III nursing-only index scores based on Minimum Data Set (MDS) data. The RUG-III nursing-only weights developed at the national level by the Health Care Financing Administration (HCFA) (see 12 VAC 30-90-320) shall be used to calculate a facility-specific case mix index (CMI). The facility-specific CMI, divided by the statewide CMI shall be the facility's NCMI. The steps in the calculation are as follows:

a. The facility-specific CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all patient days in the facility during the six months prior to the six-month period to which the NCMI shall be applied to the facility's routine operating cost and ceiling.

b. The statewide CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all specialized care patient days in all Specialized Care Nursing facilities in the state during the six months prior to the six-month period to which the NCMI shall be applied. A new statewide CMI shall be calculated for each six-month period for which a provider-specific rate must be set.

c. The facility-specific NCMI for purposes of this rate calculation shall be the facility-specific CMI from (a) above divided by the statewide CMI from (b) above.

d. Each facility's NCMI shall be updated semiannually, at the start and the midpoint of the facility's fiscal year.

e. Patient days for which the lowest RUG-III weight is imputed, as provided in subdivision 14 c of this section, shall not be included in the calculation of the NCMI.

6. Facility-specific prospective routine operating base cost per day: The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted (using DRI-Virginia inflation factors) by 50% of historical inflation and 50% of the forecasted inflation, and adjusted for case mix as described below:

a. An NCMI rate adjustment shall be applied to each facility's prospective routine nursing labor and nonlabor operating base cost per day for each semiannual period of the facility's fiscal year.

b. The NCMI calculated for the second semiannual period of the previous fiscal year shall be divided by the average of that (previous) fiscal year's two semiannual NCMIs to yield an "NCMI cost rate adjustment" to the prospective nursing labor and nonlabor operating cost base rate in the first semiannual period of the subsequent fiscal year.

c. The NCMI determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's two semiannual NCMIs to determine the NCMI cost rate adjustment to the prospective nursing labor and nonlabor operating base cost per day in the second semiannual period of the subsequent fiscal year.

See 12 VAC 30-90-310 for an illustration of how the NCMI is used to adjust routine operating cost ceilings and semiannual NCMI adjustments to the prospective routine operating base cost rates.

7. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report and Minimum Data Set (MDS) data available at the time the interim rates must be set, except that failure to submit cost and MDS data timely may result in adjustment to interim rates as provided elsewhere.

8. Ancillary costs. Specialized care ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:

a. All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. See 12 VAC 30-90-290 for the cost reimbursement limitations.

b. Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See 12 VAC 30-90-290 for the cost reimbursement limitations.

c. Kinetic therapy devices will be reimbursed only if a resident is being treated for wounds that meet specialized care Complex Health Care Category wound care criteria. Residents receiving this wound care must require kinetic bed therapy (that is, low air loss mattresses, fluidized beds, and/or rotating/turning beds) and require treatment for a grade (stage) IV decubitus, a large surgical wound that cannot be closed, or second to third degree burns covering more than 10% of the body.

9. Covered ancillary services are defined as follows: laboratory, X-ray, medical supplies (e.g., infusion pumps, incontinence supplies), physical therapy, occupational therapy, speech therapy, inhalation therapy, IV therapy, enteral feedings, and kinetic therapy. The following are not specialized care ancillary services and are excluded from specialized care reimbursement: physician services, psychologist services, total parenteral nutrition (TPN), and drugs. These services must be separately billed to DMAS. An interim rate for the covered ancillary services will be determined (using data from the most recent settled cost report) by dividing allowable ancillary costs by the number of patient days for the same cost reporting period. The interim rate will be retroactively cost settled based on the specialized care nursing facility cost reporting period.

10. Capital costs ~~(excluding pediatric specialized care units)~~. *Effective July 1, 2000,* capital cost reimbursement shall be in accordance with *12 VAC 30-90-35 through 12 VAC 30-90-37 inclusive of* the ~~current~~ NHPS, except that the ~~95% (85% if applicable)~~ *90%* occupancy requirement shall not be separately applied to specialized care. Capital cost related to specialized care patients will be cost settled on the respective nursing facility's cost reporting period. In this cost settlement the ~~95% (85% if applicable)~~ *90%* occupancy requirement shall be applied to all the nursing facility's licensed nursing facility beds inclusive of specialized care. ~~An occupancy requirement of 70% shall be applied to distinct part pediatric specialized care units.~~

11. Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEP) costs. NATCEPS costs will be paid on a pass-through basis in accordance with the current NHPS.

12. Pediatric routine operating cost rate. For pediatric specialized care in a distinct part pediatric specialized care unit, one routine operating cost ceiling will be developed. The routine operating cost ceiling will be computed as follows:

a. The Complex Health Care Payment Rate effective July 1, 1996, and updated for inflation, will be reduced by (i) the weighted average capital cost per day developed from the 1994 audit data and (ii) the weighted average ancillary cost per day from the 1994 audit data updated for inflation in the same manner as described in subdivision 4 a of this subsection.

b. The statewide operating ceiling shall be adjusted for each nursing facility in the same manner as described in subdivisions 4 and 5 of this section.

c. The final routine operating cost reimbursement rate shall be computed as described for other than pediatric units in subdivision 3 of this section.

13. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with the current NHPS, except that the occupancy requirement shall be 70% rather than ~~95% or 85%~~ *90%*. ~~An interim capital rate will be calculated from the latest cost report and retrospectively cost settled on the respective specialized care provider's cost reporting period.~~

14. MDS data submission. MDS data relating to specialized care patients must be submitted to the department in a submission separate from that which applies to all nursing facility patients.

a. Within 30 days of the end of each month, each specialized care nursing facility shall submit to the department, separately from its submission of MDS data for all patients, a copy of each MDS Version 2.0 which has been completed in the month for a Medicaid specialized care patient in the nursing facility. This shall include (i) the MDS required within 14 days of admission to the nursing facility (if the patient is admitted as a specialized care patient), (ii) the one required by the department upon admission to specialized care, (iii) the one required within 12 months of the most recent full assessment, and (iv) the one required whenever there is a significant change of status.

b. In addition to the monthly data submission required in (a) above, the same categories of MDS data required in (a) above shall be submitted for all patients receiving specialized care from January 1, 1996,

through December 31, 1996, and shall be due February 28, 1997.

c. If a provider does not submit a complete MDS record for any patient within the required timeframe, the department shall assume that the RUG-III weight for that patient, for any time period for which a complete record is not provided, is the lowest RUG-III weight in use for specialized care patients. A complete MDS record is one that is complete for purposes of transmission and acceptance by the Health Care Financing Administration.

15. Case mix measures in the initial semiannual periods. In any semiannual periods for which calculations in 12 VAC 39-90-310 requires an NCMI from a semiannual period beginning before January 1996, the case mix used shall be the case mix applicable to the first semiannual period beginning after January 1, 1996, that is a semiannual period in the respective provider's fiscal period. For example, December year-end providers' rates applicable to the month of December 1996, would normally require (in Appendix I (12 VAC 30-90-270 et seq.) of Part III of this chapter) an NCMI from July to December 1995, and one from January to June 1996, to calculate a rate for July to December 1996. However, because this calculation requires an NCMI from a period before January 1996, the NCMIs that shall be used will be those applicable to the next semiannual period. The NCMI from January to June 1996, and from July to December 1996, shall be applied to December 1996, as well as to January to June 1997. Similarly, a provider with a March year end would have it's rate in December 1996, through March 1997, calculated based on an NCMI from April through September 1996, and October 1996, through March 1997.

16. Cost reports of specialized care providers are due not later than 150 days after the end of the provider's fiscal year. Except for this provision, the requirements of 12 VAC 30-90-70 and 12 VAC 30-90-80 shall apply.

~~**12 VAC 30-90-280. Leasing of facilities.**~~

~~I. Determination of allowable lease costs.~~

~~A. The provisions of this Part (Appendix II) shall apply to all lease agreements, including sales and leaseback agreements and lease purchase agreements, and including whether or not such agreements are between parties which are related (as defined in 12 VAC 30-90-50 of the Nursing Home Payment System (NHPS)).~~

~~B. Reimbursement of lease costs pursuant to a lease between parties which are not related shall be limited to the DMAS allowable cost of ownership as determined in E. below. Reimbursement of lease costs pursuant to a lease between parties which are related (as defined in 12 VAC 30-90-50) shall be limited to the DMAS allowable cost of ownership. Whether the lease is between parties which are or are not related, the computation of the allowable annual lease expense shall be subject to DMAS audit.~~

~~C. The DMAS allowable cost of ownership shall be determined by the historical cost of the facility to the owner of record at the date the lease becomes effective. When a lease agreement is in effect, whether during the original term or a subsequent renewal, no increase in the reimbursement shall be allowed as a result of a subsequent sale of the facility.~~

~~D. When a bona fide sale has taken place, the facility must have been held by the seller for a period of no less than five years for a lease effected subsequent to the sale date to be compared to the buyer's cost of ownership. Where the facility has been held for less than 5 years, the allowable lease cost shall be computed using the seller's historical cost.~~

~~E. Reimbursement of lease costs pursuant to a lease between parties which are not related (as defined in 12 VAC 30-90-50) shall be limited to the DMAS allowable cost of ownership. The following reimbursement principles shall apply to leases, other than those covered in 12 VAC 30-90-50 and subdivision IV (Appendix II), entered into on or after October 1, 1990:~~

~~1. An "Allowable Cost of Ownership" schedule shall be created for the lease period to compare the total lease expense to the allowable cost of ownership.~~

~~2. If the lease cost for any cost reporting period is below the cost of ownership for that period, no adjustment shall be made to the lease cost, and a "carryover credit" to the extent of the amount allowable for that period under the "Allowable Cost of Ownership" schedule shall be created but not paid.~~

~~3. If the lease cost for a future cost reporting period is greater than the "Cost of Ownership" for that period, the provider shall be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or his actual lease cost, whichever is less. At no time during the lease period shall DMAS reimbursement exceed the actual cumulative "Cost of Ownership."~~

~~4. Once DMAS has determined the allowable cost of ownership, the provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of cost of ownership vs. lease cost to support the "carryover credit" as reported in the "Allowable Cost of Ownership" schedule, and shall submit such a schedule with each cost report.~~

~~II. Documentation of costs of ownership.~~

~~A. Leases shall provide that the lessee or DMAS shall have access to any and all documents required to establish the underlying cost of ownership.~~

~~B. In those instances where the lessor will not share this information with the lessee, the lessor can forward this information direct to DMAS for confidential review.~~

~~III. Computation of cost of ownership.~~

~~A. Before any rate determination for allowable lease costs is made, the lessee must supply a schedule comparing lease expense to the underlying cost of ownership for the life of the lease. Supporting documentation, including but not limited to, the lease and the actual cost of ownership (mortgage instruments, financial statements, purchase agreements, etc.) must be included with this schedule.~~

B. The underlying straight-line depreciation, interest, property taxes, insurance, and amortization of legal and commitment fees shall be used to determine the cost of ownership for comparison to the lease costs. Any cost associated with the acquisition of a lease other than those outlined herein shall not be considered allowable unless specifically approved by the Department of Medical Assistance Services.

1. Straight line depreciation.

a. Depreciation shall be computed on a straight line basis only.

b. New or additions facilities shall be depreciated in accordance with AHA Guidelines.

c. Allowable depreciation for on-going facilities shall be computed on the historical cost of the facility determined in accordance with limits on allowable building and fixed equipment cost.

d. The limits contained in 12 VAC 30-90-30, and Part VI (12 VAC 30-90-160) shall apply, as appropriate, whether the facility is newly constructed or an on-going facility.

2. Interest. Interest expense shall be limited to actual expense incurred by the owner of the facility in servicing long-term debt and shall be subject to the interest rate limitations stated in 12 VAC 30-90-30.

3. Taxes and insurance. Taxes are limited to actual incurred real estate and property taxes. Insurance is limited to the actual cost of mortgage insurance, fire and property liability insurance. When included in the lease as the direct responsibility of the lessee, such taxes and insurance shall not be a part of the computation of the cost of ownership.

4. Legal and commitment fees. Amortization of actual incurred closing costs paid by the owner, such as attorney's fees, recording fees, transfer taxes and service or "finance" charges from the lending institution may be included in the comparison of the cost of ownership computation. Such fees shall be subject to limitations and tests of reasonableness stated in these regulations. These costs shall be amortized over the life of the mortgage.

5. Return on Equity.

a. Return on equity will be limited to the equity of the facility's owner when determining allowable lease expense. Return on equity will be limited to 10%. For the purpose of determining allowable lease expense, equity will be computed in accordance with PRM 15 principles. The allowable base will be determined by monthly averaging of the annual equity balances. The base will be increased by the amount of paid up principal in a period but will be reduced by depreciation expense in that period.

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

IV. Leases approved prior to August 18, 1975.

A. Leases approved prior to August 18, 1975, shall have the terms of those leases honored for reimbursement throughout the duration of the lease.

B. Renewals and extensions to these leases shall be honored for reimbursement purposes only when the dollar amount negotiated at the time of renewal does not exceed the amount in effect at the termination date of the existing lease. No escalation clauses shall be approved.

C. Payments of rental costs for leases reimbursed pursuant to subsection A above shall be allowed whether the provider occupies the premises as a lessee, sublessee, assignee, or otherwise. Regardless of the terms of any present or future document creating a provider's tenancy or right of possession, and regardless of whether the terms thereof or the parties thereto may change from time to time, future reimbursement shall be limited to the lesser of (1) the amount actually paid by the provider, or (2) the amount reimbursable by DMAS under these regulations as of the effective date this amendment. In the event extensions or renewals are approved pursuant to subsection B of this section, no escalation clauses shall be approved or honored for reimbursement purposes.

V. Nothing in this (Appendix II) shall be construed as assuring providers that reimbursement for rental costs will continue to be reimbursable under any further revisions of or amendment to these regulations.

VA.R. Doc. No. R00-215; Filed June 28, 2000, 3:16 p.m.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

DEPARTMENT OF MINES, MINERALS AND ENERGY

EDITOR'S NOTICE: The following forms have been amended by the Department of Mines, Minerals and Energy. The forms are not being published due to the large number of pages; however, the name of each form is listed below. The forms are available for public inspection at the Department of Mines, Minerals and Energy, Ninth Street Office Building, 202 North 9th Street, Richmond, VA 23219, or at the department's Abingdon, Big Stone Gap, or Charlottesville offices. Copies of the forms may be obtained from Cheryl Cashman, Department of Mines, Minerals and Energy, Ninth Street Office Building, 202 North 9th Street, Richmond, VA 23219, telephone (804) 692-3213.

Title of Regulation: **4 VAC 25-30-10 et seq. Minerals Other Than Coal Surface Mining Regulations.**

FORMS

Mineral Mining Annual Tonnage Report, DMM-146 (rev. 9/98).

Permit/License Application, DMM-101 (rev. 9/98).

Request for Release of Mine Map, DMM-155/DM-MR-1 (rev. 3/97).

Notice of Application to Mine, DMM-103 (rev. 11/94).

Statement Listing the Names and Addresses of Adjoining Property Owners, DMM-103a (rev. 1/88; included in DMM-103).

Yearly Progress Report, DMM-105 (rev. 12/94).

Surety Bond, DMM-107 (rev. 4/98).

Legend, DMM-109 (rev. 11/94).

Relinquishment of Mining Permit, DMM-112 (rev. 11/94).

Request for Amendment, DMM-113 (rev. 2/95).

Consolidated Biennial Report of Waivered Counties, Cities and Towns, DMM-116 (rev. ~~6/90~~ *12/99*).

Biennial Waivered Counties, Cities and Towns Report of Individual Mining Companies, DMM-117 (rev. ~~6/90~~ *12/99*).

Consent for Right of Entry on Surface Mined Orphaned Land, DMM-120 (rev. ~~8/87~~ *12/99*).

Mineral Mining Annual Tonnage Report, DMM-146 (rev. 11/94).

DMM Course Evaluation, DMM-152 (rev. 4/90).

Training/Exam Application, DMM-154 (rev. 7/95).

Request for Release of Mine Map, DMM-155 (rev. 11/94).

Notice of Operator Intent, DMM-156 (rev. 1/95).

License Renewal Application, DMM-157 (rev. 9/98).

GOVERNOR'S COMMENTS ON PROPOSED REGULATIONS

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD FOR BRANCH PILOTS

Title of Regulation: **18 VAC 45-20-10 et seq. Board for Branch Pilots Rules and Regulations.**

Governor's Comment:

I have reviewed the proposed regulation on a preliminary basis. While I reserve the right to take action under the Administrative Process Act during the final adoption period, I have no objection to this regulation on the information and public comment currently available.

/s/ James S. Gilmore, III
Governor
Date: May 18, 2000

VA.R. Doc. No. R99-175; Filed June 29, 2000, 2:22 p.m.

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TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Title of Regulation: **22 VAC 40-680-10 et seq. Virginia Energy Assistance Program.**

Governor's Comment:

I have reviewed the proposed regulation on a preliminary basis. While I reserve the right to take action under the Administrative Process Act during the final adoption period, I have no objection to this regulation based on the information and public comment currently available.

/s/ James S. Gilmore, III
Governor
Date: May 18, 2000

VA.R. Doc. No. R99-180; Filed June 29, 2000, 2:22 p.m.

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The Legislative Record is available on the Internet at http://dls.state.va.us/pubs/legisrec/

STATE CORPORATION COMMISSION

June 23, 2000

Administrative Letter 2000-9

TO: All Carriers Licensed to Market Accident and Sickness Insurance in Virginia

RE: Medicare Supplement Insurance

On April 7, 2000, the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) published a final rule in the Federal Register (Vol. 65, No 68 p. 18434) that will implement a prospective payment system for hospital outpatient services provided to Medicare beneficiaries. The prospective payment system was established by the Balanced Budget Act of 1997 (BBA). This system changes the manner in which coinsurance payments are calculated under section 1882 of the Social Security Act, which governs Medicare Supplement Insurance. Under the prospective payment system, coinsurance for hospital outpatient department services will no longer be based on a percentage of the cost of Medicare eligible expenses under Part B, but instead will be paid according to an established fixed copayment amount for the particular service provided.

The purpose of this letter is to notify all carriers marketing Medicare Supplement Insurance in Virginia as well as carriers with existing Medicare Supplement business in force in Virginia that the Bureau of Insurance (the Bureau) will expect and require full compliance with this federal standard on its effective date, August 1, 2000, both with respect to contracts in force as well as contracts issued on and after this date. In order to effect compliance with this standard, carriers must provide coverage for applicable copayments related to hospital outpatient department services under a prospective payment system.

Virginia's *Rules Governing Minimum Standards for Medicare Supplement Policies*, 14 VAC 5-170-10, et seq., will be amended to address this coverage change. It is anticipated that the additional coverage requirement will be addressed in 14 VAC 5-170-70 C 5 concerning the standards for basic (core) benefits common to all benefit plans, and 14 VAC 5-170-150 C 4 concerning required disclosure in the outline of coverage. Until such time as the rules are amended, carriers are expected and required to revise policy forms and outlines of coverage accordingly. All forms revised to comply with these requirements must be submitted to the Bureau for approval prior to their use in the Commonwealth of Virginia. Insurance companies are obligated to follow the federal law regardless of the status of form filings with the Bureau.

Questions regarding this matter may be directed IN WRITING to Jacqueline K. Cunningham, Supervisor, Forms and Rates Section, Life and Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, Virginia 23218.

/s/ Alfred W. Gross
Commissioner of Insurance

* * *

June 30, 2000

Administrative Letter 2000-10

TO: All Insurers Licensed to Write Life Insurance or Annuities in Virginia

RE: Equity Indexed Annuities
Equity Indexed Life Insurance Products

THIS REPLACES ADMINISTRATIVE LETTER 1997-4

The Bureau of Insurance ("the Bureau") is issuing this Administrative Letter in place of Administrative Letter 1997-4, dated May 9, 1997, in which insurers were advised that Equity Indexed Annuities and Equity Indexed Life Insurance products would be accepted for approval by the Bureau subject to the certification of a number of items included in an affidavit that was attached to that Administrative Letter, and further subject to compliance with applicable statutory and regulatory requirements.

The purpose of this Administrative Letter is to notify insurers of, and provide insurers with the Bureau's current posture regarding these products and to provide a revised affidavit form. Completion of this affidavit will be required prospectively for approval of equity indexed products, and, to the extent that they differ, affidavits executed by insurers prior to the date of this letter will be interpreted and administered in the same manner, in every respect, as the revised affidavit attached to and made part of this Administrative Letter.

The revised affidavit omits certification number 5, as well as the entire "agreement" provision immediately following certification number 5, all of which appeared on page two (2) of the previous affidavit. The Bureau has concluded that such certification and agreement is not necessary to consider equity indexed products for approval in Virginia. The remainder of the revised affidavit is identical to the version being replaced.

All submissions of equity indexed products must be accompanied by a copy of the attached affidavit, signed by an executive officer of the company. Equity indexed products will be reviewed for compliance with all applicable statutory and regulatory requirements and will be approved accordingly, subject to inclusion of the completed affidavit.

Questions regarding this letter should be directed IN WRITING to Jacqueline K. Cunningham, Supervisor, Forms and Rates Section, Life and Health Division, P.O. Box 1157, Richmond, Virginia 23218, 804-371-9110.

/s/ Alfred W. Gross
Commissioner of Insurance

AFFIDAVIT

Company Name: _____ (Insurer)
NAIC Number: _____ State of Domicile: _____

RE: Form Number(s)

_____ _____ _____
_____ _____ _____

In connection with the filing of the captioned forms with the Commonwealth of Virginia State Corporation Commission Bureau of Insurance, I, an officer of the above-named company, the Insurer, represent that each of the captioned forms identifies a product, herein referred to as "equity indexed products," in which all or a portion of the policy value accumulates at a rate which is based on an investment index; and, on behalf of the Insurer, I certify to each of the following:

1. The Insurer is in good standing and holds an active license as a life, or life and health, insurer in its state of domicile and in the Commonwealth of Virginia.

2. The Insurer is authorized and appropriately licensed in its state of domicile to underwrite and offer for sale in its state of domicile the products described in the captioned forms and herein referred to as "equity indexed products"; and as evidence of such authority confirms with a check mark (✓) the applicability of one or more of the following:

___ The Insurer is a foreign insurer that has been authorized by its domiciliary regulator specifically for "equity indexed products."
___ The Insurer is a foreign insurer and its domiciliary regulator has approved one or more of the captioned forms or a similar form for use in the sale of substantially the same product in its domiciliary state.
___ The Insurer is a foreign insurer that is currently marketing equity indexed products in its state of domicile.
___ The Insurer is domiciled in Virginia and has been granted licensing authority specifically to sell variable annuities or variable life insurance.
___ The Insurer is domiciled in Virginia and attaches and files with this affidavit the following: (i) a plan of operation for the issuance of "equity indexed products" which has been approved by the Board of Directors, (ii) a general description of the products offered and to be offered, (iii) a description of any investment advisory services which may be used to underwrite or market these products; and (iv) a statement of the insurer's actuary describing the mortality, disintermediation, investment and expense risks which the Insurer will bear under these products.

3. The sale of equity indexed products is and will in the future be fully disclosed, in conformity with NAIC annual statement instructions, in the annual statements filed by the Insurer with the Commission, the NAIC, and with the Insurer's state of domicile, and also in quarterly statements filed with the Insurer's state of domicile; and

Equity Indexed Products
Affidavit
6/2000

4. The Insurer is required by its state of domicile to file annually a statement of actuarial opinion prepared by a qualified actuary and setting forth his or her opinion relating to policy reserves and other actuarial items in the insurer's general AND separate accounts; a copy of the most recently filed statement of actuarial opinion has been filed also with the Commission; and, further, such statement included an asset adequacy analysis that conforms with the rules set forth in 14 VAC 5-310-80; and memoranda complying with 14 VAC 5-310-90 shall be available to the Commission, upon request, for each of the years in which an equity indexed product is offered for sale or delivery or is in force in the Commonwealth of Virginia.

_____
Signature

_____
Print Name

_____
Date

_____
Title

Notarial Acknowledgment

State of _____

County/City of _____

_____, being duly sworn according to law, deposes and says that he/she executed the above instrument and that the statements contained therein are true and correct to the best of his/her knowledge and belief.

Subscribed and sworn to before me this ___day of _____,20___.

_____
Notary Public

(S E A L)

My Commission Expires: _____

Equity Indexed Products
Affidavit
6/2000

* * * * * * * *

EDITOR'S NOTE: Appendices A, B and C referenced in the following order are not being published. However, these appendices are available for public inspection at the State Corporation Commission, Document Control Center, Tyler Building, 1300 East Main Street, 1st Floor, Richmond, Virginia, from 8:15 a.m. to 5 p.m., Monday through Friday.

Summary:

The State Corporation Commission has initiated the following proceeding pursuant to § 56-581.1 of the Virginia Electric Utility Restructuring Act (§ 56-576 et seq.). Under § 56-581.1 of the Code of Virginia, the commission must recommend to the Legislative Transition Task Force of the Virginia General Assembly on or before January 1, 2001, after notice and an opportunity for hearing, whether metering services, billing services, or both, may be provided competitively for persons licensed to provide such services. The commission has initiated Case No. PUE000346 to assist it in the development of a recommendation and draft plan for retail billing and metering services. Its staff has proposed discussion draft plans and issues related to the implementation of retail billing and metering billings on which the commission seeks comments in order to initiate the development of the recommendation and draft plan the commission will present to the Legislative Transition Task Force. Comments or requests for hearing on the discussion drafts and accompanying issues must be filed with the Clerk of the Commission by August 25, 2000. Any request for hearing must explain why the issues raised cannot be adequately addressed in written comments.

Contact: Thomas Lamm, State Corporation Commission, Division of Energy Regulation, P.O. Box 1197, Richmond, Virginia 23218-1197, telephone (804) 371-9392.

AT RICHMOND, JULY 12, 2000

COMMONWEALTH OF VIRGINIA, ex rel.
STATE CORPORATION COMMISSION

Ex Parte: In the matter concerning a draft plan for retail electric metering and billing services — CASE NO. PUE000346

ORDER PRESCRIBING NOTICE AND INVITING COMMENTS

The General Assembly enacted § 56-581.1 of the Virginia Electric Utility Restructuring Act (the "Act"), Chapter 23 (§ 56-576 et seq.) of Title 56 of the Code of Virginia (the "Code"), effective July 1, 2000. The statute directs the State Corporation Commission ("Commission") to recommend to the Legislative Transition Task Force, on or before January 1, 2001, and after notice and an opportunity for hearing, whether metering services, billing services, or both, may be provided by persons licensed to provide such services. The Commission is to recommend to the Legislative Transition Task Force "the appropriateness of and date of commencement of" the competitive provision of electric metering or billing services. The statute further directs the Commission to develop a draft plan for implementation to be presented to the Legislative Transition Task Force that may vary by service, type of seller, region, incumbent electric utility, and customer group.

Section 56-581.1 of the Code requires that the Commission's recommendation and draft plan:

1. [b]e consistent with the goal of facilitating the development of effective competition in electric service for all customer classes;

2. [t]ake into account the readiness of customers and suppliers to buy and sell such services;

3. [t]ake into account the technological feasibility of furnishing any such services on a competitive basis;

4. [t]ake into account whether reasonable steps have been or will be taken to educate and prepare customers for the implementation of competition for any such services;

5. [n]ot jeopardize the safety, reliability or quality of electric service;

6. [c]onsider the degree of control exerted over utility operations by utility customers;

7. [n]ot adversely affect the ability of an incumbent electric utility authorized or obligated to provide electric service to customers who do not buy such services from competitors to provide electric service to such customers at reasonable rates; and

8. [g]ive due consideration to the potential effects of such determinations on utility tax collection by state and local governments in the Commonwealth.

Pursuant to this statutory directive, the Commission establishes this proceeding to assist in the development of a recommendation and draft plan pertaining to retail billing and metering services. To this end, our Staff has proposed discussion draft plans and issues related to implementation, based on the statutory requirements imposed by § 56-581.1 of the Code, that are intended to initiate the development of the recommendation and draft plan we will present to the Legislative Transition Task Force. These discussion draft plans and issues are attached hereto and identified as Attachment 1 and Attachment 2 (collectively the "Attachments").[1] The Attachments may serve as a basis for deliberation and provide a framework from which the Commission can generate discussion and elicit comments from interested parties. Consequently, the Commission seeks public comment on the Attachments. Interested parties are requested to evaluate and respond to the discussion draft plans and associated issues contained in the Attachments hereto, to suggest alternatives to any provision of the

[1] Attachment 1 to the Order contains the Discussion Draft Plan for Retail Billing Service and Issues for Consideration Regarding the Discussion Draft Plan. Attachment 2 to the Order contains the Discussion Draft Plan for Retail Metering Service and Issues for Consideration Regarding the Discussion Draft Plan.

discussion draft plans, and to supplement the issues list as they believe advisable.

As an organizational matter, comments in response to the Attachments should be specific and correspond to the structure of the discussion draft plans and questions provided in the Attachments to the Order. Any interested party also may request that the Commission hold a hearing to address competitive metering and billing service implementation issues and the discussion draft plans. At the conclusion of this matter, the Commission will issue a recommendation and draft plan for retail metering and billing services for consideration by the Legislative Transition Task Force.

Accordingly, we are of the opinion and find that: this matter should be docketed; interested persons should be afforded an opportunity to file written comments or request a hearing on the discussion draft plans and issues contained in the Attachments; notice of this Order should be published on one occasion in newspapers of general circulation throughout the Commonwealth, and a copy of this Order and the Attachments should be forwarded to the Registrar of Regulations for publication in the *Virginia Register of Regulations*;[2] and notice of this Order should be served on the parties set forth in Appendices A, B, and C appended hereto.

Accordingly, IT IS ORDERED THAT:

(1) This matter shall be docketed and assigned Case No. PUE000346.

(2) On or before July 21, 2000, the Commission's Division of Information Resources shall cause the following notice to be published as classified advertising on one occasion in newspapers of general circulation throughout the Commonwealth:

NOTICE OF COMMENTS REQUESTED BY THE STATE CORPORATION COMMISSION PURSUANT TO THE VIRGINIA ELECTRIC UTILITY RESTRUCTURING ACT ON A DRAFT PLAN FOR AND ISSUES RELATING TO RETAIL ELECTRIC METERING AND BILLING SERVICES
CASE NO. PUE000346

The General Assembly enacted § 56-581.1 of the Virginia Electric Utility Restructuring Act (the "Act"), Chapter 23 (§ 56-576 et seq.) of Title 56 of the Code of Virginia (the "Code"), effective July 1, 2000. The statute directs the State Corporation Commission ("Commission") to recommend to the Legislative Transition Task Force, after notice and an opportunity for hearing, whether metering services, billing services, or both, may be provided by persons licensed to provide such services. The Commission is to recommend to the Legislative Transition Task Force "the appropriateness of and date of commencement of" the competitive provision of electric metering or billing services. The statute further directs the Commission to develop a draft plan for implementation to be presented to the Legislative Transition Task Force that may vary by service, type of seller, region, incumbent electric utility, and customer group. The Commission therefore is initiating this proceeding to assist it in developing a recommendation and draft plan.

A copy of the Order Prescribing Notice and Inviting Comments ("Order"), together with discussion draft plans for retail services and issues for which a response is sought (Attachments 1 and 2 to the Order), may be reviewed from 8:15 a.m. to 5:00 p.m., Monday through Friday, in the State Corporation Commission's Document Control Center, First Floor, Tyler Building, 1300 East Main Street, Richmond, Virginia. Interested persons also may obtain a copy of the Order and the Attachments from the Commission's website, http://www.state.va.us/scc/orders.htm, or by directing a written request for a copy of same to Joel H. Peck, Clerk of the Commission, at the address set forth below, and referring to Case No. PUE000346.

Any person who wishes to submit comments or request a hearing in this matter shall file an original and fifteen (15) copies of such comments or request with the Clerk of the Commission, on or before August 25, 2000, and shall refer in the comments to Case No. PUE000346. The comments shall state the person's interest in this proceeding. A request for hearing shall set out in detail why a hearing is necessary. A request for hearing shall identify the issues upon which the party seeks a hearing, the evidence expected to be offered therein, and should explain why the issues raised cannot be adequately addressed in written comments. Should no sufficient requests for hearing be received, the Commission may develop a recommendation and draft plan based upon the filed comments and without convening a hearing at which oral testimony is received.

All communications to the Commission regarding this proceeding shall refer to Case No. PUE000346, and shall be directed to Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218.

DIVISION OF ENERGY REGULATION OF THE STATE CORPORATION COMMISSION

(3) The Commission's Division of Information Resources shall forthwith cause this Order, together with Attachments 1 and 2 to the Order, to be forwarded to the Registrar of Regulations for publication in the *Virginia Register of Regulations*.

(4) The Commission's Division of Information Resources shall file promptly with the Clerk of the Commission proof of the publication of the notices required herein as they become available.

[2] An unofficial version of the text of this Order also is available on the Commission's web site at http://www.state.us.va/scc/orders.htm.

(5) Interested persons may obtain a copy of this Order, together with the Attachments to the Order, by directing a request in writing for the same to Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218. Such requests shall refer to Case No. PUE000346. Interested persons also may obtain a copy of the Order and Attachments from the Commission's website which may be accessed at http://www.state.va.us/scc/orders.htm.

(6) A copy of this Order, together with the Attachments hereto, also shall be made available for public review at the Commission's Document Control Center, located on the first floor of the Tyler Building, 1300 East Main Street, Richmond, Virginia 23219, during its regular hours of operation, Monday through Friday, from 8:15 a.m. to 5:00 p.m.

(7) On or before August 25, 2000, any interested person who wishes to submit comments or request a hearing on the discussion draft plans or issues set forth in the Attachments hereto shall file an original and fifteen (15) copies of such comments or request in writing with Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218. Such comments and requests shall refer to Case No. PUE000346. Such comments shall set forth the person's interest in this proceeding. A request for hearing shall set out in detail why a hearing is necessary. A request for hearing should identify with specificity the issues proposed to be addressed at such hearing, the evidence expected to be offered therein, and should explain why the issues raised cannot be adequately addressed in written comments. Should no sufficient requests for hearing be received, the Commission may develop a recommendation and draft plan based upon the filed comments and without convening a hearing at which oral testimony is received.

(9) This matter shall be continued, pending further order of the Commission.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: the electric cooperatives and electric utilities as set out in Appendix A to this Order; the gas utilities as set out in Appendix B to this Order; the interested parties identified in Appendix C to this Order; John F. Dudley, Senior Assistant Attorney General, Division of Consumer Counsel, Office of Attorney General, 900 East Main Street, Second Floor, Richmond, Virginia 23219; the Commission's Office of General Counsel; and the Commission's Division of Information Resources, Division of Economics and Finance, and Division of Energy Regulation.

ATTACHMENT 1

Discussion Draft Plan for Retail Billing Service

Effective January 1, 2002, and coincident with the implementation schedule for electric retail choice licensed competitive energy service providers ("ESPs") are authorized to offer retail customers in the Virginia service territories of incumbent electric utilities ("LDCs"), subject to the conditions and exceptions listed below, one or more of the following three billing options:

1. Separate bills rendered by the ESP and the LDC;
2. Consolidated bill rendered by the LDC; and
3. Consolidated bill rendered by the ESP.

LDCs shall undertake the necessary coordination with ESPs to support each of the retail-billing options, subject to the following conditions and exceptions:

A. LDCs normally shall be required to support consolidated billing options under "bill-ready"[3] and "rate-ready"[4] protocols.

B. LDCs shall not be required to provide an LDC consolidated billing option for any retail account that receives services from more than one ESP; nor shall LDCs be required to prorate or provide LDC billing charges for one retail account to more than one ESP for purposes of consolidated ESP billing.

C. LDCs and ESPs shall not be required to buy or sell receivables in conjunction with consolidated billing options, but may negotiate such arrangements.

D. LDCs and ESPs may contract with wholesale providers of billing services, but shall retain ultimate responsibility for compliance with relevant Virginia statutes, Commission rules, Commission approved tariffs, established standard business practices, and data exchange protocols governing the provision of retail billing services.

E. Except as authorized by the Commission, LDCs shall provide no retail billing or billing support services to an affiliated ESP, unless the same such services are offered to all other ESPs under terms and conditions that are no less favorable than those offered to the affiliated ESP.

F. LDCs shall retain responsibility for the billing and collection of state and local consumption taxes.

G. The Commission may delay implementation of any element of the plan for the period of time necessary, but no longer than one year, to resolve issues arising from considerations of billing accuracy, timeliness, quality, or consumer readiness. The Commission will report any such delays and the underlying reasons to the Legislative Transition Task Force or the General Assembly within a reasonable time.

Issues for Consideration Regarding the Discussion Draft Plan

Incumbent electric utilities ("LDCs") shall respond and interested parties are invited to respond to the following questions in comments:

[3] Consolidated billing under a "bill-ready" protocol requires the non-billing party to calculate its total charges for each customer and to provide that billing information to the billing party for inclusion in allocated space on the customer's bill.

[4] Consolidated billing under a "rate-ready" protocol requires the non-billing party to provide its rate structure to the billing party, which calculates and includes non-billing party charges on the customer's bill.

1. Does the Discussion Draft Plan for Retail Billing Service satisfy and balance the requirements of the eight specific statutory criteria provided in § 56-581.1 of the Code of Virginia? If not, as specifically as possible, identify and explain each deficiency and propose correcting modifications or alternatives to the Discussion Draft Plan.

2. Does the Discussion Draft Plan promote the overall public interest in the transition of billing practices as part of Virginia's implementation of electric industry restructuring? If not, as specifically as possible and to the extent not addressed in the response to Question 1, identify each deficiency and propose correcting modifications or alternatives to the Discussion Draft Plan. Evaluate each proposed modification or alternative by application of the eight statutory criteria found in § 56-581.1 of the Code of Virginia.

3. Explain whether, and if so to what extent and how, the billing requirements of the Draft Plan to be presented to the Legislative Transition Task Force should vary by service, type of seller, region, incumbent electric utility, and customer group as provided in § 56-581.1 of the Code of Virginia. Consider the eight statutory criteria found in § 56-581.1 of the Code of Virginia.

4. If LDCs are required to support LDC and/or ESP consolidated billing options, should a "bill-ready" protocol, a "rate-ready" protocol, or both protocols be required? Compare these alternatives from both an LDC perspective and an ESP perspective relative to: implementation requirements and cost; on-going administrative operations and cost; potential impacts on bill accuracy, reliability, and timeliness; and the ability of ESPs to enter and participate in Virginia's competitive retail energy supply market.

5. Identify any issues requiring resolution or statutory modification with respect to the continued LDC collection of state and local consumption taxes under the Discussion Draft Plan and under any proposed modifications or alternatives to the Discussion Draft Plan.

6. With respect to the Discussion Draft Plan, identify and explain any elements that might result in consumer confusion, or risks to billing accuracy, quality, and timeliness. Identify any appropriate risk mitigation measures.

7. Identify and explain any element included in the Discussion Draft Plan that is not technologically feasible.

8. Is there sufficient time for all parties reasonably to perform the necessary implementation activities to meet the January 1, 2002, effective date in the Discussion Draft Plan? Should the schedule for any element of the Discussion Draft Plan be delayed? If so, why and for how long?

9. Each LDC is requested to provide the estimated required length of time to modify and test LDC information systems and processes to accommodate the Discussion Draft Plan.

10. Identify and explain all major policy/implementation issues that must be addressed prior to ESP provision of retail billing service.

11. Identify the major implementation activities that LDCs, the Commission and/or the Staff should undertake along with suggested critical path completion dates in order to meet the January 1, 2002, implementation date included in the Discussion Draft Plan.

12. Explain whether, and if so to what extent and how, the LDC retail billing and collection function should be unbundled from retail rates. With respect to the proposed unbundling methodology, explain how the LDC would be able to recover prudently incurred costs as provided by § 56-581.1 D of the Code of Virginia. Additionally, explain any potential rate impacts on customers taking LDC capped-rate bundled service or default generation service.

13. If as opposed to retail rate unbundling, LDCs were to pay ESPs for ESP consolidated billing and charge ESPs for LDC consolidated billing under Commission-approved tariffs, explain as specifically as possible how such LDC payments and charges should be developed. Should the charge and payment be the same? Why or why not? Would this "wholesale transaction" approach avoid customer confusion by eliminating billing charges and credits on the retail bill, and by eliminating required manipulations to the "price to compare" benchmark or the regulated price for services that may be offered competitively? Would such an approach require modification to § 56-581.1 F of the Code of Virginia? What are the advantages and disadvantages of such an approach? Should such an approach be considered?

14. Each LDC is requested to provide its total current annual embedded billing and collection costs. Provide such costs on a per customer basis for large commercial/industrial customers, medium size commercial customers, and small commercial/residential customers. Identify the corporate activities comprising the billing and collection function that result in these costs. Would any of these costs be avoided by the LDC under any of the billing options in the Discussion Draft Plan? Why or why not?

15. Under the assumption that the LDC must provide a consolidated retail bill in the absence of further General Assembly action, each LDC is requested to provide the estimated incremental cost impact of such a requirement on the responses provided to Question 14. Identify the source of such incremental costs.

16. Each LDC is requested to provide the estimated incremental cost impacts on the combined responses provided to Questions 14 and 15, that would result from required LDC support of the two additional retail billing options in the Discussion Draft Plan (i.e., separate LDC and ESP billing and ESP consolidated billing). Identify the source of such incremental costs.

ATTACHMENT 2

Discussion Draft Plan for Retail Metering Service

Effective January 1, 2003, and coincident with the implementation schedule for electric retail choice, licensed energy service providers ("ESPs") are authorized to offer and provide metering service to non-residential retail customers with peak loads of 50 kW or more in the Virginia service territories of incumbent electric utilities ("LDCs"), subject to the conditions and exceptions listed below.

Effective January 1, 2004, licensed ESPs are authorized to offer and provide metering service to retail customers in the Virginia service territories of LDCs, subject to the conditions and exceptions listed below.

Retail metering service includes:

1. Provision of the electric meter including meter sale or rental;

2. Physical metering service including meter installation, removal, maintenance, repair, calibration, and testing; and

3. Meter information service including data collection, processing (validation, editing, and estimation), storage, and communication.

LDCs shall undertake the necessary coordination with ESPs to support ESP provision of retail metering service, subject to the following conditions and exceptions:

A. Upon satisfying any applicable disclosure requirements, ESPs may sell or coordinate the sale of electric metering devices that comply with applicable standards to retail customers. While retail customer-owned metering devices may be deployed, physical metering service and meter information service must be provided by the customer's ESP or LDC.

B. If the ESP elects to provide retail metering service, the ESP is responsible for the provision of all components of retail metering service as defined above, except for the provision of the meter when the retail customer already owns a meter that complies with applicable standards.

C. LDCs shall provide all components of retail metering service if the ESP elects not to provide such service, except for the provision of the meter when the retail customer already owns a meter that complies with applicable standards.

D. LDCs and ESPs may contract with wholesale providers of metering services, but shall retain ultimate responsibility for compliance with applicable Virginia statutes, Commission rules, Commission approved tariffs, established standard business practices, and data exchange protocols governing the provision of retail metering service.

E. LDCs shall maintain a meter tracking system for all meters within their service territory and shall conduct annual site inspections for each metering location within their service territory. ESPs providing retail metering service shall comply with applicable requirements for the reporting of meter information to the LDC.

F. The metering party will provide for the reasonable accommodation of meter tests upon request by the retail customer, the non-metering party (LDC or ESP), or the Commission Staff. The requesting party may witness such meter tests.

G. Except as authorized by the Commission, LDCs shall provide no metering services to an affiliated ESP unless the same such services are offered to all other ESPs under terms and conditions that are no less favorable than those offered to the affiliated ESP.

H. The Commission may delay implementation of any element of this plan for the period of time necessary, but no longer than one year, to resolve issues arising from considerations of metering safety, accuracy, timeliness, quality, or consumer readiness. The Commission will report any such delays and the underlying reasons to the Legislative Transition Task Force or the General Assembly within a reasonable time.

Issues for Consideration Regarding the Discussion Draft Plan

Incumbent electric utilities ("LDCs") shall respond and interested parties are invited to respond to the following questions in comments:

1. Does the Discussion Draft Plan for Retail Metering Service satisfy and balance the requirements of the eight specific statutory criteria as provided in §56-581.1 of the Code of Virginia? If not, as specifically as possible, identify and explain each deficiency and propose correcting modifications or alternatives to the Discussion Draft Plan.

2. Does the Discussion Draft Plan promote the overall public interest in transitioning metering practices as part of Virginia's implementation of electric industry restructuring? If not, as specifically as possible and to the extent not addressed in the response to Question 1, identify each deficiency and propose correcting modifications or alternatives to the Discussion Draft Plan. Evaluate each proposed modification or alternative by application of the eight statutory criteria found in § 56-581.1 of the Code of Virginia.

3. Explain whether, and if so to what extent and how, the metering requirements of the Draft Plan to be presented to the Legislative Transition Task Force should vary by service, type of seller, region, incumbent electric utility, and customer group as provided in § 56-581.1 of the Code of Virginia. Consider the eight statutory criteria found in § 56-581.1 of the Code of Virginia.

4. Should any service component(s) included in the Discussion Draft Plan definition of retail metering service be excluded? Explain the justification for excluding such service component(s) based on the eight statutory criteria found in § 56-581.1 of the Code of Virginia. Explain the practical impact of such exclusion on the ability of the ESP to provide retail metering service.

5. Identify any service component(s) that should be added to the Discussion Draft Plan definition of retail metering service. Explain the justification for including such service component(s) based on the eight statutory criteria found in § 56-581.1 of the Code of Virginia. Explain the practical impact of such inclusion on the ability of the ESP to provide retail metering service.

6. Explain whether all retail customers, customers with loads above a certain size, or no retail customers should be allowed to purchase and own their meters? Identify the advantages, disadvantages, and all key issues associated with retail customer ownership of the meter.

7. Should the Discussion Draft Plan definition of retail metering service include identified physical metering service components? Identify the advantages, disadvantages, and all key issues associated with the inclusion of physical metering service components.

8. Should the Discussion Draft Plan definition of retail metering service include identified metering information service components? Identify the advantages, disadvantages, and all key issues associated with the inclusion of metering information service components.

9. With respect to the Discussion Draft Plan, identify and explain any elements that might result in consumer confusion, or risks to safety or metering accuracy. Identify any appropriate risk mitigation measures.

10. Identify and explain any element included in the Discussion Draft Plan that is not technologically feasible.

11. What metering-related responsibilities, if any, should LDCs retain if ESPs are authorized to provide retail metering services? For example: Should LDCs be required to maintain meter tracking information systems and perform annual site inspections to minimize energy diversion opportunities? Should LDCs be required or have the right to inspect ESP meter installations? If so, who should absorb this cost? Should LDCs be required to provide ESPs with meter worker training and certification?

12. If ESPs provide retail metering service, what specific rights and obligations should the LDC retain to ensure accurate and reliable metering? For example, should LDCs have the right or responsibility to periodically perform reasonable audits of ESP metering processes to ensure accurate and reliable metering for LDC billing purposes?

13. When LDCs provide retail metering service, what specific rights and obligations should the ESP have to ensure accurate and reliable metering? For example, should ESPs have the right or responsibility to periodically perform reasonable audits of LDC metering processes to ensure accurate and reliable metering for ESP billing purposes?

14. Identify activities the commenter believes the Commission should perform with respect to retail metering oversight. For each activity, explain the necessity of regulatory intervention and describe the programs and resources required to effectively accomplish the activity.

15. Is there sufficient time for all parties reasonably to perform the necessary implementation activities to meet the January 1, 2003, and January 1, 2004, effective dates in the Discussion Draft Plan? Should the schedule for any element of the Discussion Draft Plan be advanced or delayed? If so, identify the specific element(s) of the plan. Explain how and why the schedule should be modified.

16. Each LDC is requested to provide the estimated length of time required to modify and test LDC information systems and processes to accommodate the Discussion Draft Plan for Retail Metering Service.

17. Identify and explain all major policy/implementation issues that must be addressed prior to ESP provision of retail metering service.

18. Identify the major activities that LDCs, the Commission, and/or the Staff should undertake along with suggested critical path completion dates in order to meet the January 1, 2003, and January 1, 2004, implementation dates included in the Discussion Draft Plan. Identify any key concerns regarding the ability to meet those dates.

19. Explain whether, and if so to what extent and how, the LDC retail metering function should be unbundled from retail rates. With respect to the proposed unbundling methodology, explain how the LDC would be able to recover prudently incurred costs as provided by § 56-581.1 D of the Code of Virginia. Additionally, explain any potential rate impacts on customers taking LDC capped-rate bundled service or default generation service.

20. If, as opposed to retail rate unbundling, LDCs were to pay ESPs for the provision of retail metering service under Commission-approved tariffs, explain as specifically as possible how such LDC payments should be developed. Would this "wholesale transaction" approach avoid customer confusion by eliminating additional billing charges and credits on the retail bill, and by eliminating required manipulations to the "price to compare" benchmark or the regulated price for services that may be offered competitively? Would such an approach require modification to § 56-581.1 F of the Code of Virginia? Should such an approach be considered?

21. Under the Discussion Draft Plan, identify metering costs that could be avoided by the LDC when the ESP provides retail metering service. For each identified avoidable cost, each LDC is requested to estimate the average avoidable costs on a per-meter-read basis for a large commercial/industrial customer, a medium size commercial customer, and a small commercial/residential customer.

22. Each LDC is requested to provide its total current annual embedded metering costs. Provide such costs on a per-customer basis, for large commercial/industrial

customers, medium size commercial customers, and small commercial/residential customers. Identify the corporate activities comprising the metering function that result in these costs.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Legal Notice Regarding DRG Payment Rates and DRG Weights

The Department of Medical Assistance Services hereby notifies, consistent with federal regulatory requirements, the regulated hospital community of these final DRG payment rates and DRG weights. The final DRG rates are published below for inpatient acute care hospitals. The final per diem rates are published for inpatient psychiatric hospitals (both acute and freestanding) and inpatient rehabilitation hospitals.

These final rates/weights have been determined using: 1998 claims data, 1998 cost report data to determine the ratio of operating payments to operating cost, 1998 cost-to-charge ratio, and any public comments that were adopted.

The DRG weights to be applied to DRG claims can be accessed on the Internet at www.cns.state.va.us/dmas. The DMAS methodology and justifications can be found on the Commonwealth's Regulatory Townhall at www.townhall.state.va.us and in the Virginia Register (16:19 VA.R. 2391-2396 June 5, 2000) (http://legis.state.va.us/codecomm/register/vol16/v16i18.pdf).

Please direct your questions to N. Stanley Fields, Director, Cost Settlement and Reimbursement, Division of Financial Management, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-5590 or FAX (804) 786-0729.

If you are unable to access the table of DRG weights or the DRG methodology justifications on the Internet, please contact Vicki Simmons (at (804) 786-7959) for a free paper copy.

Final DRG and Psychiatric Rates 07/01/00 - 06/30/01			
Provider Name	**Operating Case Rate for DRG Cases**	**Operating Per Diem for Psych Cases**	**Capital Percent Add-on**
George Washington University Hospital	3,102.22	484.01	19.19%
Georgetown University Hospital	3,102.22	484.01	15.37%
Washington Hospital Center	3,102.22	484.01	16.31%
Children's Hospital NMC	3,102.22	484.01	21.14%
Duke University Medical Center	2,935.69	458.03	15.11%
North Carolina Baptist Hospital	2,854.85	445.41	15.27%
Bristol Memorial Hospital	2,813.82	439.01	26.54%
Holston Valley Hospital	2,813.82	439.01	28.38%
Johnson City Medical Center (&NICU)	2,813.82	439.01	22.51%
Indian Path Hospital	2,813.82	439.01	19.76%
Norton Community Hospital	2,583.25	403.04	14.28%
Russell County Medical Center	2,583.25	403.04	8.96%
Richmond Eye & Ear Hospital	2,820.40	440.04	27.41%
Rockingham Memorial Hospital	2,583.25	403.04	15.06%
Winchester Medical Center	2,583.25	403.04	30.11%
Shenandoah County Memorial Hospital	2,583.25	403.04	20.20%
Sentara Norfolk General Hospital	2,675.68	417.46	8.81%
UVA Hospital	4,633.56	694.64	11.56%
Depaul Medical Center	2,675.68	417.46	21.37%
Lee County Community Hospital	2,583.25	403.04	22.06%
Halifax-South Boston Community Hospital	2,583.25	403.04	14.96%
Health South of Virginia, Inc.	2,820.40	440.04	44.75%
Maryview Hospital	2,675.68	417.46	9.93%
Augusta Medical Center	2,583.25	403.04	25.76%
Culpeper Memorial Hospital	3,102.22	484.01	8.07%
John Randolph Hospital	2,820.40	440.04	11.76%
Virginia Baptist Hospital (Centra Health	2,660.45	415.08	15.60%
Mary Washington Hospital	3,102.22	484.01	24.06%
Fauquier Hospital	3,102.22	484.01	15.70%
Roanoke Memorial Hospital	2,690.57	419.78	15.17%
St. Mary's Hospital Norton	2,583.25	403.04	10.11%
Stonewall Jackson Hospital	2,583.25	403.04	22.75%
MCV Hospital	4,662.46	698.97	6.06%
Warren Memorial Hospital	3,102.22	484.01	17.14%
Shore Memorial Hospital	2,583.25	403.04	7.89%
Smyth County Community Hospital	2,583.25	403.04	7.22%
Alexandria Hospital	3,102.22	484.01	9.05%
Mary Immaculate Hospital	2,675.68	417.46	14.16%
Radford Community Hospital	2,583.25	403.04	17.45%
Loudoun Hospital Center	3,102.22	484.01	9.58%
Louise Obici Memorial Hospital	2,675.68	417.46	13.16%
Prince William Hospital	3,102.22	484.01	13.76%
Sentara Leigh Hospital	2,675.68	417.46	13.31%
Page Memorial Hospital	2,583.25	403.04	5.65%
Lewis Gale Hospital	2,690.57	419.78	18.32%
Arlington Hospital	3,102.22	484.01	13.55%
Riverside Hospital	2,675.68	417.46	9.86%
Johnston Memorial Hospital	2,813.82	439.01	18.63%
R. J. Reynolds Patrick County Memorial	2,583.25	403.04	8.02%

Virginia Beach General Hospital	2,675.68	417.46	16.83%
St. Mary's Hospital Richmond	2,820.40	440.04	17.36%
Clinch Valley	2,583.25	403.04	16.93%
Fairfax Hospital	3,102.22	484.01	14.57%
Williamsburg Community Hospital	2,675.68	417.46	25.27%
Southside Regional Medical Center	2,820.40	440.04	8.68%
Bon Secours Memorial Regional Medical	2,820.40	440.04	12.97%
Retreat Hospital	2,820.40	440.04	10.68%
Vencor Hospital – Arlington	3,102.22	484.01	6.63%
Danville Regional Medical Center	2,646.26	412.87	11.68%
Martha Jefferson Hospital	2,802.92	437.31	11.72%
Mem Hospital Martinsville Henry Co.	2,583.25	403.04	15.26%
Riverside Tappannock	2,583.25	403.04	24.61%
Giles Memorial Hospital	2,583.25	403.04	12.93%
Bedford County Memorial Hospital	2,660.45	415.08	12.34%
Franklin Memorial Hospital	2,583.25	403.04	18.47%
Southside Community Hospital	2,583.25	403.04	10.47%
Stuart Circle Hospital – Bon Secours	2,820.40	440.04	18.53%
Southampton Memorial Hospital	2,583.25	403.04	15.11%
Sentara Hampton General Hospital	2,675.68	417.46	20.32%
Richmond Community Hospital	2,820.40	440.04	12.21%
CHKD	2,675.68	417.46	16.92%
Greensville Memorial Hospital	2,583.25	403.04	11.37%
Community Memorial Hospital	2,583.25	403.04	8.08%
Bath County Community Hospital	2,583.25	403.04	19.73%
Fair Oaks Hospital	3,102.22	484.01	30.46%
Columbia Reston Hospital Center	3,102.22	484.01	19.24%
Montgomery Regional Hospital	2,583.25	403.04	38.14%
Wythe County Community Hospital	2,583.25	403.04	13.24%
Chippenham Hospital & Johnston-Willis	2,820.40	440.04	10.50%
Potomac Hospital Corp.	3,102.22	484.01	14.71%
Wellmont Lonesome Pine Hospital	2,583.25	403.04	14.13%
Twin County Community Hospital	2,583.25	403.04	8.90%
Pulaski Community Hospital	2,583.25	403.04	18.00%
Tazewell Community Hospital	2,583.25	403.04	15.89%
Henrico Doctors Hospital	2,820.40	440.04	21.50%
Sentara Bayside Hospital	2,675.68	417.46	21.55%
Chesapeake General Hospital	2,675.68	417.46	23.20%
Mount Vernon Hospital	3,102.22	484.01	15.44%
Rappahannock General Hospital	2,583.25	403.04	14.48%
Capital Medical Center	2,820.40	440.04	9.30%
Alleghany Regional Hospital	2,583.25	403.04	19.48%
Buchanan General Hospital	2,583.25	403.04	14.51%
Riverside Middle Peninsula	2,675.68	417.46	9.82%
Dickenson County Medical Center	2,583.25	403.04	18.51%
Children's Hospital	2,820.40	440.04	38.09%

Final Rehabilitation Rates 07/01/00 - 06/30/01		
Provider Name	**Operating Per Diem for Rehab Cases**	**Capital Percent Add-on**
Sheltering Arms Day Rehab Program	556.17	6.93%
Depaul Medical Center	527.63	16.62%
Danville Regional Medical Center	521.83	14.47%
Lee County Community Hospital	509.40	17.72%
Chippenham Hospital & Johnston-Willis	556.17	8.20%
Sentara Norfolk General Hospital	527.63	7.60%
UVA Hospital	896.69	10.11%
Maryview Hospital	527.63	14.47%
Riverside Tappannock	509.40	14.47%
Health South of Virginia, Inc.	556.17	22.53%
UVA HealthSouth	552.72	14.47%
CHKD	527.63	14.47%
Augusta Medical Center	509.40	33.55%
Norton Community Hospital	509.40	14.47%
Virginia Baptist Hospital (Centra Health	524.63	17.62%
Roanoke Memorial Hospital	530.57	12.65%
Rehabilitation Institute of VA	527.63	8.23%
MCV Hospital	902.28	6.48%
Winchester Medical Center	509.40	22.32%
Lewis Gale Hospital	530.57	11.21%
Clinch Valley	509.40	14.99%
Healthsouth Rehab Hospital of Virginia	556.17	10.33%
Mount Vernon Hospital	611.74	14.01%
Cumberland Hospital	556.17	6.80%
Children's Hospital	556.17	16.13%

Freestanding Psychiatric Hospital Final Rates 7-1-00 – 6-30-01

Freestanding Psychiatric Hospital Final Rates 07/01/00 – 06/30/01

Provider Name	Per Diem
Dominion Hospital	554.32
Popular Springs Hospital	503.09
Peninsula Center for Behavioral Health	476.65
Carilion Saint Albans Hospital	459.70
Charter Behavioral Health System	491.11
Woodside Hospital LLC	476.65
Charter Greensboro Behavioral	491.11
West End Behavioral Health Center	503.09
Behavioral Healthcare of Norfolk	476.65
Graydon Manor	554.32
Piedmont Behavioral Health Care LLC	554.32
Woodridge Hospital	501.88
Charter Hospital of Charlottesville	499.90
Central State Hospital	503.09
DeJarnette Center	459.70
Northern Virginia Mental Health Institute	554.32
Southern Virginia Mental Health Institute	471.26
Southwestern Virginia Mental Health Institute	459.70
Western State Hospital	459.70
Virginia Beach Psychiatric Hospital	476.65

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DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Notice of Periodic Review of Regulations

The Department of Mental Health, Mental Retardation and Substance Abuse Services invites comments from the public on the following regulations. The department intends to review these regulations in accordance with Executive Order 25 (98). Written comments are requested regarding the performance and effectiveness of these regulations in achieving the following goals.

12 VAC 35-170-10 et seq. Regulations for Certification of Case Management.

1. To assure provision of quality care and efficient use of Medicaid resources devoted to the provision of Medicaid mental health and mental retardation targeted case management services;

2. To clearly articulate a case management certification process and provider requirements that assure services are provided by qualified individuals; and

3. To ascertain whether a regulatory certification process is the least intrusive and costly approach for ensuring that providers of Medicaid targeted case management services have the necessary qualifications.

The department also requests suggestions to improve the content and organization of the regulations to make them more useful and understandable for citizens and provider organizations.

12 VAC 35-190-10 et seq. Regulations Establishing Procedures for Voluntarily Admitting Persons who are Mentally Retarded to State Mental Retardation Facilities.

1. To clearly articulate requirements and actions required to admit a person to a mental retardation training center;

2. To clearly define due process protections afforded to persons with mental retardation who are being admitted to a training center and to their families; and

3. To assure that training center admission procedures are minimally intrusive for individuals and their families and have minimal possible cost to training centers.

12 VAC 35-200-10 et seq. Regulations for Respite and Emergency Care Admissions to Mental Retardation Facilities.

1. To clearly articulate requirements that must be met to access emergency services and respite care in a mental retardation training center; and

2. To assure procedures for obtaining emergency services and respite care in a training center are minimally intrusive for individuals seeking access to respite and emergency care and their families and have the minimum possible cost to training centers.

The department also requests suggestions to improve the content and organization of the regulations to make them more useful and understandable for citizens and provider organizations.

Written comments may be submitted through 5 p.m. Friday, August 25, 2000. Please identify the regulations by full name and Virginia Administrative Code number. Copies of the regulations may be obtained from the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Contact: Wendy V. Brown, Office of Planning and Regulations, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, Virginia 23218-1797, telephone (804) 225-2252, FAX (804) 371-0092 or e-mail wbrown @dmhmrsas.state.va.us.

STATE MILK COMMISSION

Notice of Periodic Review

Pursuant to Executive Order Number 25 (98) and 2 VAC 15-11-100, the Virginia State Milk Commission intends to commence a review of 2 VAC 15-11-10 through 2 VAC 15-11-120, Public Participation Guidelines, to determine if this regulation should be terminated, amended or retained in its current form. The review shall be guided by the principles specified in Executive Order Number 25 (98).

The commission seeks public comment on the regulation's interference in public enterprise and life, essential need for the regulation, less burdensome and intrusive alternatives to the regulation, specific and measurable goals that the regulation is intended to achieve, and whether the regulation is clearly written and easily understandable. It is also requested that public comment address the regulation's effectiveness, efficiency, and cost of compliance.

In addition to comments on the above-referenced matters, provide the following information:

1. Name, mailing address, telephone number and, if applicable, the organization represented.

2. Number and title of the specific regulation addressed.

3. Commentator's interest in the regulation.

4. Description on the need and justification for development, repeal, or amendment of the regulation.

5. Suggested language for a developed or amended regulation.

6. Statement of impact on the commentator or other affected parties.

The commission intends to hold a public hearing on this matter on August 30, 2000 at 11 a.m. in Senate Room B, General Assembly Building, Richmond, Virginia. This hearing will be conducted under the provisions of 2 VAC 15-20-125.

Comments may be submitted until August 20, 2000, to Edward C. Wilson, Deputy Administrator, 200 North Ninth

Street, Suite 915, Richmond, Virginia 23219, telephone (804) 786-2013, FAX (804) 786-3779, or e-mail ewilson@smc.state.va.us.

Notice of Periodic Review

Pursuant to Executive Order Number 25 (98) and 2 VAC 15-11-100, the Virginia State Milk Commission intends to commence a review of 2 VAC 15-20-10 through 2 VAC 15-20-130, Regulations for the Control and Supervision of Virginia's Milk Industry, to determine if this regulation should be terminated, amended or retained in its current form. The review shall be guided by the principles specified in Executive Order Number 25 (98).

The commission seeks public comment on the regulation's interference in public enterprise and life, essential need for the regulation, less burdensome and intrusive alternatives to the regulation, specific and measurable goals that the regulation is intended to achieve, and whether the regulation is clearly written and easily understandable. It is also requested that public comment address the regulation's effectiveness, efficiency, and cost of compliance.

In addition to comments on the above-referenced matters, provide the following information:

1. Name, mailing address, telephone number, and, if applicable, the organization represented.

2. Number and title of the specific regulation addressed.

3. Commentator's interest in the regulation.

4. Description on the need and justification for development, repeal, or amendment of the regulation.

5. Suggested language for a developed or amended regulation.

6. Statement of impact on the commentator or other affected parties.

The commission intends to hold a public hearing on this matter on August 30, 2000, at 11 a.m. in Senate Room B, General Assembly Building, Richmond, Virginia. This hearing will be conducted under the provisions of 2 VAC 15-20-125.

Comments may be submitted until August 20, 2000, to Edward C. Wilson, Deputy Administrator, 200 North Ninth Street, Suite 915, Richmond, Virginia 23219, telephone (804) 786-2013, FAX (804) 786-3779, or e-mail ewilson@smc.state.va.us.

DEPARTMENT OF SOCIAL SERVICES

Notice of Periodic Review of Regulations

Pursuant to Executive Order Number 25 (98), the Department of Social Services is currently reviewing the below listed regulations to determine if they should be terminated, amended, or retained in their current form. The review will be guided by the principles listed in Executive Order Number 25 (98) and in the department's Plan for Review of Existing Agency Regulations.

The department seeks public comment regarding the regulations' interference in private enterprise and life, essential need of the regulations, less burdensome and intrusive alternatives to the regulations, specific and measurable goals that the regulations are intended to achieve, and whether the regulations are clearly written and easily understandable.

The regulations are:

22 VAC 15-60-10 et seq., Standards and Regulations for Licensed Child Day Center Systems.

22 VAC 40-92-10 et seq., Standards and Regulations for Licensed Child Day Center Systems.

Written comments may be submitted until August 20, 2000.

Contact: Arlene Kasper, Program Development Consultant, Division of Licensing Programs, 730 East Broad Street, Richmond, Virginia 23219-1849, by e-mail to adk7@dss.state.va.us, or by facsimile to (804) 692-2370.

Virginia Tax Bulletin

Virginia Department of Taxation

June 29, 2000 00-4

INTEREST RATES
THIRD QUARTER 2000

Changes to Virginia Interest Rates: In 1999, the General Assembly enacted legislation to equalize Virginia's interest rates on most tax overpayments (refunds) and underpayments (assessments) for both corporate and noncorporate taxpayers. Effective January 1, 2000, Virginia's overpayment rate for all overpayments is now equal to the federal overpayment rate for noncorporate taxpayers plus 2% under this change. However, the interest rate on "large corporate underpayments," remains unchanged and is equal to the federal rate for large corporate underpayments plus 2%.

Federal rates unchanged: State and certain local interest rates are subject to change every quarter based on changes in federal rates established pursuant to IRC § 6621. The federal rates for the third quarter of 2000 will remain at 9% for tax underpayments (assessments), 9% for tax overpayments (refunds) by taxpayers other than corporations, and 11% for "large corporate underpayments" as defined in IRC § 6621(c). Code of Virginia § 58.1-15 provides that the underpayment rates for Virginia taxes will be 2% higher than the corresponding federal rates and overpayment rates for Virginia taxes will be 2% higher than the federal rate for noncorporate taxpayers. Accordingly, the Virginia rates for the third quarter of 2000 will be 11% for tax underpayments (assessments), 11% for tax overpayments (refunds), and 13% for "large corporate underpayments."

Rate for Addition to Tax for Underpayments of Estimated Tax

Taxpayers with taxable years ending on June 30, 2000: Tax returns are due on October 15, 2000. For the purpose of computing the addition to the tax for underpayment of Virginia estimated income taxes on Form 760C (for individuals, estates and trusts), Form 760F (for farmers and fishermen) or on Form 500C, the third quarter 11% underpayment rate will apply through the due date of the return, October 15, 2000.

Local Tax

Assessments: Localities that assess interest on delinquent taxes under Code of Virginia § 58.1-3916 may impose interest at a rate not to exceed 10% for the first year of delinquency, and at a rate not to exceed 10% or the federal underpayment rate in effect for the applicable quarter, whichever is greater, for the second and subsequent years of delinquency. For the third quarter of 2000, the federal underpayment rate is 9%.

Refunds: Effective July 1, 1999, localities which charge interest on delinquent taxes are required paying interest to taxpayers on all overpayments or erroneously assessed taxes at the same rate as they charge interest on delinquent taxes under Code of Virginia § 58.1-3916.

Recent Interest Rates

Accrual Beginning	Period Through	Non - Corporation Overpayment (Refund)	Corporation Overpayment (Refund)	Underpayment (Assessment)	Large Corporate Underpayment
1-Oct-89	31-Mar-91	10%	10%	11%	----
1-Apr-91	30-Jun-91	9%	9%	10%	----
1-Jul-91	31-Dec-91	9%	9%	12%	14%
1-Jan-92	31-Mar-92	8%	8%	11%	13%
1-Apr-92	30-Sep-92	7%	7%	10%	12%
1-Oct-92	30-Jun-94	6%	6%	9%	11%
1-Jul-94	30-Sep-94	7%	7%	10%	12%
1-Oct-94	31-Mar-95	8%	8%	11%	13%
1-Apr-95	30-Jun-95	9%	9%	12%	14%
1-Jul-95	31-Mar-96	8%	8%	11%	13%
1-Apr-96	30-Jun-96	7%	7%	10%	12%
1-Jul-96	31-Mar-98	8%	8%	11%	13%
1-Apr-98	31-Dec-98	7%	7%	10%	12%
1-Jan-99	31-Mar-99	7%	6%	9%	11%
1-Apr-99	31-Dec-99	8%	7%	10%	12%
1-Jan-00	31-Mar-00	10%	10%	10%	12%
1-Apr-00	30-Sep-00	11%	11%	11%	13%

For additional information: Contact the Office of Customer Services, Virginia Department of Taxation, P. O. Box 1115, Richmond, Virginia 23218-1115, or call the following numbers for additional information about interest rates and penalties.

Individual & Fiduciary Income Tax	(804) 367-8031
Corporation Income Tax	(804) 367-8037
Withholding Tax	(804) 367-8037
Soft Drink Excise Tax	(804) 367-8098
Aircraft Sales & Use Tax	(804) 367-8098
Other Sales & Use Taxes	(804) 367-8037

BOARD OF VETERINARY MEDICINE

Notice of Periodic Review of Regulations

Pursuant to Executive Order 25 (98) and its Public Participation Guideline Regulations, the Board of Veterinary Medicine is requesting comment on existing regulations:

18 VAC 150-20-10 et seq. Regulations Governing the Practice of Veterinary Medicine

Goals of the Regulations: 1) Achieve high ratings on the Customer Service Satisfaction Survey for application process and renewal of licensure. 2) Achieve a reduction in the number of deficiencies noted in facility inspections.

The board will consider whether the existing regulations are essential to protect the health, safety and welfare of the public and provide assurance that practitioners are competent to practice. Alternatives to the current regulations or suggestions for clarification of the regulation will also be received and considered.

If any member of the public would like to comment on these regulations, please send comments by September 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 www.townhall.state.va.us or copies will be sent upon request.

STATE WATER CONTROL BOARD

Proposed Consent Special Order Po River Water and Sewer Company Indian Acres of Thornburg Sewage Treatment Plant

The State Water Control Board (board) proposes to issue a Consent Special Order (order) to Po River Water and Sewer Company (permittee) regarding Indian Acres of Thornburg Sewage Treatment Plant (facility) located in Spotsylvania County, Virginia.

Indian Acres of Thornburg Sewage Treatment Plant is subject to VPDES Permit No. VA0029769. The order requires that the permittee upgrade the STP in order to comply with permit limitations and provides interim effluent permit limitations for ammonia. The permittee has agreed to payment of a civil charge.

On behalf of the board, the Department of Environmental Quality's Northern Virginia regional office will receive written comments relating to the order through August 29, 2000. Please address comments to Susan A. Oakes, Northern Virginia Regional Office, Department of Environmental Quality, 13901 Crown Court, Woodbridge, Virginia, 22193. Please write or visit the Woodbridge address, or call (703) 583-3863, in order to examine or to obtain a copy of the order.

Proposed Consent Special Order Town of New Market

The State Water Control Board proposes to enter into a Consent Special Order with the Town of New Market to resolve violations of the State Water Control Law and regulations at the Town of New Market's water treatment plant (WTP) in Shenandoah County. New Market's WTP discharges treated filter backwash water to Smith Creek in the Shenandoah River subbasin, Potomac River basin under authority of a VPDES Permit.

New Market is presently under a Consent Special Order, which became effective on March 8, 1996. The 1996 order was designed to address the town's failure to construct facilities to meet final limitations contained in the permit. Under the 1996 order, the town was required to develop and connect various drinking water wells to a new water treatment plant in lieu of upgrading the Smith Creek WTP, and to take the Smith Creek WTP offline. The town was unable to complete all the actions required in that order due to circumstances beyond their control. The town has failed to comply with the 1996 order's schedule of compliance to meet final effluent limitations and take the old facility offline and closeout.

The proposed Consent Special Order settles the outstanding Notice of Violation, cancels and supercedes the 1996 order, and incorporates a schedule of compliance to connect the water wells to the new water treatment plant and to take the old Smith Creek treatment plant offline and to properly closeout.

The board will receive written comments relating to the proposed Consent Special Order for 30 days from the date of publication of this notice. Comments should be addressed to Steven W. Hetrick, Department of Environmental Quality, Post Office Box 3000, Harrisonburg, Virginia 22801, and should refer to the Consent Special Order.

The proposed order may be examined at the Department of Environmental Quality, Valley Regional Office, 4411 Early Road, Harrisonburg, Virginia 22801. A copy of the order may be obtained in person or by mail from this office.

Proposed Consent Special Order Virginia Metalcrafters, Inc.

The State Water Control Board proposes to enter into a Consent Special Order with Virginia Metalcrafters, Inc., to address toxicity contamination present in the facility's stormwater discharge. The proposed order supersedes previous orders issued to the company in 1997 and 1998 for this same purpose.

Virginia Metalcrafters, Inc., discharges stormwater collected at its Waynesboro facility into an unnamed tributary of the South River. The stormwater is discharged from four separate outfalls and is regulated under a VPDES permit. The VPDES permit includes provisions to address the toxicity known to be present in the stormwater discharged from one of the four outfalls. A 1997 order required the company to complete specific modifications to the facility thought to be the

source of the toxicity. The 1998 order required the company to continue to monitor the stormwater discharge for toxicity and to institute additional corrective measures if the toxicity contamination persisted. Stormwater testing conducted under the 1998 order demonstrated continuing toxicity problems; accordingly, under the proposed order, the company will install a wet scrubber on its buffing dust collection room to remove the air contaminants believed to be the source of the stormwater toxicity. Following installation of the wet scrubber, the order provides for the company to convert from regulation under an individual VPDES permit to a general VPDES permit.

The board will receive written comments relating to the proposed Consent Special Order for 30 days from the date of publication of this notice. Comments should be addressed to Edward A. Liggett, Department of Environmental Quality, Post Office Box 3000, Harrisonburg, Virginia 22801, and should refer to the Consent Special Order.

The proposed order may be examined at the Department of Environmental Quality, Valley Regional Office, 4411 Early Road, Harrisonburg, Virginia 22801. A copy of the order may be obtained in person or by mail from this 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

BOARD OF ACCOUNTANCY

† **October 16, 2000 - 10 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 5W, Richmond, Virginia.♿ (Interpreter for the deaf provided upon request)

A meeting to conduct routine business. A public comment period will be held at the beginning of the meeting.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2648, FAX (804) 367-6128, (804) 367-9753/TTY ☎, e-mail accountancy@dpor.state.va.us.

COMMONWEALTH COUNCIL ON AGING

July 31, 2000 - 10 a.m. -- Open Meeting
Virginia Department for the Aging, 1600 Forest Avenue, Suite 102, Richmond, Virginia.♿ (Interpreter for the deaf provided upon request)

A regular business meeting of the Legislative Committee.

Contact: Marsha Mucha, Administrative Staff Assistant, Department for the Aging, 1600 Forest Ave., Suite 102, Richmond, VA 23229, telephone (804) 662-9312.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Virginia Charity Food Assistance Advisory Board

August 10, 2000 - 10:30 a.m. -- Open Meeting
Department of Agriculture and Consumer Services, Washington Building, 1100 Bank Street, 2nd 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, Department of Agriculture and Consumer Services, Washington Building, 1100 Bank St., Room 809, Richmond, VA 23219, telephone (804) 786-3936, FAX (804) 371-7788.

Virginia Cotton Board

August 24, 2000 - 3 p.m. -- Open Meeting
Tidewater Agricultural Research and Extension Center, 6321 Holland Road, Suffolk, Virginia.♿ (Interpreter for the deaf provided upon request)

The board will meet to approve minutes of the last meeting. In addition, the board will review financial reports and status reports on projects and contracts, discuss priorities for future funding initiatives and any other business that may come before the board. 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 board at least five days before the meeting date so that suitable arrangements can be made.

Contact: Gail Moody Milteer, Program Director, Department of Agriculture and Consumer Services, Virginia Cotton Board, 1100 Armory Dr., Suite 120, Franklin, VA 23851, telephone (757) 569-1100, FAX (757) 562-6104.

Virginia Farmers Market Board

August 8, 2000 - 9:30 a.m. -- Open Meeting
Virginia Department of Forestry, Fontaine Research Park, 300 Natural Resources Drive, 2nd Floor Board Room,

Charlottesville, Virginia. (Interpreter for the deaf provided upon request)

The board will convene for its quarterly meeting for the purpose of conducting business to benefit the Virginia Farmers Market System. During the meeting, the board members will hear and approve the financial report and approve the minutes of the May 9, 2000, meeting. In addition, contracted private sector operators of the shipping point markets in the system will present reports on operations of the four markets. 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 board at least five days before the meeting date so that suitable arrangements can be made.

Contact: Susan K. Simpson, Program Director, Department of Agriculture and Consumer Services, Virginia Farmers Market Board, 1100 Bank St., Room 1002, Richmond, VA 23219, telephone (804) 786-2112, FAX (804) 371-7786.

Virginia Irish Potato Board

August 7, 2000 - 7 p.m. -- Open Meeting
Aberdeen Barn of Virginia Beach, 5805 Northampton Boulevard, Virginia Beach, Virginia. (Interpreter for the deaf provided upon request)

A discussion of programs (promotion, research, and education), annual budget and other business that may come before the board. 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 board at least five days before the meeting date so that suitable arrangements can be made.

Contact: J. William Mapp, Program Director, Department of Agriculture and Consumer Services, Virginia Irish Potato Board, P.O. Box 26, Onley, VA 23418, telephone (757) 787-5867, FAX (757) 787-1041.

Virginia Soybean Board

† **August 15, 2000 - 1 p.m.** -- Open Meeting
2177 Mount Prospect Road, Laneview, Virginia.

The board will discuss checkoff revenues and the financial status of the board following the end of the fiscal year ending June 30, 2000, and will hear and approve the minutes of the February 24, 2000, meeting. Reports will be heard from the Chairman, United Soybean Board representatives, and other committees. 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, Department of Agriculture and Consumer Services, 1100 Bank St., Room 1005, Richmond, VA 23219, telephone (804) 371-6157, FAX (804) 371-7786.

Virginia Sweet Potato Board

August 15, 2000 - 7 p.m. -- Open Meeting
Little Italy Restaurant, 10227 Rogers Drive, Nassawadox, Virginia. (Interpreter for the deaf provided upon request)

The board will hear and approve minutes of the last meeting and the presentation of the board's financial statement. The board will discuss and consider programs (promotion, research, and education), the annual budget and other business that may be presented. 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 board at least five days before the meeting date so that suitable arrangements can be made.

Contact: J. William Mapp, Program Director, Department of Agriculture and Consumer Services, Virginia Sweet Potato Board, P.O. Box 26, Onley, VA 23418, telephone (757) 787-5867, FAX (757) 787-5973.

STATE AIR POLLUTION CONTROL BOARD

† **August 2, 2000 - 7 p.m.** -- Public Hearing
Dynax America Corporation, 568 East Park Drive, Eastpark Commerce Center, Cafeteria/Lunchroom, Botetourt, Virginia. (Interpreter for the deaf provided upon request)

A public hearing to receive comments on an air permit application from Dynax America Corporation to increase production at the facility.

Contact: Steven Dietrich, State Air Pollution Control Board, 3019 Peters Creek Rd., Roanoke, VA 24019, telephone (540) 562-6762, FAX (540) 562-6725, e-mail sadietrich@deq.state.va.us.

† **September 7, 2000 - 9 a.m.** -- Open Meeting
Main Street Centre, 600 East Main Street, Lower Level, Conference Room, Richmond, Virginia.

A public meeting to receive comment on the board's intent to modify 9 VAC 5-20-21 to update information related to technical documents incorporated by reference and maintain consistency with Title 40 of the Code of Federal Regulations.

The department is soliciting comments on (i) the intended regulatory action, to include ideas to assist the department in the development of the proposal and (ii) the costs and benefits of alternatives. This public meeting is being held by the board to receive comments on and to discuss the intended action. Unlike a public hearing, which is intended only to receive testimony, this meeting is being held to discuss and exchange ideas and information relative to regulation development.

Contact: Karen Sabasteanski, State Air Pollution Control Board, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4426, FAX (804) 698-4510, (804) 698-4021/TTY ☎, e-mail kgsabastea@deq.state.va.us.

ALCOHOLIC BEVERAGE CONTROL BOARD

August 8, 2000 - 9:30 a.m. -- Open Meeting
Department of Alcoholic Beverage Control, 2901 Hermitage Road, Richmond, Virginia.

Receipt and discussion of reports and activities from staff members. Others 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, FAX (804) 213-4442, e-mail wccolen@abc.state.va.us.

ALZHEIMER'S DISEASE AND RELATED DISORDERS COMMISSION

August 7, 2000 - 10 a.m. -- Open Meeting
Westminster at Lakeridge Virginia, 12185 Clipper Drive, Lakeridge, Virginia. (Interpreter for the deaf provided upon request)

A regular business meeting.

Contact: Virginia Pomata, Chairman, Alzheimer's Disease and Related Disorders Commission, 639 Nalls Farm Way, Great Falls, VA 22066, telephone (703) 430-1426 or FAX (703) 430-9796.

BOARD FOR ARCHITECTS, PROFESSIONAL ENGINEERS, LAND SURVEYORS, CERTIFIED INTERIOR DESIGNERS AND LANDSCAPE ARCHITECTS

August 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)

A meeting of the Architects Section to conduct board business. Persons desiring to participate in the meeting and requiring special accommodations or interpretative services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail apelsla@dpor.state.va.us.

August 16, 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 of the Professional Engineers Section to conduct board business. Persons desiring to participate in the meeting and requiring special accommodations or interpretative services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail apelsla@dpor.state.va.us.

August 23, 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 of the Land Surveyors Section to conduct board business. Persons desiring to participate in the meeting and requiring special accommodations or interpretative services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail apelsla@dpor.state.va.us.

August 30, 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 of the Landscape Architects Section to conduct board business. Persons desiring to participate in the meeting and requiring special accommodations or interpretative services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail apelsla@dpor.state.va.us.

September 6, 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 of the Certified Interior Designers Section to conduct board business. Persons desiring to participate in the meeting and requiring special accommodations or interpretative services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail apelsla@dpor.state.va.us.

September 13, 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 meeting to conduct business of the APELSCIDLA Board. Persons desiring to participate in the meeting and requiring special accommodations or interpretative services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail apelsla@dpor.state.va.us.

BOARD FOR ASBESTOS AND LEAD

† **August 16, 2000 - 10 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 5W, Richmond, Virginia.

A meeting to conduct routine business. A public comment period will be held at the beginning of the meeting.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2648, FAX (804) 367-6128, (804) 367-9753/TTY ☎, e-mail asbestos@dpor.state.va.us.

COMPREHENSIVE SERVICES FOR AT-RISK YOUTH AND THEIR FAMILIES

State Executive Council

† **August 30, 2000 - 9 a.m.** -- Open Meeting
† **September 27, 2000 - 9 a.m.** -- Open Meeting
† **October 25, 2000 - 9 a.m.** -- Open Meeting
Department of Social Services, 730 East Broad Street, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting to provide for interagency programmatic and fiscal policies, oversee the administration of funds appropriated under the Act, and advise the Secretary of Health and Human Resources and the Governor.

Contact: Alan G. Saunders, Director, Comprehensive Services for At-Risk Youth and Families, 1604 Santa Rosa Rd., Suite 137, Richmond, VA 23219, telephone (804) 662-9815, FAX (804) 662-9831, e-mail ags992@central.dss.state.va.us.

State Management Team

August 3, 2000 - 9:15 a.m. -- Open Meeting
St. Joseph's Villa, 8000 Brook Road, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting to discuss recommendations for policies and procedures to the State Executive Council on the Comprehensive Services Act. There will be a public comment period from 9:45 to 10 a.m.

Contact: Elisabeth Hutton, Secretary, Department of Health, P.O. Box 2448, Richmond, VA 23218, telephone (804) 371-4099.

BOARD FOR BARBERS AND COSMETOLOGY

August 28, 2000 - 8:30 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 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 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., Richmond, VA 23230, telephone (804) 367-8590, FAX (804) 367-6295, (804) 367-9753/TTY ☎, e-mail barbers@dpor.state.va.us.

BOARD FOR BRANCH PILOTS

August 2, 2000 - 9:30 a.m. -- Open Meeting
Virginia Port Authority, 600 World Trade Center, Norfolk, Virginia. (Interpreter for the deaf provided upon request)

A meeting to conduct any and all board business. Persons desiring to participate in the meeting and requiring special accommodations or interpretative services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that

suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail branchpilots@dpor.state.va.us.

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August 2, 2000 - 9:30 a.m. -- Public Hearing
Virginia Port Authority, 600 World Trade Center, 6th Floor, Norfolk, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Branch Pilots intends to amend regulations entitled: **18 VAC 45-20-05 et seq. Board for Branch Pilots Rules and Regulations.** The purpose of the proposed action is to clarify the regulations relating to chemical and physical impairments and testing thereof and make other changes which may be necessary pursuant to the board's periodic review of its regulations.

Statutory Authority: § 54.1-902 of the Code of Virginia.

Public comments may be submitted until August 21, 2000.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475 or (804) 367-9753/TTY ☎

CEMETERY BOARD

† **August 23, 2000 - 8:30 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.

Contact: Karen W. O'Neal, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2039, FAX (804) 367-2475, (804) 367-9753/TTY ☎

† **August 23, 2000 - 9:30 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A general business meeting.

Contact: Karen W. O'Neal, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2039, FAX (804) 367-2475, (804) 367-9753/TTY ☎

CHILD DAY-CARE COUNCIL

† **August 10, 2000 - 8:30 a.m.** -- Open Meeting
Brandermill Inn and Conference Center, 13550 Harbour Pointe Parkway, Midlothian, Virginia. (Interpreter for the deaf provided upon request)

A meeting to discuss issues and concerns that impact child day centers, camps, school age programs and preschools/nursery schools. Public comment period will be received at noon. Please call ahead for possible changes in meeting time.

Contact: Arlene Kasper, Program Consultant, Division of Licensing Programs, Department of Social Services, 730 E. Broad St., Richmond, VA 23219-1849, telephone (804) 692-1791, FAX (804) 692-2370.

COMPENSATION BOARD

† **August 22, 2000 - 11 a.m.** -- Open Meeting
Compensation Board, Ninth Street Office Building, Richmond, Virginia.

A monthly board meeting.

Contact: Cindy Waddell, Administrative 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

Chippokes Plantation Farm Foundation

† **August 1, 2000 - 9:30 a.m.** -- Open Meeting
Chippokes Mansion, Chippokes Plantation State Park, Conference Room, Surry, Virginia. (Interpreter for the deaf provided upon request)

A meeting of the Fund Raising Committee to discuss the job description for the development manager position.

Contact: Katherine Write, Executive Secretary, Department of Conservation and Recreation, 101 N. 14th St., Richmond, VA 23219, telephone (804) 786-7950, FAX (804) 371-8500, e-mail kwright@dcr.state.va.us.

Falls of the James Scenic River Advisory Board

August 3, 2000 - Noon -- Open Meeting
Planning Commission Conference Room, 5th Floor, City Hall, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A discussion of river issues. Meetings will be held if deemed necessary. Interested persons should call the Board Chairman at 804-828-1537. Requests for an interpreter for the deaf should be filed two weeks prior to the meeting.

Contact: Richard Gibbons, Environmental Program Manager, Department of Conservation and Recreation, 203 Governor St., Richmond, VA 23219, telephone (804) 786-4132, FAX (804) 371-7899, e-mail rgibbons@dcr.state.va.us.

Lake Anna State Park Master Plan Advisory Committee

August 3, 2000 - 6 p.m. -- Open Meeting
Lake Anna State Park Visitor Center, 6800 Lawyers Road, Spotsylvania, Virginia. (Interpreter for the deaf provided upon request)

A meeting to continue work on the park master plan. Requests for interpreter for the deaf must be filed two weeks prior to the meeting.

Contact: Derral Jones, Planning Bureau Manager, Department of Conservation and Recreation, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-9042, FAX (804) 371-7899, e-mail djones@dcr.state.va.us.

Rappahannock Scenic River Advisory Board

† **August 2, 2000 - 7 p.m.** -- Open Meeting
Virginia Deli, 101 William Street, Fredericksburg, Virginia. (Interpreter for the deaf provided upon request)

A meeting to discuss issues pertaining to the Rappahannock Scenic River.

Contact: Richard G. Gibbons, Environmental Program Manager, Department of Conservation and Recreation, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-4132, FAX (804) 371-7899, e-mail rgibbons@dcr.state.va.us.

BOARD FOR CONTRACTORS

† **August 16, 2000 - 10 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 4W, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting of the Tradesman Committee to consider items of interest relating to Tradesman/Backflow Prevention Device Workers/LPGs and Natural Gas Fitters. Other appropriate matters pertaining to the Tradesman Section of the Board for Contractors will be considered including review of the tradesman regulations.

Contact: Robert F. Tortolani, Administrator, Board for Contractors, 3600 W. Broad St, Richmond, VA 23230, telephone (804) 367-2607, FAX (804) 367-2474, (804) 367-9753/TTY ☎, e-mail tortolani@dpor.state.va.us.

BOARD OF CORRECTIONS

† **August 8, 2000 - 10 a.m.** -- Open Meeting
Department of Corrections, 6900 Atmore Drive, Board Room, Richmond, Virginia.

A meeting of the Liaison Committee to discuss criminal justice matters that may be presented to the full board.

Contact: Barbara Fellows, Administrative Assistant, Department of Corrections, 6900 Atmore Dr., telephone (804) 674-3235, FAX (804) 674-3130, e-mail fellowsbl@vadoc.state.va.us.

† **August 8, 2000 - 1:30 p.m.** -- Open Meeting
Department of Corrections, 6900 Atmore Drive, Board Room, Richmond, Virginia.

A meeting of the Correctional Services Committee to discuss correctional services matters for possible presentation to the full board.

Contact: Barbara Fellows, Administrative Assistant, Department of Corrections, 6900 Atmore Dr., Richmond VA 23225, telephone (804) 674-3235, FAX (804) 674-3130, e-mail fellowsbl@vadoc.state.va.us.

† **August 9, 2000 - 8:30 a.m.** -- Open Meeting
Department of Corrections, 6900 Atmore Drive, Board Room, Richmond, Virginia.

A meeting of the Administrative Committee to discuss administrative matters for possible presentation to the full board.

Contact: Barbara Fellows, Administrative Assistant, Department of Corrections, 6900 Atmore Dr., Richmond, VA 23225, telephone (804) 674-3235, FAX (804) 674-3130, e-mail fellowsbl@vadoc.state.va.us.

† **August 9, 2000 - 10 a.m.** -- Open Meeting
Department of Corrections, 6900 Atmore Drive, Board Room, Richmond, Virginia.

A meeting to discuss matters that may be presented to the full board. Public comment will be received.

Contact: Barbara Fellows, Administrative Assistant, Department of Corrections, 6900 Atmore Dr., Richmond, VA 23225, telephone (804) 674-3235, FAX (804) 674-3130, e-mail fellowsbl@vadoc.state.va.us.

BOARD OF COUNSELING

† **August 2, 2000 - 8:30 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia.

A meeting of the Executive Committee to review the agenda for the full board meeting.

Contact: Joyce D. Williams, Administrative Assistant, Board of Counseling, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 660-9912, FAX (804) 663-7250, (804) 662-7197/TTY ☎, e-mail coun@dhp.state.va.us.

† **August 24, 2000 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Richmond, Virginia.

A meeting of the Examination Committee to review the National Board for Certified Counselors examinations.

Contact: Joyce D. Williams, Administrative Assistant, Board of Counseling, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9912, FAX (804) 662-7250, (804) 662-7197/TTY ☎, e-mail coun@dhp.state.va.us.

August 24, 2000 - 1 p.m. -- Open Meeting
Department of Health Professions, 6606 West Broad St., 5th Floor, Conference Room 1, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting of the Regulatory Committee to review a preliminary proposal to improve consistency among its regulations in areas where language is generic for all professions.

Contact: Janet Delorme, Deputy Executive Director, Board of Counseling, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9575, FAX (804) 662-7250, (804) 662-7197/TTY ☎, e-mail jdelorme@dhp.state.va.us.

† **August 24, 2000 - 3:30 p.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia.

A meeting of the Credentials Committee to review applicant credentials.

Contact: Joyce D. Williams, Administrative Assistant, Board of Counseling, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9912, FAX (804) 662-7250, (804) 662-7197/TTY ☎, e-mail coun@dhp.state.va.us.

August 25, 2000 - 9 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia.

A regular meeting to hear reports from standing committees. The Examination Committee will report on its comparison of the national counseling examinations with the board's licensure exam. The board will consider a preliminary Notice of Intended Regulatory Action to amend its regulations to improve consistency among its regulations where the language is generic to all professions. Meeting dates for 2001 will be scheduled.

Contact: Evelyn B. Brown, Executive Director, Board of Counseling, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9912, FAX (804) 662-9943, (804) 662-7197/TTY ☎, e-mail ebrown@dhp.state.va.us.

DEPARTMENT FOR THE DEAF AND HARD-OF-HEARING

† **August 2, 2000 - 9:30 a.m.** -- Open Meeting
Virginia Department for the Deaf and Hard-of-Hearing, Ratcliffe Building, 1602 Rolling Hills Drive, 2nd Floor, Conference Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular quarterly meeting of the advisory board. The public is invited to address the board during the public comment time on the agenda at 11:30 a.m.

Contact: Leslie G. Hutcheson, Regulatory Coordinator, Department for the Deaf and Hard-of-Hearing, 1602 Rolling Hills Dr., Suite 203, Richmond, VA 23229-5012, telephone (804) 662-9703, FAX (804) 662-9718, e-mail hutchelg@ddhh.state.va.us

VIRGINIA ECONOMIC DEVELOPMENT PARTNERSHIP

September 5, 2000 - 11 a.m. -- Open Meeting
Virginia Economic Development Partnership, Riverfront Plaza, 901 East Byrd Street, 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: Mara Hilliar, Office Manager, Virginia Economic Development Partnership, P.O. Box 798, Richmond, VA 23218-0798, telephone (804) 371-8106 or FAX (804) 371-8112.

STATE BOARD OF EDUCATION

September 28, 2000 - 9 a.m. -- Open Meeting
Location to be announced.

A business meeting. Persons requesting services of an interpreter for the deaf should do so in advance.

Contact: Dr. Margaret N. Roberts, Office of Policy, Board of Education, P.O. Box 2120, 101 N. 14th Street, 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, e-mail mroberts@mail.vak12ed.edu.

DEPARTMENT OF ENVIRONMENTAL QUALITY

July 31, 2000 - 7 p.m. -- Public Hearing
Shenandoah County Government Center, 600 North Main Street, Conference Room, Woodstock, Virginia. (Interpreter for the deaf provided upon request)

A public hearing to receive comments on a draft permit amendment for the Shenandoah County Sanitary Landfill located three miles north of Edinburg.

Contact: E. Paul Farrell, Jr., Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4214, toll-free (804) 698-4021, e-mail epfarrell@deq.state.va.us.

VIRGINIA FIRE SERVICES BOARD

† **August 10, 2000 - 8:30 a.m.** -- Open Meeting
Microtel Inn and Suites, 135 Ponderosa Drive, Christiansburg, Virginia.

The following committees of the Virginia Fire Services Board will meet on this date:

Fire Education and Training - 8:30 a.m.
Administration and Policy - 10 a.m.
Fire Prevention and Control - 1 p.m.
Finance - 3 p.m.

Contact: Troy H. Lapetina, Executive Director, Department of Fire Programs, 101 N. 14th St., 18th Floor, Richmond, VA 23219, telephone (804) 371-0220, FAX (804) 371-0217.

† **August 11, 2000 - 9 a.m.** -- Open Meeting
Microtel Inn and Suites, 135 Ponderosa Drive, Christiansburg, Virginia.

A regular meeting of the board.

Contact: Troy H. Lapetina, Executive Director, Department of Fire Programs, 101 N. 14th St., 18th Floor, Richmond, VA 23219, telephone (804) 371-0220, FAX (804) 371-0217.

BOARD OF GAME AND INLAND FISHERIES

August 24, 2000 - 9 a.m. -- Public Hearing
Department of Game and Inland Fisheries, 4000 West Broad Street, Richmond, Virginia. (Interpreter for the deaf provided upon request)

The board will propose amendments to regulations governing fish and fishing, and wildlife diversity (i.e., wildlife other than in the contexts of hunting, trapping, or fishing). This is the regular biennial review for these regulations. The Board of Game and Inland Fisheries is exempted from the Administrative Process Act (§ 9-6.14:4.1 of the Code of Virginia) in promulgating wildlife management regulations, including the length of seasons, bag limits and methods of take set on the wildlife resources within the Commonwealth of Virginia. It is required by § 9-6.14:22 to publish all proposed and final regulations. Under board procedures, regulatory actions occur over two sequential board meetings. The second board meeting in this regulatory review is scheduled for October 26, 2000. Further information on the biennial regulation review is provided in a separate announcement in the General Notices section of the Virginia Register. At the August 24 meeting the board also (i) will adopt 2000-2001 hunting seasons and bag limits for migratory waterfowl (ducks and coots, geese and brant, swan, gallinules and moorhens) and falconry, based on frameworks provided by the U.S. Fish and Wildlife Service; (ii) will solicit and receive comments from the public during the public hearing portion of the meeting; (iii) may review possible proposals for legislation for the 2001 Session of the General Assembly; (iv) may discuss other general and administrative issues; and (v) may hold an executive session before the public session begins. The board may also elect to hold a dinner Wednesday evening, August 23, at a location and time to be determined.

Contact: Phil Smith, Policy Analyst and Regulatory Coordinator, Department of Game and Inland Fisheries, 4010 W. Broad St., Richmond, VA 23230, telephone (804) 367-1000, e-mail regcomments@dgif.state.va.us.

DEPARTMENT OF GAME AND INLAND FISHERIES

August 8, 2000 - 7 p.m. -- Public Hearing
Department of Game and Inland Fisheries, 4000 West Broad Street, Richmond, Virginia. (Interpreter for the deaf provided upon request)

The Virginia Department of Game and Inland Fisheries (DGIF) Wildlife Division is holding a public input meeting to discuss and receive public comments regarding season lengths and bag limits for the 2000-2001 hunting seasons for migratory waterfowl (ducks and coots, geese and brant, swan, gallinules and moorhens) and falconry. All interested citizens are invited to attend. DGIF Wildlife Division staff will discuss the population status of these species, and present hunting season frameworks for them provided by the U.S. Fish and Wildlife Service. The public's comments will be solicited in the public hearing portion of the meeting. A summary of the results of this public hearing will be presented to the Virginia Board of Game and Inland Fisheries prior to its scheduled August 24, 2000 meeting. At the August 24 meeting, the board will hold another public hearing, after which it intends to set 2000-2001 hunting seasons and bag limits for the above species.

Contact: Bob Ellis, Wildlife Division Assistant Director, Department of Game and Inland Fisheries, 4010 W. Broad St., Richmond, VA 23230, telephone (804) 367-0904.

STATE BOARD OF HEALTH

August 10, 2000 - 10 a.m. -- Open Meeting
August 11, 2000 - 9 a.m. -- Open Meeting
Holiday Inn, 2864 Pruden Boulevard, Suffolk, Virginia.

A work session and business meeting.

Contact: Lena Burrell, Executive Secretary, Department of Health, Main Street Station, 1500 East Main St., Room 214, Richmond, VA 23219, telephone (804) 786-6970, FAX (804) 786-4616, e-mail lburrell@vdh.state.va.us.

DEPARTMENT OF HEALTH PROFESSIONS

August 11, 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)

A meeting of the Health Practitioner's Intervention Program Committee and its contractor and representatives on the status of the program. The committee will meet in open session for general discuss

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, 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 ☎

HOPEWELL INDUSTRIAL SAFETY COUNCIL

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 Street, Hopewell, VA 23860, telephone (804) 541-2298.

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

† **August 15, 2000 - 11 a.m.** -- Open Meeting
Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, Virginia.

A regular meeting of the Board of Commissioners. The Board of Commissioners will (i) review and, if appropriate, approve the minutes from the prior monthly meeting; (ii) consider and, if appropriate, approve amendments to the authority's rules and regulations for administration of rent reduction tax credits; (iii) consider for approval and ratification mortgage loan commitments under its various programs; (iv) review the authority's operations for the prior month; and (v) consider such other matters and take such other actions as they may deem appropriate. Various committees of the Board of Commissioners may also meet before or after the regular meeting and consider matters within their purview. The planned agenda of the meeting will be available at the offices of the authority one week prior to the date of the meeting.

Contact: J. Judson McKellar, Jr., General Counsel, Virginia Housing Development Authority, 601 S. Belvidere St., Richmond, VA 23220, telephone (804) 343-5540, FAX (804) 783-6701, toll-free (800) 968-7837, (804) 783-6705/TTY ☎

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

September 27, 2000 - 1:30 p.m. -- Open Meeting
James Monroe Building, 101 North 14th Street, 1st Floor, Conference Room B, Richmond, Virginia.

A quarterly meeting of the State Advisory Council. The council will be discussing issues surrounding the state employee health benefits program.

Contact: Anthony Graziano, Director, Office of Health Benefit Programs, Department of Human Resource Management, 101 N. Fourteenth St., 13th Floor, Richmond, VA 23294, telephone (804) 371-7931.

DEPARTMENT OF LABOR AND INDUSTRY

Virginia Apprenticeship Council

August 10, 2000 - 9:30 a.m. -- Open Meeting
Department of Labor and Industry, 13 South Thirteenth Street, Mezzanine Conference Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting of the Apprenticeship Council Subcommittee to discuss exemption from examination.

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

September 21, 2000 - 10 a.m. -- Open Meeting
Chesterfield Technical Center, 10101 Courthouse Road, Chesterfield, Virginia. (Interpreter for the deaf provided upon request)

Agenda to be announced.

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.

STATE LAND EVALUATION ADVISORY COUNCIL

August 8, 2000 - 10 a.m. -- Open Meeting
Department of Motor Vehicles, 2300 West Broad Street, Room 702, Richmond, Virginia.

A meeting to adopt suggested ranges of values for agricultural, horticultural, forest and open-space land use and the use-value assessment program.

Contact: H. Keith Mawyer, Property Tax Manager, Department of Taxation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8020.

LITTER CONTROL AND RECYCLING FUND ADVISORY BOARD

† **August 29, 2000 - 10 a.m.** -- Open Meeting
701 East Franklin Street, Lower Level Conference Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting to review the FY 2000 litter prevention and recycling grants and funding splits for 2001. The board will also discuss its current policy on carry forward grant

balances and the status of the noncompetitive grant applications/awards.

Contact: Michael P. Murphy, Director, Environmental Enhancement, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240-0009, telephone (804) 698-4003, FAX (804) 698-4319, (804) 698-4021/TTY☎ or toll-free 1-800-592-5482, e-mail mpmurphy@deq.state.va.us.

COMMISSION ON LOCAL GOVERNMENT

† **September 25, 2000 - 2 p.m.** -- Open Meeting
Timberville area; site to be determined.

A regular meeting to consider matters that may be presented. Persons desiring to participate in the proceedings and requiring special accommodations or interpreter services should contact the commission or the Virginia Relay Center.

Contact: Barbara Bingham, Administrative Assistant, Commission on Local Government, Pocahontas Bldg., 900 East Main Street, Suite 103, Richmond, VA 23219-3513, telephone (804) 786-6508, FAX (804) 371-7999 or toll-free 1-800-828-1120/VA Relay Center.

MARINE RESOURCES COMMISSION

August 22, 2000 - 9:30 a.m. -- Open Meeting
September 26, 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 ☎

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

August 17, 2000 - 2 p.m. -- Open Meeting
Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Board Room, Richmond, Virginia.

A meeting to conduct routine business of the Virginia Medicaid Drug Utilization Review Board.

Contact: Marianne Rollings, DUR Board Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 225-4268, FAX (804) 786-1680, toll-free 1-800-343-0634/TTY ☎, e-mail mrollings@dmas.state.va.us.

† **September 11, 2000 - 1 p.m.** -- Open Meeting
Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia.

A meeting of the Virginia Medicaid Pharmacy Liaison Committee to conduct routine 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, or toll-free 1-800-343-0634/TTY ☎, e-mail mrollings@dmas.state.va.us.

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September 29, 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 Department of Medical Assistance Services intends to amend regulations entitled:

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

12 VAC 30-50-10 et seq. Amount, Duration, and Scope of Medical and Remedial Care Services.

12 VAC 30-80-10 et seq. Methods and Standards for Establishing Payments Rates; Other Types of Care.

12 VAC 30-130-10 et seq. Amount, Duration and Scope of Selected Services.

These proposed regulations provide for Medicaid coverage of residential psychiatric treatment services for children and adolescents.

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

Public comments may be submitted until September 29, 2000, to Anita Cordill, Analyst, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-8854 or FAX (804) 371-4981.

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September 29, 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 Department of Medical Assistance Services intends to amend regulations entitled: **12 VAC 30-50-10 et seq. Amount, Duration, and Scope of Medical and Remedial Care Services.** The proposed amendments provide for the expansion of health care services that can be rendered by employees of school divisions to special education children and be reimbursed by Medicaid.

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

Public comments may be submitted until September 29, 2000, to Jeff Nelson, Analyst, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-8854 or FAX (804) 371-4981.

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September 29, 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 Department of Medical Assistance Services intends to amend regulations entitled:

12 VAC 30-50-10 et seq. Amount, Duration, and Scope of Medical and Remedial Care Services.

12 VAC 30-60-10 et seq. Standards Established and Methods Used to Assure High Quality Care.

12 VAC 30-80-10 et seq. Methods and Standards for Establishing Payment Rates; Other Types of Care.

12 VAC 30-130-10 et seq. Amount, Duration and Scope of Selected Services.

These proposed amendments provide for coverage by Medicaid of case management services for children who are receiving treatment foster care services.

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

Public comments may be submitted until September 29, 2000, to Anita Cordill, Analyst, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-8854 or FAX (804) 371-4981.

BOARD OF MEDICINE

August 4, 2000 - 8 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 2, Richmond, Virginia.

The Executive Committee will meet in open and closed sessions to review disciplinary files requiring administrative action, adoption of amendments to regulations as presented, and action on other issues that come before the board. Public comment will be received for 15 minutes following adoption of the agenda.

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.

August 10, 2000 - 9 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 4, Richmond, Virginia.

The Advisory Board on Occupational Therapy will review public comments on regulations and recommend any amendments.

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

August 3, 2000 - 9 a.m. -- Open Meeting
Holiday Inn Express, 2801 Plank Road, Fredericksburg, Virginia. (Interpreter for the deaf provided upon request)

August 9, 2000 - 8:30 a.m. -- Open Meeting
August 18, 2000 9 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, Richmond, Virginia. (Interpreter for the deaf provided upon request)

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 Dixson, Board of Medicine, 6606 West Broad Street, 4th Floor, Richmond, VA 23230, telephone (804) 662-7332, FAX (804) 662-9517, (804) 662-7197/TTY ☎

VIRGINIA MILITARY INSTITUTE

August 25, 2000 - 10 a.m. -- Open Meeting
Virginia Military Institute, Preston Library, Turman Room, Lexington, Virginia.

Board of Visitors standing committee meetings to discuss committee work to be reported to the full board on August 26.

Contact: Colonel Edwin L. Dooley, Jr., Secretary to the Board of Visitors, Virginia Military Institute, Superintendent's Office, Lexington, VA 24450, telephone (540) 464-7206 or FAX (540) 464-7660.

August 26, 2000 - 8:30 a.m. -- Open Meeting
Virginia Military Institute, Preston Library, Turman Room, Lexington, Virginia.

A meeting to elect a president, vice presidents and secretary and to receive committee reports. The Board of Visitors provides an opportunity for public comment at this meeting immediately after the superintendent's comments, at approximately 9 a.m.

Contact: Colonel Edwin L. Dooley, Jr., Secretary to the Board of Visitors, Virginia Military Institute, Superintendent's Office, Lexington, VA 24450, telephone (540) 464-7206 or FAX (540) 464-7660.

STATE MILK COMMISSION

August 30, 2000 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room B, 1st Floor, Richmond, Virginia.

September 21, 2000 - 10:30 a.m. -- Open Meeting
The Farm of Judith Motley, Chatham, Virginia.

A regular meeting to consider industry issues, distributor licensing, base transfers, baseholder license amendment, fiscal matters, and to review reports from staff of the agency. Any persons requiring special accommodations in order to participate in the meeting should contact Edward C. Wilson, Jr., at least five days prior to the meeting date so that suitable arrangements can be made.

Contact: Edward C. Wilson, Jr., Deputy Administrator, State Milk Commission, Ninth St. Office Bldg., 202 N. Ninth St., Room 915, Richmond, VA 23219, telephone (804) 786-2013, FAX (804) 786-3779, e-mail ewilson@smc.state.va.us.

August 30, 2000 - 11 a.m. -- Open Meeting
General Assembly Meeting, 9th and Broad Streets, Senate Room B, 1st Floor, Richmond, Virginia.

A meeting to consider public comment on regulatory review of 2 VAC 15-11-10 through 2 VAC 15-11-120 and 2 VAC 15-20-10 through 2 VAC 15-20-130 to determine if these regulations should be terminated, amended or retained in their current form. The open hearing is in accordance with 2 VAC 15-11-100 and will be conducted in accordance with 2 VAC 15-20-125.

Contact: Edward C. Wilson, Jr., Deputy Administrator, State Milk Commission, Ninth St. Office Bldg., 202 N. Ninth St., Room 915, Richmond, VA 23219, telephone (804) 786-2013, FAX (804) 786-3779, e-mail ewilson@smc.state.va.us.

DEPARTMENT OF MINES, MINERALS AND ENERGY

† **August 17, 2000 - 9:30 a.m.** -- Open Meeting
Oxbow Center, St. Paul, Virginia. (Interpreter for the deaf provided upon request)

A combined meeting of the Permit Streamline and Regulatory Work Groups. Topics to be discussed by the Permit Streamline Work Group include mountain top removal/valley fills and environmental impact statement update, AOC guidelines, fill minimization, permit revision application requirements, and sediment pond location and permitting requirements. Topics for the Regulatory Work Group include ownership and control, experimental practice, land form grading, and 95-regulation review. Public comments will not be received at this meeting.

Contact: Leslie S. Vincent, Customer Services Manager, Department of Mines, Minerals and Energy, P.O. Drawer 900, Big Stone Gap, VA 24219, telephone (540) 523-8156, FAX (540) 523-8163, toll-free 1-800-828-1120/TTY ☎, e-mail lsv@mme.state.va.us.

BOARD OF NURSING

August 1, 2000 - 8:30 a.m. -- Open Meeting
August 2, 2000 - 8:30 a.m. -- Open Meeting
August 3, 2000 - 8:30 a.m. -- Open Meeting
August 7, 2000 - 8:30 a.m. -- Open Meeting
August 8, 2000 - 8:30 a.m. -- Open Meeting
August 14, 2000 - 8:30 a.m. -- Open Meeting
August 30, 2000 - 8:30 a.m. -- Open Meeting
September 7, 2000 - 8:30 a.m. -- Open Meeting
September 25, 2000 - 8:30 a.m. -- Open Meeting
September 27, 2000 - 8:30 a.m. -- Open Meeting
September 28, 2000 - 8:30 a.m. -- Open Meeting
October 5, 2000 - 8:30 a.m. -- Open Meeting
October 10, 2000 - 8:30 a.m. -- Open Meeting
October 12, 2000 - 8:30 a.m. -- Open Meeting
October 16, 2000 - 8:30 a.m. -- Open Meeting
October 17, 2000 - 8:30 a.m. -- Open Meeting
October 26, 2000 - 8:30 a.m. -- Open Meeting
October 31, 2000 - 8:30 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Rooms 1, 2, 3 or 4, Richmond, Virginia. (Interpreter for the deaf provided upon request)

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 Street, 4th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY ☎, e-mail nursebd@dhp.state.va.us.

Ad Hoc Advisory Committee on Massage Therapy

August 16, 2000 - 1:30 p.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 4, Richmond, Virginia.

The committee will conduct a periodic review of regulations for the certification of massage therapists as required by Executive Order 25 (98). Public comment will be received at the beginning of the meeting.

Contact: Nancy K. Durrett, R.N., Executive Director, Board of Nursing, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY ☎, e-mail ndurrett@dhp.state.va.us.

OLD DOMINION UNIVERSITY

August 14, 2000 - 3 p.m. -- Open Meeting
October 9, 2000 - 3 p.m. -- Open Meeting
Old Dominion University, Webb University Center, Norfolk, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting of the executive committee of the governing board of the institution to discuss business of the board and the institution as determined by the Rector and the President.

Contact: Donna Meeks, Assistant to the Vice President for Administration and Finance, Old Dominion University, 225 Koch Hall, Norfolk, VA 23529, telephone (757) 683-3072, FAX (757) 683-5679, e-mail dmeeks@odu.edu.

September 14, 2000 - 2:30 p.m. -- Open Meeting
Old Dominion University, Webb University Center, Norfolk, Virginia. (Interpreter for the deaf provided upon request)

A quarterly meeting of the governing board of the institution to discuss business of the board and the institution as determined by the Rector and the President.

Contact: Donna Meeks, Assistant to the Vice President for Administration and Finance, Old Dominion University, 225 Koch Hall, Norfolk, VA 23529, telephone (757) 683-3072, FAX (757) 683-5679, e-mail dmeeks@odu.edu.

BOARD FOR OPTICIANS

August 25, 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)

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 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., 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.

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September 29, 2000 - Public comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Opticians intends to amend regulations entitled: **18 VAC 100-20-10 et seq. Board for Opticians Regulations.** The purpose of the proposed amendments is to (i) establish a definitions section; (ii) clarify entry requirements for licensure; (iii) specify examination procedures and examination content for licensure and contact lens examinations; and (iv) modify the procedures and provisions regarding renewal, reinstatement, and the standards of practice and conduct.

Statutory Authority: § 54.1-201 and Chapter 17 (§ 54.1-1700 et seq.) of Title 54.1 of the Code of Virginia.

Contact: Nancy T. Feldman, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-6295 or (804) 367-9753/TTY ☎, e-mail opticians@dpor.state.va.us.

BOARD OF OPTOMETRY

† **August 11, 2000 - 8 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 3, Richmond, Virginia. (Interpreter for the deaf provided upon request)

Informal hearings. This is a public meeting; however, public comment will not be received.

Contact: Carol Stamey, Administrative Assistant, Board of Optometry, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9910, FAX (804) 662-7098, (804) 662-7197/TTY ☎, e-mail cstamey@dhp.state.va.us.

† **August 11, 2000 - 1:30 p.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 3, Richmond, Virginia.

The board will receive an update from the Attorney General's office regarding an opinion on mercantile practice.

Contact: Elizabeth A. Carter, Ph.D., Executive Director, Board of Optometry, Southern States Bldg., 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9910, FAX (804) 662-9504, (804) 662-7197/TTY ☎, e-mail ecarter@dhp.state.va.us.

VIRGINIA OUTDOORS FOUNDATION

Preservation Trust Fund Advisory Board-Region II

September 6, 2000 - 10 a.m. -- Open Meeting
Piedmont Environmental Council, Conference Room, Warrenton, Virginia.

A meeting to review Region II Preservation Trust Fund Applications

Contact: Sherry Buttrick, Director, Charlottesville Office, Virginia Outdoors Foundation, 1010 Harris St., #4, Charlottesville, VA 22903, telephone (804) 293-3423, FAX (804) 293-3859, e-mail vofsherryb@aol.com.

Preservation Trust Fund Advisory Board-Region V

August 30, 2000 - 10:30 a.m. -- Open Meeting
Lynchburg Chamber of Commerce, Conference Room, Lynchburg, Virginia.

A meeting to review Preservation Trust Fund Region V applications.

Contact: Sherry Buttrick, Virginia Outdoors Foundation, 1010 Harris St., #4, Charlottesville, VA 22903, telephone (804) 293-3423, FAX (804) 293-3859, e-mail vofsherryb@aol.com.

VIRGINIA BOARD FOR PEOPLE WITH DISABILITIES

August 2, 2000 - 8:30 a.m. -- Open Meeting
Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A quarterly meeting.

Contact: Tom Ariail, Assistant Director of Board Operations, Virginia Board for People with Disabilities, 202 N. 9th Street, 9th Floor, Richmond VA 23219, telephone (804) 786-0016, FAX (804) 786-1118, toll-free (800) 846-4464, (804) 786-0016/TTY ☎, e-mail ariailtm@vbpd.state.va.us.

BOARD OF PHARMACY

† **August 15, 2000 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, Fifth Floor, Conference Room 2, Richmond, Virginia.

A meeting to consider regulatory and disciplinary matters and take other business as may be presented. Public comment will be received at the beginning of the meeting as indicated on the agenda.

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.

VIRGINIA PUBLIC GUARDIAN AND CONSERVATOR ADVISORY BOARD

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, Department for the Aging, 1600 Forest Avenue, 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

August 16, 2000 - 9:30 a.m. -- Open Meeting
Tyler Building, 1300 East Main Street, Richmond, Virginia.

A regular meeting to hear a report from Colonial Downs concerning the preparations for two live racing meetings in the fall, including a segment for public participation.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, 10700 Horsemen's Rd., New Kent, VA 23124, telephone (804) 966-7404, FAX (804) 966-7418, or e-mail Anderson@vrc.state.va.us.

BOARD OF REHABILITATIVE SERVICES

September 28, 2000 - 10 a.m. -- Open Meeting
Woodrow Wilson Rehabilitation Center, Fishersville, Virginia. (Interpreter for the deaf provided upon request)

A quarterly business meeting. Public comments will be received at 10:15 a.m.

Contact: Barbara G. Tyson, Administrative Staff Specialist, Department of Rehabilitative Services, 8004 Franklin Farms Dr., P.O. Box K-300, Richmond, VA 23288-0300, telephone (804) 662-7010, toll-free (800) 552-5019, (804) 662-7000/TTY ☎

VIRGINIA RESOURCES AUTHORITY

August 11, 2000 - 9 a.m. -- Open Meeting
Martha Washington Inn, Abingdon, Virginia. (Interpreter for the deaf provided upon request)

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 its 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, Executive Assistant, Virginia Resources Authority, 707 E. Main St., Suite 1350, Richmond, VA 23219, telephone (804) 644-3100, FAX (804) 644-3109, e-mail bhoyle@vra.state.va.us.

VIRGINIA SMALL BUSINESS FINANCING AUTHORITY

† **August 22, 2000 - 10 a.m. --** Open Meeting
September 27, 2000 - 10 a.m. -- Open Meeting
Department of Business Assistance, 707 East Main Street, 3rd Floor, Main Board Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting of the Board of Directors to review applications for loans submitted to the authority for approval and for general business of the board. Contact the authority for confirmation of meeting time.

Contact: Cathleen M. Surface, Executive Director, Virginia Small Business Financing Authority, P.O. Box 446, Richmond, VA 23218-0446, telephone (804) 371-8254 or FAX (804) 225-3384.

STATE BOARD OF SOCIAL SERVICES

September 1, 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 adopt regulations entitled: **22 VAC 40-35-5 et seq. Virginia Independence Program.** The purpose of the proposed action is to implement the Virginia Employer Tax Credit.

Statutory Authority: §§ 58.1-439.9 and 63.1-25 of the Code of Virginia.

Contact: Thomas J. Steinhauser, Division of Temporary Assistance Programs, 730 E. Broad St., Richmond, VA 23219, telephone (804) 692-1703.

VIRGINIA TOURISM AUTHORITY

† **August 8, 2000 - 10:30 a.m.** -- Open Meeting
Virginia Economic Development Partnership, 901 East Byrd Street, Riverfront Plaza, West Tower, 19th Floor, Board Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting to receive and review the recommendations of the Ad Hoc Marketing and promotion Committee for Cooperative Marketing Program Awards and to review and receive the recommendations of the Ad Hoc Articles and By-Laws Committee for the new articles and by-laws. Public comment will be taken at the end of the meeting.

Contact: Winston Evans, Administrative Assistant, Virginia Tourism Authority, 901 E. Byrd St. Richmond, VA 23219, telephone (804) 371-8174, FAX (804) 786-1919, (804) 371-0327/TTY ☎, e-mail wevans@virginia.org.

COMMONWEALTH TRANSPORTATION BOARD

† **August 16, 2000 - 2 p.m.** -- Open Meeting
Department of Transportation Board Room, 1401 East Broad Street, Richmond, Virginia.

A work session of the Commonwealth Transportation Board and the Department of Transportation staff.

Contact: Cathy M. Ghidotti, Assistant Secretary to the Board, Commonwealth Transportation Board, 1401 E. Broad St., Richmond, VA 23219, telephone (804) 786-6675, FAX (804) 786-6683, e-mail ghidotti_cm@vdot.state.va.us.

† **August 17, 2000 - 10 a.m.** -- Open Meeting
Department of Transportation Board Room, 1401 East Broad Street, Richmond, Virginia.

A monthly meeting to vote on proposals presented regarding bids, permits, additions and deletions to the highway system, and any other matters requiring board approval. Public comment will be received at the outset of the meeting on items on the meeting agenda for which the opportunity for public comment has not been afforded the public in another forum. Remarks will be limited to 5 minutes. Large groups are asked to select one individual to speak for the group. The board reserves the right to amend these conditions. Separate committee meetings may be held on call of the Chairman. Contact VDOT Public Affairs at (804) 786-2715 for schedule.

Contact: Cathy M. Ghidotti, Assistant Secretary to the Board, Commonwealth Transportation Board, 1401 E. Broad St., Richmond, VA 23219, telephone (804) 786-6675, FAX (804) 786-6683, e-mail ghidotti_cm@vdot.state.va.us.

TRANSPORTATION SAFETY BOARD

† **September 13, 2000 - 9 a.m.** -- Open Meeting
Department of Motor Vehicles, 2300 West Broad Street, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A quarterly meeting to discuss matters of interest regarding traffic safety.

Contact: Angelisa Jennings, Management Analyst, Department of Motor Vehicles, 2300 W. Broad St., P.O. Box 27412, Room 405, Richmond, VA 23269, telephone (804) 367-2026.

BOARD OF VETERINARY MEDICINE

Informal Conference Committee

† **August 23, 2000 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 W. Broad St., 5th Floor, Richmond, Virginia. (Interpreter for the deaf provided upon request)

Informal conferences. These are public meetings, but public comment will not be received.

Contact: Terri H. Behr, Administrative Assistant, Board of Veterinary Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9915, FAX (804) 662-7098, (804) 662-7197/TTY ☎, e-mail tbehr@dhp.state.va.us.

DEPARTMENT FOR THE VISUALLY HANDICAPPED

Statewide Rehabilitation Council for the Blind

September 16, 2000 - 10 a.m. -- Open Meeting
Administrative Headquarters Building, 397 Azalea Avenue, Richmond, Virginia. (Interpreter for the deaf provided upon request)

The council meets quarterly to advise the Department for the Visually Handicapped 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 ☎, e-mail taylorjg@dvh.state.va.us.

STATE WATER CONTROL BOARD

August 10, 2000 - 9 a.m. -- Open Meeting
September 7, 2000 - 9 a.m. -- Open Meeting
September 20, 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.

August 10, 2000 - 2 p.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, House Room C, Richmond, Virginia.

A public meeting to receive comments on amending the Virginia Water Protection Permit Program regulation.

Contact: Ellen Gilinsky, State Water Control Board, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4375, FAX (804) 698-4032, e-mail egilinsky@deq.state.va.us.

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

† **September 7, 2000 - 10 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 5W, Richmond, Virginia.

A meeting of the Education Committee.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, Virginia 23230, telephone (804) 367-2648, FAX (804) 367-6128, (804) 367-9753/TTY ☎, e-mail waterwasteoper@dpor.state.va.us.

NOTE: CHANGE IN MEETING DATE
September 21, 2000 - 8:30 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 W. Broad Street, Conference Room 5W, Richmond, Virginia.

A regular meeting. A public comment period will be held at the beginning of the meeting.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8505, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail waterwasteoper@dpor.state.va.us.

INDEPENDENT

STATE CORPORATION COMMISSION

October 2, 2000 - 10 a.m. -- Public Hearing
State Corporation Commission, Tyler Building, 1300 East Main Street, 2nd Floor Courtroom, Richmond, Virginia.

A public hearing on the adoption of rules governing the filing of applications for approval pursuant to Chapter 4 (§ 56-76 et seq.) of Title 56 of the Code of Virginia (Affiliate Rules).

Contact: Robert Dalton, State Corporation Commission, Division of Public Utility Accounting, Tyler Bldg., 1300 E. Main St., P.O. Box 1197, Richmond, VA 23218, telephone (804) 371-9206 or FAX (804) 371-9211.

LEGISLATIVE

VIRGINIA CODE COMMISSION

August 16, 2000 - 10 a.m. -- Open Meeting
Charlottesville, Virginia area. (Interpreter for the deaf provided upon request)

September 27, 2000 - 10 a.m. -- Open Meeting
September 28, 2000 - 10 a.m. -- Open Meeting
October 18, 2000 - 10 a.m. -- Open Meeting
October 19, 2000 - 10 a.m. -- Open Meeting
General Assembly Building, 6th Floor, Speaker's Conference Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regularly scheduled meeting. Public comment will be received at the end of the meeting for a period not to exceed 15 minutes.

Contact: Jane D. Chaffin, Registrar of Regulations, Division of Legislative Services, General Assembly Building, 910 Capitol Street, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591, FAX (804) 692-0625 or e-mail jchaffin@leg.state.va.us.

JOINT SUBCOMMITTEE STUDYING THE RESPONSIBILITIES, POLICIES, AND ACTIVITIES OF THE STATE CORPORATION COMMISSION (SJR 173/HJR 187, 2000)

† **August 24, 2000 - 10 a.m.** -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room B, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting. Individuals requiring interpreter services or other accommodations should call or write John McE. Garrett seven working days before the meeting.

Contact: John McE. Garrett, Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, telephone (804) 698-7450 or (804) 698-7419/TTY ☎

LEGISLATIVE TRANSITION TASK FORCE OF THE VIRGINIA ELECTRICAL UTILITY RESTRUCTURING ACT (SB 1269, 1999)

August 21, 2000 - 1 p.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room B, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting. Individuals requiring interpreter services or other accommodations should call or write Thomas C. Gilman seven working days before the meeting.

Contact: Thomas C. Gilman, Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, telephone (804) 698-7450 or (804) 698-7419/TTY ☎

SENATE COMMITTEE ON GENERAL LAWS

† **August 21, 2000 - 1 p.m. --** Open Meeting
General Assembly Building, 9th and Broad Streets, 3rd Floor West, Conference Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting of Subcommittee #3 to discuss overtime compensation for fire and law-enforcement employees (SB 200), and to discuss professions and occupations: pawnbrokers (SB 273). Individuals requiring interpreter services or other accommodations should call or write Senate Committee Operations seven working days before the meeting.

Contact: John McE. Garrett, Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, telephone (804) 698-7450 or (804) 698-7419/TTY ☎

† **August 22, 2000 - 2 p.m.** -- Open Meeting
General Assembly Building, 9th and Broad Streets, 3rd Floor West, Conference Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting of Subcommittee #2 to discuss the Public Procurement Act; payment of living wage (SB 103). Individuals requiring interpreter services or other accommodations should call or write Senate Committee Operations seven working days before the meeting.

Contact: John McE. Garrett, Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, telephone (804) 698-7450 or (804) 698-7419/TTY ☎

† **October 16, 2000 - 10 a.m. --** Open Meeting
General Assembly Building, 9th and Broad Streets, 3rd Floor West, Conference Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting of Subcommittee #5 to discuss the Charitable Gaming Commission; volunteer fire departments and rescue squads (SB 426), and fraternal and veterans' organizations (SB 556). Individuals requiring interpreter services or other accommodations should call or write Senate Committee Operations seven working days before the meeting.

Contact: John McE. Garrett, Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, telephone (804) 698-7450 or (804) 698-7419/TTY ☎

† **December 6, 2000 - 2 p.m.** -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room B, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting to consider legislation continued to the 2001 Session of the General Assembly.

Contact: John McE. Garrett, Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, telephone (804) 698-7450 or (804) 698-7419/TTY ☎

COMMISSION ON ACCESS AND DIVERSITY IN HIGHER EDUCATION IN VIRGINIA (HJR 202/2000)

† **August 1, 2000 - 10 a.m.** -- Open Meeting
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia. (Interpreter for the deaf provided upon request)

The commission will be briefed by the Deputy Secretary of the United States Department of Education regarding the Office of Civil Rights (OCR) review. Questions regarding the meeting should contact Brenda Edwards, Division of Legislative Services, (804) 786-3591. Individuals requiring interpreter services or other special assistance should contact Dawn Smith at least 10 working days prior to the meeting.

Contact: Dawn B. Smith, Committee Operations, House of Delegates, State Capitol, P.O. Box 406, Richmond, VA 23218, telephone (804) 698-1540 or (804) 786-2369/TTY ☎

JOINT REAPPORTIONMENT COMMITTEE

September 11, 2000 - 2 p.m. -- Open Meeting
October 16, 2000 - 2 p.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room B, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting. Questions regarding the meeting agenda should be directed to Mary Spain or Jack Austin, Division of Legislative Services, (804) 786-3591.

Contact: Patricia J. Lung, Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, telephone (804) 698-7450 or (804) 698-7419/TTY ☎

JOINT SUBCOMMITTEE STUDYING SATELLITE CHIP MILLS (HJR 730, 1999)

August 23, 2000 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting. Questions regarding the meeting should be addressed to Marty Farber or Nicole Rovner, Division of Legislative Services, (804) 786-3591. Individuals requiring interpreter services or special assistance should contact Barbara Regen at least 10 working days prior to the meeting.

Contact: Barbara Regen, Committee Operations, House of Delegates, State Capitol, P.O. Box 406, Richmond, VA 23218, telephone (804) 698-1544 or (804) 786-2369/TTY ☎

COMMISSION ON VIRGINIA'S STATE AND LOCAL TAX STRUCTURE FOR THE 21ST CENTURY

† **August 22, 2000 - 9 a.m.** -- Open Meeting
† **October 2, 2000 - 9 a.m.** -- Open Meeting
† **October 31, 2000 - 9 a.m.** -- Open Meeting
University of Virginia, Alumni Hall, Charlottesville, 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, Staff Director, or Rob Hodder, 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, e-mail leisasteele@erols.com.

JOINT SUBCOMMITTEE STUDYING THE FUNDING REQUIREMENTS OF THE VIRGINIA UNEMPLOYMENT TRUST FUND

August 22, 2000 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting. Questions regarding the meeting should be addressed to Frank Munyan or Maureen Stinger, Division of Legislative Services, (804) 786-3591. Individuals requiring interpreter services or special assistance should contact Lois Johnson at least 10 working days prior to the meeting.

Contact: Lois V. Johnson, Committee Operations, House of Delegates, State Capitol, P.O. Box 406, Richmond, VA 23218, telephone (804) 698-1544 or (804) 786-2369/TTY ☎

JOINT SUBCOMMITTEE STUDYING THE FEASIBILITY OF DEVELOPING A CENTER FOR CONTINUING AND VOCATIONAL EDUCATION

August 15, 2000 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room B, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting. Questions regarding the meeting should be directed to Senate Committee Operations.

Contact: Thomas C. Gilman, Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, telephone (804) 698-7450 or (804) 698-7419/TTY ☎

STATE WATER COMMISSION

August 14, 2000 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting. Questions regarding the meeting should be addressed to Dennis Walter or Marty Farber, Division of Legislative Services, (804) 786-3591. Individuals requiring interpreter services or special

assistance should contact Lois Johnson at least 10 working days prior to the meeting.

Contact: Lois V. Johnson, Committee Operations, House of Delegates, State Capitol, P.O. Box 406, Richmond, VA 23218, telephone (804) 698-1544 or (804) 786-2369/TTY ☎

CHRONOLOGICAL LIST

OPEN MEETINGS

July 31
Aging, Commonwealth Council on
- Legislative Committee

Environmental Quality, Department of

August 1
† Conservation and Recreation, Department of
- Chippokes Plantation Farm Foundation Fund Raising Committee

† Higher Education in Virginia, Commission on Access and Diversity in
Hopewell Industrial Safety Council
Nursing, Board of
- Special Conference Committee

August 2
† Air Pollution Control Board, State
Branch Pilots, Board for
† Conservation and Recreation, Department of
- Rappahannock Scenic River Advisory Board

† Counseling, Board of
- Executive Committee

† Deaf and Hard-of-Hearing, Department for the
Nursing, Board of
People with Disabilities, Virginia Board for

August 3
At-Risk Youth and Their Families, Comprehensive Services for
- State Management Team

Conservation and Recreation, Department of
- Falls of the James Scenic River Advisory Board
- Lake Anna State Park Master Plan Advisory Committee

Medicine, Board of
- Informal Conference Committee

Nursing, Board of
- Special Conference Committee

August 4
Medicine, Board of

August 7
Agriculture and Consumer Services, Department of
- Virginia Irish Potato Board

Alzheimer's Disease and Related Disorders Commission
Nursing, Board of
- Special Conference Committee

August 8
Agriculture and Consumer Services, Department of
- Virginia Farmers Market Board

Alcoholic Beverage Control Board
† Corrections, Board of
- Correctional Services Committee
- Liaison Committee

Game and Inland Fisheries, Department of
Land Evaluation Advisory Council, State
Nursing, Board of
- Special Conference Committee

† Tourism Authority, Virginia

August 9
Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, Board of
- Architects Section

† Corrections, Board of
- Administrative Committee

Medicine, Board of
- Informal Conference Committee

August 10
Agriculture and Consumer Services, Department of
- Virginia Charity Food Assistance Advisory Board

† Child Day-Care Council
† Fire Services Board, Virginia
- Administration and Policy Committee
- Finance Committee
- Fire Education and Training Committee
- Fire Prevention and Control Committee

Health, State Board of
Labor and Industry, Department of
- Apprenticeship Council Subcommittee

Medicine, Board of
Water Control Board, State

August 11
† Fire Services Board, Virginia
Health, State Board of
Health Professions, Department of
- Health Practitioners' Intervention Program Committee

† Optometry, Board of
- Informal Conference Committee

Resources Authority, Virginia
- Board of Directors

August 14
Nursing, Board of
- Special Conference Committee

Old Dominion University
- Executive Committee

Water Commission, State

August 15
† Agriculture and Consumer Services, Department of
- Virginia Soybean Board
- Virginia Sweet Potato Board

† Housing Development Authority, Virginia
- Board of Commissioners

† Pharmacy, Board of
Vocational Education, Joint Subcommittee Studying the Feasibility of Developing a Center for Continuing and

August 16
Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, Board of
- Professional Engineers Section

† Asbestos and Lead, Board for
Code Commission, Virginia
† Contractors, Board for
- Tradesman Committee

Nursing, Board of
- Ad Hoc Advisory Committee on Massage Therapy

Racing Commission, Virginia
† Transportation Board, Commonwealth

August 17
Medical Assistance Services, Department of
† Mines, Minerals and Energy, Department of
† Transportation Board, Commonwealth

August 18
Medicine, Board of
- Informal Conference Committee

August 21
Electrical Utility Restructuring Act, Virginia
- Legislative Transition Task Force

† General Laws, Senate Committee on

August 22
† Compensation Board
† General Laws, Senate Committee on
Marine Resources Commission
† Small Business Financing Authority, Virginia
† Tax Structure for the 21st Century, Commission on Virginia's State and Local
Unemployment Trust Fund, Joint Subcommittee Studying the Funding Requirements of the Virginia

August 23
Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, Board of
- Land Surveyors Section

† Cemetery Board
- Regulatory Review Committee

Satellite Chip Mills, Joint Subcommittee Studying
† Veterinary Medicine, Board of

August 24
Agriculture and Consumer Services, Department of
- Virginia Cotton Board

† Corporation Commission, Joint Subcommittee Studying the Responsibilities, Policies, and Activities of the State
† Counseling, Board of
- Credentials Committee
- Examination Committee
- Regulatory Committee

Game and Inland Fisheries, Board of

August 25
Counseling, Board of
Military Institute, Virginia
- Board of Visitors

Opticians, Board for

August 26
Military Institute, Virginia
- Board of Visitors

August 28
Barbers and Cosmetology, Board for

August 29
† Litter Control and Recycling Fund Advisory Board

August 30
Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, Board of
- Landscape Architects Section

† At-Risk Youth and Their Families, Comprehensive Services for
- State Executive Council

Milk Commission, State
Nursing, Board of
- Special Conference Committee

Outdoors Foundation, Virginia

September 5
Economic Development Partnership, Virginia
- Board of Directors

Hopewell Industrial Safety Council

September 6
Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, Board of
- Certified Interior Designers Section

Outdoors Foundation, Virginia

September 7
† Air Pollution Control Board, State
Nursing, Board of
- Special Conference Committee

Water Control Board, State
† Waterworks and Wastewater Works Operators, Board for
- Education Committee

September 11
† Medical Assistance Services, Department of
- Virginia Medicaid Pharmacy Liaison Committee

Reapportionment Committee, Joint

September 13
Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, Board of
† Transportation Safety Board

September 14
Old Dominion University
- Board of Visitors

September 16
Visually Handicapped, Department for the
- Statewide Rehabilitation Council for the Blind

September 18
Public Guardian and Conservator Advisory Board, Virginia

September 20
Water Control Board, State

September 21
Labor and Industry, Department of
- Virginia Apprenticeship Council
Milk Commission, State
Waterworks and Wastewater Works Operators, Board for

September 25
† Local Government, Commission on
Nursing, Board of
- Special Conference Committee

September 26
Marine Resources Commission

September 27
† At-Risk Youth and Their Families, Comprehensive Services for
- State Executive Council
Code Commission, Virginia
Human Resource Management, Department of
Nursing, Board of
- Special Conference Committee
Small Business Financing Authority, Virginia

September 28
Code Commission, Virginia
Education, State Board of
Nursing, Board of
- Special Conference Committee
Rehabilitative Services, Board of

October 2
† Tax Structure for the 21st Century, Commission on Virginia's State and Local

October 5
Nursing, Board of
- Special Conference Committee

October 9
Old Dominion University
- Board of Visitors Executive Committee

October 10
Nursing, Board of
- Special Conference Committee

October 12
Nursing, Board of
- Special Conference Committee

October 16
† Accountancy, Board of
† General Laws, Senate Committee on
Nursing, Board of
- Special Conference Committee
Reapportionment Committee, Joint

October 17
Nursing, Board of
- Special Conference Committee

October 18
Code Commission, Virginia

October 19
Code Commission, Virginia

October 25
† At-Risk Youth and Their Families, Comprehensive Services for
- State Executive Council

October 26
Nursing, Board of
- Special Conference Committee

October 31
Nursing, Board of
- Special Conference Committee
† Tax Structure for the 21st Century, Commission on Virginia's State and Local

December 16
† General Laws, Senate Committee on

PUBLIC HEARINGS

August 2
Branch Pilots, Board for

October 2
Corporation Commission, State