VIRGINIA REGISTER OF REGULATIONS

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VIRGINIA REGISTER INFORMATION PAGE

THE VIRGINIA REGISTER OF REGULATIONS is an official state publication issued every other week throughout the year. Indexes are published quarterly, and are cumulative for the year. 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*. In addition, the *Virginia Register* is a source of other information about state government, including petitions for rulemaking, emergency regulations, executive orders issued by the Governor, and notices of public hearings on regulations.

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 Joint Commission on Administrative Rules (JCAR) or the appropriate standing committee of each house 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 body, 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 legislative body 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 objection 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 and no earlier than 15 days from publication of the readopted action.

A regulatory action may be withdrawn by the promulgating agency at any time before the regulation becomes final.

FAST-TRACK RULEMAKING PROCESS

Section 2.2-4012.1 of the Code of Virginia provides an exemption from certain provisions of the Administrative Process Act for agency regulations deemed by the Governor to be noncontroversial. To use this process, Governor's concurrence is required and advance notice must be provided to certain legislative committees. Fast-track regulations will become effective on the date noted in the regulatory action if no objections to using the process are filed in accordance with § 2.2-4012.1.

EMERGENCY REGULATIONS

Pursuant to § 2.2-4011 of the Code of Virginia, an agency, upon consultation with the Attorney General, and at the discretion of the Governor, may adopt emergency regulations that are necessitated by an emergency situation. An agency may also adopt an emergency regulation when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment. 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 no more than 18 months in duration; however, may be extended for six months under certain circumstances as provided for in § 2.2-4011 D. 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 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2 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. **29:5 VA.R. 1075-1192 November 5, 2012,** refers to Volume 29, Issue 5, pages 1075 through 1192 of the *Virginia Register* issued on November 5, 2012.

The Virginia Register of Regulations is published pursuant to Article 6 (§ 2.2-4031 et seq.) of Chapter 40 of Title 2.2 of the Code of Virginia.

PUBLICATION SCHEDULE AND DEADLINES

This schedule is available on the *Register*'s Internet home page (http://register.dls.virginia.gov).

July 2017 through July 2018

Volume: Issue	Material Submitted By Noon*	Will Be Published On
33:23	June 21, 2017	July 10, 2017
33:24	July 5, 2017	July 24, 2017
33:25	July 19, 2017	August 7, 2017
33:26	August 2, 2017	August 21, 2017
34:1	August 16, 2017	September 4, 2017
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34:3	September 13, 2017	October 2, 2017
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34:5	October 11, 2017	October 30, 2017
34:6	October 25, 2017	November 13, 2017
34:7	November 8, 2017	November 27, 2017
34:8	November 21, 2017 **(Tuesday)**	December 11, 2017
34:9	December 6, 2017	December 25, 2017
34:10	December 19, 2017 **(Tuesday)**	January 8, 2018
34:11	January 3, 2018	January 22, 2018
34:12	January 17, 2018	February 5, 2018
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34:15	February 28, 2018	March 19, 2018
34:16	March 14, 2018	April 2, 2018
34:17	March 28, 2018	April 16, 2018
34:18	April 11, 2018	April 30, 2018
34:19	April 25, 2018	May 14, 2018
34:20	May 9, 2018	May 28, 2018
34:21	May 23, 2018	June 11, 2018
34:22	June 6, 2018	June 25, 2018
34:23	June 20, 2018	July 9, 2018
34:24	July 3, 2018 **(Tuesday)**	July 23, 2018

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF COUNSELING

Agency Decision

Title of Regulation: **18VAC115-20. Regulations Governing the Practice of Professional Counseling.**

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

Name of Petitioner: Dominique Adkins.

Nature of Petitioner's Request: To accept supervised hours of a practicum and internship in a Council for Accreditation of Counseling and Related Educational Programs accredited doctoral program towards the required hours for a residency in counseling.

Agency Decision: Request granted.

Statement of Reason for Decision: At its meeting on May 19, 2017, the board discussed the request to amend regulations and all comment received. The board has voted to submit a Notice of Intended Regulatory Action (NOIRA) to initiate rulemaking and receive further information and comment. Once the NOIRA is approved by the Governor, it will be published and a 30-day comment period will be opened. The regulatory process typically takes 18 months to complete.

Agency Contact: Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, or email elaine.yeatts@dhp.virginia.gov.

VA.R. Doc. No. R17-12; Filed June 13, 2017, 8:34 a.m.

NOTICES OF INTENDED REGULATORY ACTION

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Medical Assistance Services intends to consider amending **12VAC30-80, Methods and Standards for Establishing Payment Rate; Other Types of Care**. The purpose of the proposed action is to replace the current fee-for-service methodology for pharmacy services with one that conforms to new federal requirements.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Public Comment Deadline: August 9, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

VA.R. Doc. No. R17-4546; Filed June 19, 2017, 8:32 a.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Medical Assistance Services intends to consider amending **12VAC30-120, Waivered Services**. The purpose of the proposed action is to establish Commonwealth Coordinated Care Plus (CCC Plus), the new statewide Medicaid managed long-term services and supports program that will serve approximately 214,000 individuals with complex care needs through an integrated delivery model across the full continuum of care. Care management is at the heart of the CCC Plus high-touch, person-centered program design. CCC Plus focuses on improving quality, access, and efficiency, and enrollment into CCC Plus is required for qualifying populations.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Public Comment Deadline: August 9, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

VA.R. Doc. No. R17-4974; Filed June 19, 2017, 7:48 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF VETERINARY MEDICINE

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Veterinary Medicine intends to consider amending **18VAC150-20, Regulations Governing the Practice of Veterinary Medicine**. The purpose of the proposed action is to address the opioid abuse crisis in Virginia by adopting regulations for veterinarians prescribing controlled substances containing opioids. The proposed regulations for the management of acute pain include requirements for the evaluation of the patient, limitations on quantity and dosage, and recordkeeping. The proposed regulations provide requirements for prescribing an opioid beyond 14 days for chronic pain and certain chronic conditions and allow for prescribing of buprenorphine in a dosage, quantity, and formulation appropriate for an animal species and size. Finally, the proposed regulations include requirements for continuation of treatment and for the content of the medical record.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

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

Public Comment Deadline: August 9, 2017.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Veterinary Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4468, FAX (804) 527-4471, or email leslie.knachel@dhp.virginia.gov.

VA.R. Doc. No. R17-5103; Filed June 16, 2017, 9:35 p.m.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

BOARD OF GAME AND INLAND FISHERIES

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: **4VAC15-50. Game: Bear (amending 4VAC15-50-11, 4VAC15-50-71, 4VAC15-50-120).**

Statutory Authority: §§ 29.1-103 and 29.1-501 of the Code of Virginia.

Effective Date: August 1, 2017.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 7870 Villa Park Drive, Suite 400, Henrico, VA 23228, telephone (804) 367-8341, or email phil.smith@dgif.virginia.gov.

Summary:

The amendments (i) add a three-day open season for hunting bear in 36 counties or portions of counties to run Monday through Wednesday in the week prior to the statewide archery hunting season; (ii) change the start date of the fall bear hound training season to August 1; and (iii) change the bear hound training season dates in the Counties of Brunswick, Charlotte, Greensville, Lunenburg, and Mecklenburg to match the western bear hound training season.

4VAC15-50-11. Open season; generally.

A. It shall be lawful to hunt bears ~~within~~ in the following localities, including the cities and towns therein, during the following seasons:

Location	Season
Accomack County	Closed
Albemarle County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Alleghany County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Amelia County	Monday nearest December 2 and for 5 consecutive hunting days following.
Amherst County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Appomattox County	Monday nearest December 2 and for 5 consecutive hunting days following.
Arlington County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Augusta County (North of US-250)	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Augusta County (South of US-250)	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Bath County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Bedford County	Fourth Monday in November through the first Saturday in January, both dates inclusive.

Bland County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Botetourt County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Brunswick County	Monday nearest December 2 and for 5 consecutive hunting days following.
Buchanan County	~~First~~ Monday following the last Saturday in September and for 2 days following; and the first Monday in December through the first Saturday in January, both dates inclusive.
Buckingham County	Monday nearest December 2 and for 5 consecutive hunting days following.
Campbell County	Monday nearest December 2 and for 5 consecutive hunting days following.
Caroline County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Carroll County	First Monday in December and for 19 days following.
Charles City County	Monday nearest December 2 and for 5 consecutive hunting days following.
Charlotte County	Monday nearest December 2 and for 5 consecutive hunting days following.
Chesapeake (City of)	October 1 through the first Saturday in January, both dates inclusive.
Chesterfield County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Clarke County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Craig County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Culpeper County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Cumberland County	Monday nearest December 2 and for 5 consecutive hunting days following.
Dickenson County	~~First~~ Monday following the last Saturday in September and for 2 days following; and the first Monday in December through the first Saturday in January, both dates inclusive.
Dinwiddie County	Monday nearest December 2 and for 5 consecutive hunting days following.
Essex County	Monday nearest December 2 and for 5 consecutive hunting days following.
Fairfax County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Fauquier County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Floyd County	First Monday in December and for 19 days following.
Fluvanna County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Franklin County	First Monday in December and for 19 days following.

Frederick County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Giles County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Gloucester County	Monday nearest December 2 and for 5 consecutive hunting days following.
Goochland County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Grayson County	First Monday in December and for 19 days following.
Greene County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Greensville County	Monday nearest December 2 and for 5 consecutive hunting days following.
Halifax County	Monday nearest December 2 and for 5 consecutive hunting days following.
Hanover County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Henrico County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Henry County	First Monday in December and for 19 days following.
Highland County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Isle of Wight County	Monday nearest December 2 and for 5 consecutive hunting days following.
James City County	Monday nearest December 2 and for 5 consecutive hunting days following.
King and Queen County	Monday nearest December 2 and for 5 consecutive hunting days following.
King George County	Monday nearest December 2 and for 5 consecutive hunting days following.
King William County	Monday nearest December 2 and for 5 consecutive hunting days following.
Lancaster County	Monday nearest December 2 and for 5 consecutive hunting days following.
Lee County	~~First~~ Monday following the last Saturday in September and for 2 days following; and the first Monday in December through the first Saturday in January, both dates inclusive.
Loudoun County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Louisa County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Lunenburg County	Monday nearest December 2 and for 5 consecutive hunting days following.
Madison County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Mathews County	Monday nearest December 2 and for 5 consecutive hunting days following.
Mecklenburg County	Monday nearest December 2 and for 5 consecutive hunting days following.
Middlesex County	Monday nearest December 2 and for 5 consecutive hunting days following.

Montgomery County (southeast of I-81)	First Monday in December and for 19 days following.
Montgomery County (northwest of I-81)	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Nelson County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
New Kent County	Monday nearest December 2 and for 5 consecutive hunting days following.
Northampton County	Closed
Northumberland County	Monday nearest December 2 and for 5 consecutive hunting days following.
Nottoway County	Monday nearest December 2 and for 5 consecutive hunting days following.
Orange County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Page County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Patrick County	First Monday in December and for 19 days following.
Pittsylvania County	Monday nearest December 2 and for 5 consecutive hunting days following.
Powhatan County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Prince Edward County	Monday nearest December 2 and for 5 consecutive hunting days following.
Prince George County	Monday nearest December 2 and for 5 consecutive hunting days following.
Prince William County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Pulaski County (southeast of I-81)	First Monday in December and for 19 days following.
Pulaski County (northwest of I-81)	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Rappahannock County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Richmond County	Monday nearest December 2 and for 5 consecutive hunting days following.
Roanoke County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Rockbridge County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Rockingham County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Russell County (except on the Channels State Forest and Clinch Mountain WMA)	~~First~~ Monday following the last Saturday in September and for 2 days following; and the first Monday in December through the first Saturday in January, both dates inclusive.

Russell County (on the Channels State Forest and Clinch Mountain WMA)	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Scott County	~~First~~ Monday following the last Saturday in September and for 2 days following; and the first Monday in December through the first Saturday in January, both dates inclusive.
Shenandoah County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Smyth County (southeast of I-81)	First Monday in December and for 19 days following.
Smyth County (northwest of I-81)	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Southampton County	Monday nearest December 2 and for 5 consecutive hunting days following.
Spotsylvania County	Fourth Monday in November through the first Saturday in January, both dates inclusive.
Stafford County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Suffolk (City of)	October 1 through the first Saturday in January, both dates inclusive.
Surry County	Monday nearest December 2 and for 5 consecutive hunting days following.
Sussex County	Monday nearest December 2 and for 5 consecutive hunting days following.
Tazewell County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Virginia Beach (City of)	October 1 through the first Saturday in January, both dates inclusive.
Warren County	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
Washington County (southeast of I-81)	First Monday in December and for 19 days following.
Washington County (northwest of I-81 and east of Route 19)	~~First~~ Monday following the last Saturday in September and for 2 days following; and the first Monday in December through the first Saturday in January, both dates inclusive.
Washington County (northwest of I-81 and west of Route 19)	~~First~~ Monday following the last Saturday in September and for 2 days following; and the first Monday in December and for 19 days following.
Westmoreland County	Monday nearest December 2 and for 5 consecutive hunting days following.
Wise County	~~First~~ Monday following the last Saturday in September and for 2 days following; and the first Monday in December through the first Saturday in January, both dates inclusive.
Wythe County (southeast of I-81)	First Monday in December and for 19 days following.
Wythe County (northwest of I-81)	~~Fourth~~ Monday following the last Saturday in September and for 2 days following; and the fourth Monday in November through the first Saturday in January, both dates inclusive.
York County	Monday nearest December 2 and for 5 consecutive hunting days following.

B. Except as provided in the subsection A of this section, bears may be hunted from the Saturday prior to the fourth Monday in November through the first Saturday in January, both dates inclusive, within the incorporated limits of any city that allows bear hunting.

4VAC15-50-71. Muzzleloading gun hunting.

A. [It ~~Except as otherwise provided in this section, it~~] shall be lawful to hunt ~~bear~~ bears during the special muzzleloading season with muzzleloading guns from the Saturday prior to the second Monday in November through the Friday prior to the third Monday in November, both dates inclusive, except in the cities of Chesapeake, Suffolk, and Virginia Beach.

[~~B. It shall be lawful to hunt bears during the muzzleloading season with muzzleloading guns from the Saturday prior to the first Monday in November through the Friday prior to the third Monday in November, both dates inclusive, in the counties (including the cities or towns within) of Albemarle, Alleghany, Amherst, Appomattox, Arlington, Augusta, Bath, Bedford, Botetourt, Buckingham, Caroline, Clarke, Culpeper, Fairfax, Fauquier, Fluvanna, Frederick, Greene, Highland, Loudoun, Louisa, Madison, Nelson, Orange, Page, Prince William, Rappahannock, Roanoke, Rockbridge, Rockingham, Shenandoah, Spotsylvania, Stafford, and Warren.~~]

[B. ~~C.~~] It shall be unlawful to hunt bear with dogs during any special season for hunting with muzzleloading guns, except that tracking dogs as defined in § 29.1-516.1 of the Code of Virginia may be used.

[C. ~~D.~~] A muzzleloading gun, for the purpose of this section, means a single shot weapon, .45 caliber or larger, firing a single projectile or sabot (with a .38 caliber or larger projectile) of the same caliber loaded from the muzzle of the weapon and propelled by at least 50 grains of black powder (or black powder equivalent or smokeless powder).

[D. ~~E.~~] It shall be unlawful to have in immediate possession any firearm other than a muzzleloading gun while hunting with a muzzleloading gun in a special muzzleloading season.

4VAC15-50-120. Bear hound training season.

A. It shall be lawful to chase black bear with dogs, without capturing or taking, from ~~the second Saturday in~~ August 1 through the last Saturday in September, both dates inclusive, in all counties and cities or in the portions in which bear hunting is permitted except in the counties of Accomack, Amelia, Appomattox, ~~Brunswick,~~ Buckingham, Campbell, Caroline, Charles City, ~~Charlotte,~~ Chesterfield, Clarke, Cumberland, Dinwiddie, Essex, Fairfax, Fauquier, Fluvanna, Frederick, Gloucester, Goochland, Grayson (west of Route 16), ~~Greensville,~~ Halifax, Hanover, Henrico, Henry, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Loudoun, Louisa, ~~Lunenburg,~~ Mathews, ~~Mecklenburg,~~ Middlesex, New Kent, Northampton, Northumberland, Nottoway, Orange, Patrick, Pittsylvania, Powhatan, Prince Edward, Prince George, Prince William, Richmond, Roanoke (south of Interstate 81), Smyth (that part south of Interstate 81 and west of Route 16), Southampton, Spotsylvania, Stafford, Surry, Sussex, Westmoreland, and York, and in the cities of Hampton, Newport News and Norfolk.

B. It shall be lawful to chase black bear with dogs, without capturing or taking, from the Saturday prior to the third Monday in November and for 14 days following, both dates inclusive, in the counties of Amelia, Appomattox, Buckingham, Brunswick, Campbell (east of the Norfolk Southern Railroad), Charles City, Charlotte, Cumberland, Essex, Gloucester, Greensville, Halifax, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Lunenburg, Mathews, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Pittsylvania (east of the Norfolk Southern Railroad), Prince Edward, Prince George, Richmond, Southampton, Surry, Sussex, Westmoreland, and York.

~~C. It shall be lawful to chase black bears with dogs, without capturing or taking, in the counties of Brunswick, Charlotte, Greensville, Lunenburg, and Mecklenburg from the first Saturday in September through the last Saturday in September, both dates inclusive.~~

~~D.~~ C. It shall be unlawful to have in possession a firearm, bow, crossbow, or any weapon capable of taking a black bear while participating in the bear hound training season. The meaning of "possession" for the purpose of this section shall include~~, but not be limited to,~~ having a firearm, bow, crossbow, or any weapon capable of taking a black bear in or on one's person, vehicle, or conveyance.

VA.R. Doc. No. R17-5069; Filed June 21, 2017, 2:30 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: **4VAC15-80. Game: Crow (amending 4VAC15-80-10).**

Statutory Authority: §§ 29.1-103 and 29.1-501 of the Code of Virginia.

Effective Date: August 1, 2017.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 7870 Villa Park Drive, Suite 400, Henrico, VA 23228, telephone (804) 367-8341, or email phil.smith@dgif.virginia.gov.

Summary:

The amendments rescind Sundays and add Mondays as days of each week on which crows may be hunted during the crow hunting season.

4VAC15-80-10. Open season.

It shall be lawful to hunt crow on Monday, Wednesday, Friday, and Saturday~~, and Sunday~~ of each week from the third Saturday in August through the third Friday in March, both dates inclusive.

VA.R. Doc. No. R17-5070; Filed June 21, 2017, 10:59 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: **4VAC15-90. Game: Deer (amending 4VAC15-90-70, 4VAC15-90-80, 4VAC15-90-89, 4VAC15-90-90, 4VAC15-90-91, 4VAC15-90-280, 4VAC15-90-291, 4VAC15-90-294).**

Statutory Authority: §§ 29.1-103 and 29.1-501 of the Code of Virginia.

Effective Date: August 1, 2017.

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Summary:

The amendments (i) allow the use of a slingbow for deer hunting during all archery deer hunting seasons, that is, the early, late, urban archery, and Northern Virginia April archery deer seasons; (ii) adjust the number of days on which deer of either sex may be taken during muzzleloading deer hunting season in various counties; (iii) reduce the minimum muzzleloading gun saboted bullet projectile size allowable for hunting deer from .38 to .35 caliber; (iv) require that antlerless deer be taken before multiple bucks may be taken during the license year in any town or city except Chesapeake, Suffolk, and Virginia Beach, and on private lands in Fauquier and Montgomery Counties; (v) simplify and standardize the language describing the antler point restriction in effect in seven western counties; (vi) adjust the number of days during which deer of either sex may be taken during the general firearms deer hunting season in a number of counties; (vii) allow the buying and selling of specified cervid parts, items made from such parts, and cervid mounts; (viii) rescind requirements for intervals and associated permanent gaps in fencing intended to not impede the free egress of deer; and (ix) authorize permitted rehabilitators to transport and temporarily possess adult deer or elk solely for the purpose of immediate humane dispatch.

4VAC15-90-70. Archery hunting.

A. It shall be lawful to hunt deer during the early special archery season with archery equipment or a slingbow from the first Saturday in October through the Friday prior to the third Monday in November, both dates inclusive.

B. In addition to the season provided in subsection A of this section, it shall be lawful to hunt deer during the late special archery season with archery equipment ~~from~~ or a slingbow:

1. From the Sunday following the close of the general firearms season on deer through the first Saturday in January, both dates inclusive, in (i) all cities, towns, and counties west of the Blue Ridge Mountains (except Clarke County and on non-national forest lands in Frederick County) ~~and~~; (ii) in the counties (including the cities and towns within) of Amherst (west of Business U.S. 29 from the James River to its intersection with U.S. 29 just south of the Town of Amherst continuing north on U.S. 29 to the Tye River), Bedford, Franklin, Henry, Nelson (west of Route 151), and Patrick ~~and~~; (iii) on the Chester F. Phelps Wildlife Management Area; and (iv) on national forest lands in Frederick County ~~and from~~.

2. From December 1 through the first Saturday in January, both dates inclusive, in the cities of Chesapeake, Suffolk (east of the Dismal Swamp Line), and Virginia Beach.

C. Deer of either sex may be taken full season during the special archery seasons as provided in subsections A and B of this section (except on PALS (Public Access Lands) in Dickenson County where it shall be unlawful to take antlerless deer during the special archery seasons provided for in subsections A and B of this section).

D. It shall be unlawful to carry firearms while hunting with archery equipment during the special archery seasons, except that a muzzleloading gun, as defined in 4VAC15-90-80, may be in the possession of a properly licensed muzzleloading gun hunter when and where a special archery deer season overlaps a special muzzleloading deer season.

E. It shall be unlawful to use dogs when hunting with archery equipment during any special archery season, except that tracking dogs as described in § 29.1-516.1 of the Code of Virginia may be used.

F. It shall be lawful to hunt antlerless deer during the special urban archery season with archery equipment or a slingbow from the first Saturday in September through the Friday prior to the first Saturday in October, both dates inclusive, and from the Sunday following the first Saturday in January through the last Sunday in March, both dates inclusive, within the incorporated limits of any city or town in the Commonwealth (except on national forest and department-owned lands) and counties with a human population density of 300 persons per square mile or more (except on national forest and department-owned lands), provided that its governing body submits by certified letter to the department prior to April 1, its intent to participate in the special urban archery season. Any city, town, or county no longer participating in this season shall submit by certified letter to the department prior to April 1 notice of its intent not to participate in the special urban archery season.

G. It shall be lawful to hunt antlerless deer during the special antlerless archery season with archery equipment or a slingbow from the Monday following the last Sunday in March through the last Sunday in April, both dates inclusive, in [the counties of] Arlington, Fairfax, Loudoun, and Prince William [~~counties~~] (including the cities and towns within).

4VAC15-90-80. Muzzleloading gun hunting.

A. It shall be lawful to hunt deer during the early special muzzleloading season with muzzleloading guns from the Saturday prior to the first Monday in November through the Friday prior to the third Monday in November, both dates inclusive, in all cities, towns, and counties where deer hunting with a rifle or muzzleloading gun is permitted, except in the cities of Chesapeake, Suffolk (east of the Dismal Swamp Line), and Virginia Beach.

B. It shall be lawful to hunt deer during the late special muzzleloading season with muzzleloading guns starting 21 consecutive days immediately prior to and on the first Saturday in January~~, in~~:

1. In all cities, towns, and counties west of the Blue Ridge Mountains (except Clarke County and on non-national forest lands in Frederick County)~~, and east~~;

2. East of the Blue Ridge Mountains in the ~~counties~~ Counties (including the cities and towns within) of Amherst (west of Business U.S. 29 from the James River to its intersection with U.S. 29 just south of the Town of Amherst continuing north on U.S. 29 to the Tye River), Bedford, Franklin, Henry, Nelson (west of Route 151), and Patrick ~~and on~~;

3. On national forest lands in Frederick County; and ~~in~~

4. In the ~~cities~~ Cities of Chesapeake, Suffolk (east of the Dismal Swamp Line), and Virginia Beach.

C. Deer of either sex may be taken during the entire early special muzzleloading season east of the Blue Ridge Mountains unless otherwise noted ~~below~~ in this subsection:

1. Deer of either sex may be taken on the second Saturday only of the early special muzzleloading season on state forest lands, state park lands (except Occoneechee State Park), department-owned lands (except on Merrimac Farm Wildlife Management Area), and Philpott Reservoir.

2. Antlered bucks only—no either-sex deer hunting days during the early special muzzleloading season on national forest lands in Amherst, Bedford, and Nelson ~~counties~~ Counties.

D. Deer of either sex may be taken on the second Saturday only during the early special muzzleloading season west of the Blue Ridge Mountains unless otherwise noted ~~below~~ in this subsection:

1. Deer of either sex may be taken during the entire early special muzzleloading season in Clarke and Floyd ~~counties~~ Counties and on private lands in Carroll, Frederick, Grayson, Montgomery, Pulaski, Roanoke, Scott, Shenandoah, and Warren ~~counties~~ Counties.

2. Deer of either sex may be taken on the second Saturday and the last five days of the early muzzleloading season on private lands in Botetourt County.

3. Antlered bucks only—no either-sex deer hunting days during the early special muzzleloading season in Buchanan, Dickenson, Lee, Russell, Tazewell, and Wise ~~counties~~ Counties and on national forest lands in Alleghany, Bland, Craig, Frederick, Giles, Grayson, Montgomery, Page, Pulaski, Rockingham, Scott, Shenandoah, Warren, and on national forest and department-owned lands in Augusta, Bath, Botetourt, Carroll, Highland (except Highland Wildlife Management Area), Roanoke, Rockbridge, Smyth, Washington, and Wythe ~~counties~~ Counties and on Channels State Forest, Grayson Highlands State Park, Hungry Mother State Park, and on private lands west of Routes 613 and 731 in Rockingham County.

E. Deer of either sex may be taken during the last six days of the late special muzzleloading season unless otherwise listed ~~below~~ in this subsection:

1. Deer of either sex may be taken full season during the entire late special muzzleloading season in the ~~counties~~ Counties (including the cities and towns within) of Amherst (west of Business U.S. 29 from the James River to its intersection with U.S. 29 just south of the Town of Amherst continuing north on U.S. 29 to the Tye River, except on national forest lands), Bedford (except on national forest lands), Floyd, Franklin, Henry, Nelson (west of Route 151, except on national forest lands), and Patrick and on private lands in Carroll, Grayson, Montgomery, Pulaski, Roanoke, Shenandoah, and Warren ~~counties~~ Counties.

2. Deer of either sex may be taken the last day only during the late special muzzleloading season in Alleghany, Bath, Dickenson ~~(north of Route 83)~~, Highland, Lee, Russell, Tazewell, and Wise ~~counties~~ Counties and on national forest lands in Amherst, Bedford, Bland, Craig, Frederick, Giles, Grayson, Montgomery, Nelson, Page, Pulaski, Rockingham, Scott, Shenandoah, and Warren ~~counties~~ Counties, and on national forest and department-owned lands in Augusta, Botetourt, Carroll, Roanoke, Rockbridge, Smyth, ~~and~~ Washington ~~counties~~, and Wythe Counties and on private lands west of Routes 613 and 731 in Rockingham County, Channels State Forest, and Grayson Highlands State Park, and Hungry Mother State Park.

3. Antlered bucks only—no either-sex deer hunting days during the late special muzzleloading season in Buchanan [~~and Dickenson (south of Route 83)~~ County].

F. Deer of either sex may be taken full season during the special muzzleloading seasons within the incorporated limits of any city or town in the Commonwealth that allows deer hunting except in the ~~counties~~ [~~Counties of Buchanan,~~

~~Dickenson, and Wise~~ Cities of Chesapeake, Suffolk, and Virginia Beach].

G. It shall be unlawful to hunt deer with dogs during any special season for hunting with muzzleloading guns, except that tracking dogs as described in § 29.1-516.1 of the Code of Virginia may be used.

H. A muzzleloading gun, for the purpose of this section, means a single shot weapon, .45 caliber or larger, firing a single projectile or sabot (with a ~~.38~~ .35 caliber or larger projectile) of the same caliber loaded from the muzzle of the weapon and propelled by at least 50 grains of black powder (or black powder equivalent or smokeless powder).

I. It shall be unlawful to have in immediate possession any firearm other than a muzzleloading gun while hunting with a muzzleloading gun in a special muzzleloading season.

4VAC15-90-89. Earn a buck (EAB).

For the purposes of this section, the term "license year" defines the period between July 1 and June 30 of the following year.

Arlington County ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer in Arlington County prior to taking at least two antlerless deer in Arlington County, and it shall be unlawful to take a third antlered deer in Arlington County prior to taking at least three antlerless deer in Arlington County.

Bedford County on private lands ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer on private lands in Bedford County prior to taking at least one antlerless deer on private lands in Bedford County, and it shall be unlawful to take a third antlered deer on private lands in Bedford County prior to taking at least two antlerless deer on private lands in Bedford County.

Clarke County on private lands ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer on private lands in Clarke County prior to taking at least one antlerless deer on private lands in Clarke County.

Fairfax County ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer in Fairfax County prior to taking at least two antlerless deer in Fairfax County, and it shall be unlawful to take a third antlered deer in Fairfax County prior to taking at least three antlerless deer in Fairfax County.

Fauquier County on private lands. During a license year, it shall be unlawful to take a second antlered deer on private lands in Fauquier County prior to taking at least one antlerless deer on private lands in Fauquier County, and it shall be unlawful to take a third antlered deer on private lands in Fauquier County prior to taking at least two antlerless deer on private lands in Fauquier County.

Frederick County on private lands ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer on private lands in Frederick County prior to taking at least one antlerless deer on private lands in Frederick County.

Loudoun County ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer in Loudoun County prior to taking at least two antlerless deer in Loudoun County, and it shall be unlawful to take a third antlered deer in Loudoun County prior to taking at least three antlerless deer in Loudoun County.

Montgomery County on private lands. During a license year, it shall be unlawful to take a second antlered deer on private lands in Montgomery County prior to taking at least one antlerless deer on private lands in Montgomery County.

Prince William County except on Department of Defense lands ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer in Prince William County (except on Department of Defense lands) prior to taking at least two antlerless deer in Prince William County (except on Department of Defense lands), and it shall be unlawful to take a third antlered deer in Prince William County (except on Department of Defense lands) prior to taking at least three antlerless deer in Prince William County (except on Department of Defense lands).

Rappahannock County ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer in Rappahannock County prior to taking at least one antlerless deer in Rappahannock County, and it shall be unlawful to take a third antlered deer in Rappahannock County prior to taking at least two antlerless deer in Rappahannock County.

Roanoke County on private lands ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer on private lands in Roanoke County prior to taking at least one antlerless deer on private lands in Roanoke County.

Warren County on private lands ~~(including the cities and towns within)~~. During a license year, it shall be unlawful to take a second antlered deer on private lands in Warren County prior to taking at least one antlerless deer on private lands in Warren County.

Cities and towns. During a license year in any town or city (except Chesapeake, Suffolk, and Virginia Beach) east of the Blue Ridge Mountains, it shall be unlawful to take a second antlered deer prior to taking at least one antlerless deer, and it shall be unlawful to take a third antlered deer prior to taking at least two antlerless deer. During a license year in any town or city west of the Blue Ridge Mountains, it shall be unlawful to take a second antlered deer prior to taking at least one antlerless deer.

4VAC15-90-90. Bag limit, bonus deer permits and special antlerless provision for youth hunters.

A. The bag limit for deer east of the Blue Ridge Mountains (except on national forest lands in Amherst, Bedford, and

Nelson ~~counties~~ Counties) is two per day ~~(except for the counties of, including the cities and towns within, Arlington, Fairfax, Loudoun, and Prince William where the daily bag limit is unlimited)~~, six per license year, three of which must be antlerless unless otherwise noted in this subsection.

[~~1. Only one antlerless deer per hunter per day may be taken on national forest and department owned lands unless otherwise noted in this subsection.~~

~~2.~~] The daily bag limit for deer is unlimited in the Counties (including the cities and towns within) of Arlington, Fairfax, Loudoun, and Prince William.

B. The bag limit for deer west of the Blue Ridge Mountains and on national forest lands in Amherst, Bedford, and Nelson ~~counties~~ Counties is [one ~~two~~] per day ~~(except for private lands in the counties including the cities and towns within Clarke, Frederick, Roanoke, Shenandoah, and Warren where the daily bag limit is two per day)~~, five per license year, three of which must be antlerless unless otherwise noted in this subsection. ~~Only one antlered buck taken in the county of Alleghany, Augusta, Bath, Highland, Shenandoah, Rockbridge, or Rockingham per license year may have less than four antler points one inch or longer on one side of the antlers.~~

1. [~~Only one antlerless deer per hunter per day may be taken on national forest and department owned lands.~~ The daily bag limit for deer is two per day on private lands in the Counties (including the cities and towns within) of Clarke, Frederick, Roanoke, Shenandoah, and Warren.]

2. If a deer hunter kills two antlered bucks in a license year in Alleghany, Augusta, Bath, Highland, Rockbridge, Rockingham, or Shenandoah County, at least one of the antlered bucks must have at least four antler points, one inch or longer, on one side of the antlers.

C. Except as noted in subsection E ~~below~~ of this section, antlerless deer may be taken only during designated either-sex deer hunting days during the special archery seasons, special muzzleloading seasons, and the general firearms season.

D. Bonus deer permits shall be valid on private land in counties and cities where deer hunting is permitted (except Buchanan, Dickenson, and Wise ~~counties~~ Counties) during the special archery seasons, special muzzleloading seasons, and the general firearms season. Bonus deer permits shall be valid on public lands, including state parks, state forests, national wildlife refuges, military areas, etc., as authorized by the managing agency. Unless otherwise posted or authorized in writing for wildlife management areas by the department, or for national forest lands by the U.S. Forest Service, the use of bonus permits is prohibited on department-owned and national forest lands. Bonus deer permits shall be valid for antlerless deer only. Deer taken on bonus permits shall count against the daily bag limit but are in addition to the seasonal bag limit.

E. Deer hunters 15 years of age and under, including those exempt from purchasing a hunting license, when in compliance with all applicable laws and license requirements, may take one antlerless deer per license year on days other than designated either-sex deer hunting days during the special muzzleloading seasons or the general firearms season in all counties that have at least one either-sex deer hunting day during the general firearms deer season.

4VAC15-90-91. General firearms season either-sex deer hunting days.

A. During the general firearms deer season, deer of either sex may be taken within:

Accomack County: full season.

Albemarle County: full season.

Alleghany County: the second Saturday and the last day.

-National forest lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Amelia County: the second and third Saturdays and the last 13 days.

-Amelia WMA: the second and third Saturdays and the last six days.

Amherst County (east of Business U.S. 29 from the James River to its intersection with U.S. 29 just south of the Town of Amherst continuing north on U.S. 29 to the Tye River): the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

Amherst County (west of Business U.S. 29 from the James River to its intersection with U.S. 29 just south of the Town of Amherst continuing north on U.S. 29 to the Tye River): full season.

-National forest lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Appomattox County: the second and third Saturdays and the last six days.

-Appomattox-Buckingham State Forest: the second and third Saturdays.

-Featherfin WMA: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

Arlington County: full season.

Augusta County: the second Saturday and the last six days.

-National forest and department-owned lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Bath County: the second Saturday and the last day.

-National forest and department-owned lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Bedford County: full season.

-National forest lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Bland County: the second Saturday and the last day.

-National forest lands: the second Saturday and the last day.

Botetourt County: full season.

-National forest and department-owned lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Brunswick County: the second and third Saturdays and the last six days.

Buchanan County: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Buckingham County: the second and third Saturdays and the last six days.

-Horsepen Lake WMA: the second and third Saturdays and the last six days.

-Appomattox-Buckingham State Forest: the second and third Saturdays.

-Featherfin WMA: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

Campbell County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

Caroline County: the second and third Saturdays and the last ~~13~~ six days.

-Mattaponi WMA: the second and third Saturdays and the last six days.

Carroll County: full season.

-National forest and department-owned lands: the second Saturday and the last day.

Charles City County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 13 days.

-Chickahominy WMA: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Charlotte County: the second and third Saturdays and the last six days.

Chesapeake (City of): the second and third Saturdays and the last 13 days.

Chesterfield County: the second and third Saturdays and the last ~~13~~ six days.

Clarke County: full season.

Craig County: full season.

-National forest lands: the second Saturday and the last day.

Culpeper County: full season.

-Chester F. Phelps WMA: the second Saturday and the last day.

Cumberland County: the second and third Saturdays and the last 13 days.

-Cumberland State Forest: the second and third Saturdays.

Dickenson County: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Dinwiddie County: the second and third Saturdays and the last six days.

Essex County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ six days.

Fairfax County: full season ~~(restricted to certain parcels of land by special permit)~~.

Fauquier County: full season.

-G. Richard Thompson WMA: the second Saturday and the last day.

-Chester F. Phelps WMA: the second Saturday and the last day.

Floyd County: full season.

Fluvanna County: second and third Saturdays and the last 13 days.

Franklin County: full season.

-Philpott Reservoir: the second Saturday and the last six days.

-Turkeycock Mountain WMA: the second Saturday and the last six days.

Frederick County: full season.

-National forest lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Giles County: full season.

-National forest lands: the second Saturday and the last day.

Gloucester County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ [~~29~~ six] days.

Goochland County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

Grayson County: full season.

-National forest lands and Grayson Highlands State Park: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Greene County: full season.

Greensville County: ~~full season~~ the second and third Saturdays and the last six days.

Halifax County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 13 days.

Hanover County: full season.

Henrico County: full season.

Henry County: the second and third Saturdays and the last 13 days.

-Fairystone Farms WMA, Fairystone State Park, and Philpott Reservoir: the second Saturday and the last six days.

-Turkeycock Mountain WMA: the second Saturday and the last six days.

Highland County: the second Saturday and the last day.

-National forest ~~and department-owned~~ lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

-Department-owned lands: the second Saturday and the last day.

Isle of Wight County: full season.

-Ragged Island WMA: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

James City County: full season.

King and Queen County: the second and third Saturdays and the last ~~13~~ six days.

King George County: ~~full season~~ the second and third Saturdays and the last [~~29~~ 13] days.

King William County: the second and third Saturdays and the last ~~13~~ six days.

Lancaster County: ~~full season~~ the second and third Saturdays and the last [~~29~~ 13] days.

Lee County: the second Saturday and the last two days.

-National forest lands: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Loudoun County: full season.

Louisa County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

Lunenburg County: the second and third Saturdays and the last six days.

Madison County: full season.

-Rapidan WMA: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

Mathews County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ [~~29~~ six] days.

Mecklenburg County: the second and third Saturdays and the last six days.

-Dick Cross WMA: the second and third Saturdays and the last six days.

Middlesex County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ [~~29~~ six] days.

Montgomery County: full season.

-National forest lands: the second Saturday and the last day.

Nelson County (east of Route 151): the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

-James River WMA: the second Saturday and the last six days.

Nelson County (west of Route 151): full season.

-National forest lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

New Kent County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 13 days.

Northampton County: full season.

Northumberland County: ~~full season~~ the second and third Saturdays and the last [~~29~~ 13] days.

Nottoway County: the second and third Saturdays and the last six days.

Orange County: full season.

Page County: the second Saturday and the last two days.

-National forest lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Patrick County: the second and third Saturdays and the last 13 days.

-Fairystone Farms WMA, Fairystone State Park, and Philpott Reservoir: the second Saturday and the last six days.

Pittsylvania County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

-White Oak Mountain WMA: the second Saturday and the last day.

Powhatan County: the second and third Saturdays and the last 13 days.

-Powhatan WMA: the second and third Saturdays and the last 13 days.

Prince Edward County: the second and third Saturdays and the last six days.

-Briery Creek WMA: the second and third Saturdays and the last six days.

-Featherfin WMA: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

-Prince Edward State Forest: the second and third Saturdays.

Prince George County: full season.

Prince William County: full season.

Pulaski County: full season.

-National forest lands: the second Saturday and the last day.

Rappahannock County: full season.

Richmond County: ~~full season~~ the second and third Saturdays and the last [~~29~~ 13] days.

Roanoke County: full season.

-National forest and department-owned lands: ~~the second Saturday and the last day~~ antlered bucks only-no either-sex days. Only deer with antlers above the hairline may be taken.

Rockbridge County: the second Saturday and the last two days.

-National forest and department-owned lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Rockingham County: ~~the second Saturday and the last six days~~ full season.

-National forest lands ~~and private lands~~: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

-Private lands west of Routes 613 and 731: the last day.

Russell County: the second Saturday and the last two days.

-Clinch Mountain WMA, Hidden Valley WMA, and the Channels State Forest: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Scott County: the second Saturday and the last six days.

-National forest lands: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Shenandoah County: full season.

-National forest lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Smyth County: the second Saturday and the last six days.

-National forest lands, Clinch Mountain WMA, and Hungry Mother State Park: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Southampton County: full season.

Spotsylvania County: the second~~,~~ and third~~, and fourth~~ Saturdays and the last ~~27~~ 29 days.

Stafford County: full season.

Suffolk (east of the Dismal Swamp Line): the second and third Saturdays and the last 13 days.

Suffolk (west of the Dismal Swamp Line): full season.

Surry County: full season.

-Carlisle ~~Tract~~ and Stewart Tracts of the Hog Island WMA: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Sussex County: full season.

- [~~Parkers Branch Tract of the~~] Big Woods WMA [(including the Parkers Branch Tract)] and Big Woods State Forest: the second and third Saturdays and the last six days.

Tazewell County: the second Saturday and the last two days.

-National forest lands and Clinch Mountain WMA: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Virginia Beach (City of): the second and third Saturdays and the last 13 days.

Warren County: full season.

-National forest lands: ~~the last day~~ antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Washington County: the second Saturday and the last six days.

-National forest lands, Clinch Mountain WMA, Hidden Valley WMA, and the Channels State Forest: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Westmoreland County: ~~full season~~ the second and third Saturdays and the last [~~29~~ 13] days.

Wise County: antlered bucks only—no either-sex days. Only deer with antlers above the hairline may be taken.

Wythe County: full season.

-National forest lands and Big Survey WMA: the second Saturday and the last day.

York County: full season.

B. Except as provided in the subsection A of this section, deer of either sex may be taken full season during the general firearms deer season within the incorporated limits of any city or town, state park, national wildlife refuge, or military installation that allows deer hunting.

4VAC15-90-280. Sale of ~~hides~~ cervid parts and cervid mounts.

~~It shall be lawful to sell hides and hooves from any legally taken deer.~~ Provided that no extraneous muscle tissue is attached, it shall be lawful to purchase or sell the hair, hide, tail, sinew, skull, antlers, bones, and feet of a legally possessed cervid carcass or cervid carcass part, any products made from these deer parts, and cervid mounts.

4VAC15-90-291. Enclosed or fenced areas that prevent or impede the free egress of deer.

A. Pursuant to § 29.1-525.1 A and B of the Code of Virginia, an enclosed or fenced area having any of the following attributes shall be deemed to prevent or impede the free egress of deer:

1. A fence greater than 61 inches high anywhere along its entire length;

2. A fence greater than 61 inches high that incorporates any topographic or other physical barrier that prevents or impedes the free egress of deer; or

3. A fence or other barrier 61 inches or less in height having any attribute that prevents or impedes the free egress of deer, including ~~but not limited to~~ being slanted, doubled, offset, or electrified~~; or~~.

~~4. A fence or other barrier, having any of the attributes described in subdivision 1, 2, or 3 of this section that does not have a permanent gap of at least 40 linear feet per every 660 linear feet (1/8 mile) along the fence or barrier, including an additional permanent gap of at least 40 linear feet at every inside angle in the fence or barrier of less than 120 degrees. For the purposes of this section, a gap is defined as an interruption in the fence or barrier devoid of any impediment.~~

B. This ~~subsection~~ section shall not apply to enclosures and lands exempted under § 29.1-525.1 C and D of the Code of Virginia.

C. The director or his designee may grant exceptions for an enclosed or fenced area having any of the above attributes where necessary for bona fide agricultural livestock operations.

4VAC15-90-294. Rehabilitation of cervids.

A. For the purposes of this section:

"Juvenile" means any cervid less than one year of age on December 31 of the current calendar year.

"Adult" means any cervid greater than one year of age on December 31 of the current calendar year.

B. No person permitted by the department to rehabilitate cervids may ~~transport, possess,~~ rehabilitate~~,~~ or release adult cervids. Rehabilitators permitted by the department may transport and temporarily possess adult cervids solely for the purpose of immediate humane dispatch but must notify the department immediately after the deer has been dispatched.

C. Juvenile cervids requiring continued rehabilitation beyond December 31 of the current calendar year shall not be transported, possessed, released, or rehabilitated without written authorization from the department.

D. Cervids that originate within an area designated by the department for disease management shall not be transported or possessed for the purposes of rehabilitation. If such a cervid is brought to a rehabilitator permitted by the department, the permittee shall hold the cervid in isolation and immediately notify the department.

E. Cervids from any county (including the cities and towns therein) containing an area designated by the department for cervid disease management may be rehabilitated and released in the county of origin only if the cervid originated from a portion of the county outside the disease management area.

VA.R. Doc. No. R17-5071; Filed June 21, 2017, 1:49 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: **4VAC15-190. Game: Quail (amending 4VAC15-190-10).**

Statutory Authority: §§ 29.1-103 and 29.1-501 of the Code of Virginia.

Effective Date: August 1, 2017.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 7870 Villa Park Drive, Suite 400, Henrico, VA 23228, telephone (804) 367-8341, or email phil.smith@dgif.virginia.gov.

Summary:

The amendment closes the quail hunting season on all public lands west of the Blue Ridge Mountains.

4VAC15-190-10. Open season; generally.

A. Except as ~~otherwise specifically~~ provided ~~by the sections appearing~~ in subsection B of this ~~chapter~~ section, it shall be lawful to hunt quail from the Saturday prior to the second Monday in November through January 31, both dates inclusive.

B. It shall be unlawful to hunt quail on all public lands west of the Blue Ridge Mountains.

VA.R. Doc. No. R17-5072; Filed June 21, 2017, 11:09 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: **4VAC15-240. Game: Turkey (amending 4VAC15-240-50, 4VAC15-240-60).**

Statutory Authority: §§ 29.1-103 and 29.1-501 of the Code of Virginia.

Effective Date: August 1, 2017.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 7870 Villa Park Drive, Suite 400, Henrico, VA 23228, telephone (804) 367-8341, or email phil.smith@dgif.virginia.gov.

Summary:

The amendments (i) provide fall and spring turkey hunting seasons in the Cities of Newport News and Hampton; (ii) close the Cities of Norfolk and Portsmouth to turkey hunting; (iii) close the archery turkey hunting season concurrent with the close of the first part of the fall turkey season, in which firearms and muzzleloader weapons are

legal weapons; and (iv) allow slingbows to be used during the archery turkey hunting season.

4VAC15-240-50. Continuous closed season in certain counties, cities and areas.

There shall be continuous closed turkey season, except where a special spring season for bearded turkeys is provided for in 4VAC15-240-40, in ~~the county of~~ Arlington County; and in the ~~cities~~ Cities of Chesapeake, ~~Hampton, Newport News~~ Norfolk, Portsmouth, and Virginia Beach.

4VAC15-240-60. Archery hunting.

A. Season. It shall be lawful to hunt turkey with archery equipment or a slingbow in those counties and areas open to fall turkey hunting from the first Saturday in October through the ~~Saturday prior to the second Monday in November~~ Friday that is 13 days after the Saturday before the last Monday in October, both dates inclusive.

B. Bag limit. The daily and seasonal bag limit for hunting turkey with archery equipment or a slingbow shall be the same as permitted during the general turkey season in those counties and areas open to fall turkey hunting, and any turkey taken shall apply toward the total season bag limit.

C. Carrying firearms prohibited. It shall be unlawful to carry firearms while hunting with archery equipment or a slingbow during the special archery season.

D. Use of dogs prohibited during archery season. It shall be unlawful to use dogs when hunting with archery equipment from the first Saturday in October through the Saturday prior to the second Monday in November, both dates inclusive.

4VAC15-240-70. Bag limit.

The bag limit for hunting turkeys shall be one a day [~~in the fall, two per day during the spring~~], three a license year, no more than two of which may be taken in the fall.

VA.R. Doc. No. R17-5073; Filed June 21, 2017, 11:26 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: **4VAC15-260. Game: Waterfowl and Waterfowl Blinds (amending 4VAC15-260-160; adding 4VAC15-260-35, 4VAC15-260-115, repealing 4VAC15-260-40).**

Statutory Authority: §§ 29.1-103, 29.1-351, and 29.1-501 of the Code of Virginia.

Effective Date: August 1, 2017.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 7870 Villa Park Drive, Suite 400, Henrico, VA 23228, telephone (804) 367-8341, or email phil.smith@dgif.virginia.gov.

Summary:

The amendments (i) clarify that all hunting, including hunting from a float blind, hunting while standing on the bottom of public waters, or any other type of hunting, is prohibited within 500 yards of any licensed stationary blind or floating blind stake; (ii) prohibit activities on the Department of Game and Inland Fisheries Kittewan Creek refuge property that are not consistent with the property's function as a refuge for waterfowl; and (iii) allow the department to designate float blind hunting areas in the Great Hunting Creek and Dyke Marsh areas using global positioning system coordinates.

[~~4VAC15-260-15. Reflective markers on stationary blinds.~~

~~Stationary blinds located in the public waters must be marked with a stake or PVC pipe with at least 100 square inches of white or amber reflecting material visibly from 360 degrees and at least three feet above the high water mark. The requirement for reflective material on stationary blinds is not in effect while the stationary blind is occupied by a licensed hunter during legal shooting hours. In addition, any abandoned or partial blind structures must be similarly marked until such time as they are removed from the public waters.~~]

4VAC15-260-35. Distance from a licensed stationary blind and off-shore blind stake.

No person shall hunt migratory waterfowl in the public waters of this Commonwealth within 500 yards of any legally licensed erected stationary blind or legally licensed offshore blind stake site of another without possessing the written consent of the licensee that is immediately available upon request by any law-enforcement officer, except when in active pursuit of a visible crippled waterfowl that was legally shot by the person.

4VAC15-260-40. ~~Distance between floating blind and stationary blind.~~ (Repealed.)

~~It shall be unlawful to tie out or anchor a mat blind, or other floating blind, within 500 yards of a stationary shore or stationary water blind on which license has been paid for the season, except by the consent of the owner of such stationary shore blind or water blind, whether the same be occupied for shooting or not.~~

[~~4VAC15-260-45. Float blind hunting areas established.~~

~~No licenses shall be issued for non-riparian stationary waterfowl blinds or offshore blind stake sites in the public waters in front of specified public, municipal, state, or federal properties in Virginia. Waterfowl hunting in public waters in front of these lands shall be by licensed floating blind only and shall occur only in designated waters and at designated times and locations as prescribed by the riparian landowner and approved by the Virginia Department of Game and Inland Fisheries. This section applies to areas where the managing agency has requested such in writing to the department by~~

~~April 1 of any given year. These privileges will remain in effect until the managing agency requests termination in writing to the department by April 1 of any given year. This section shall not alter in any respect the privileges for landowners and their lessees and permittees prescribed in §§ 29.1-344 and 29.1-347 of the Code of Virginia.~~]

4VAC15-260-115. Disturbing waterfowl on Kittewan Creek refuge in Charles City County.

It shall be unlawful to hunt on [~~the waters of~~] Kittewan Creek [Refuge] in Charles City County west (upstream) of the posted refuge boundary markers (latitude-longitude coordinates 37.29831 - 77.05134) located approximately one mile upstream from [~~its mouth at~~] the James River. In addition, camping and other recreational activities that are not consistent with the property's function as a refuge for waterfowl are not permitted.

4VAC15-260-116. [FINAL ACTION DEFERRED.]

EDITOR'S NOTE: The Board of Game and Inland Fisheries deferred action on 4VAC15-260-116 for later consideration; therefore, this section will not become effective on August 1, 2017. The proposed text of this section may be viewed in 33:17 VA.R. 1966-1967 April 17, 2017.

4VAC15-260-160. Great Hunting Creek and Dyke Marsh; floating blind area.

No license shall be issued for stationary waterfowl blinds on the Potomac River in Fairfax County adjacent to National Park Service ~~Lands~~ lands in the Great Hunting Creek and Dyke Marsh areas. Waterfowl hunting in Commonwealth waters adjacent to the above mentioned lands shall be by licensed floating blind only. Such floating blinds (i) must be attached securely to a post or buoy affixed to the river bottom by the department~~,~~ or anchored at global positioning system (GPS) locations designated by the department and (ii) are limited to one floating blind per post at any time. Hunters in licensed floating blinds may hunt from designated locations during legal shooting hours on Thanksgiving Day and on Mondays, Wednesdays and Fridays during the open seasons for hunting waterfowl in Virginia. Blind sites shall be occupied on a daily first-come basis, such sites to be occupied no earlier than 4 a.m. or later than one-half hour after sunset. All such blinds shall be removed each day.

VA.R. Doc. No. R17-5074; Filed June 21, 2017, 10:50 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: **4VAC15-270. Game: Firearms (adding 4VAC15-270-96).**

Statutory Authority: §§ 29.1-103 and 29.1-501 of the Code of Virginia.

Effective Date: August 1, 2017.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 7870 Villa Park Drive, Suite 400, Henrico, VA 23228, telephone (804) 367-8341, or email phil.smith@dgif.virginia.gov.

Summary:

The amendments (i) set the minimum caliber for pneumatic rifles used for hunting deer at .35 and (ii) prohibit the use of pneumatic rifles for hunting bear or elk.

4VAC15-270-96. Pneumatic rifles permitted for hunting deer; prohibited for hunting bear and elk.

Pneumatic (air or gas) rifles must be .35 caliber or larger for the hunting or killing of deer. Pneumatic rifles are prohibited for the hunting or killing of bear and elk.

VA.R. Doc. No. R17-5075; Filed June 21, 2017, 11:34 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: **4VAC15-290. Game: Permits (amending 4VAC15-290-140).**

Statutory Authority: §§ 29.1-103 and 29.1-501 of the Code of Virginia.

Effective Date: August 1, 2017.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 7870 Villa Park Drive, Suite 400, Henrico, VA 23228, telephone (804) 367-8341, or email phil.smith@dgif.virginia.gov.

Summary:

The amendments require all hunters of migratory game birds, including those who are exempt from being licensed, to possess Harvest Information Program (HIP) authorization.

4VAC15-290-140. Possession and display of a harvest information program ~~registration number~~ authorization to hunt migratory game birds.

Every person ~~required to obtain a harvest information program registration number to hunt~~, whether licensed or exempt from being licensed, (i) must be registered with the Virginia Harvest Information Program (HIP) to hunt migratory game birds, including waterfowl, doves, woodcock, snipe, rails, gallinules, moorhens, and coots; (ii) must carry the ~~registration number~~ HIP authorization on his person when hunting; and (iii) shall present it immediately upon demand of any officer whose duty it is to enforce the game and inland fish laws. The penalty for violation of this section is prescribed by § 29.1-505 of the Code of Virginia.

VA.R. Doc. No. R17-5076; Filed June 21, 2017, 11:46 a.m.

TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Forms

REGISTRAR'S NOTICE: Forms used in administering the following regulation have been filed by the Department of Environmental Quality. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, Richmond, Virginia 23219.

Titles of Regulations: **9VAC25-210. Virginia Water Protection Permit Program Regulation.**

9VAC25-660. Virginia Water Protection General Permit for Impacts Less Than One-Half Acre.

9VAC25-670. Virginia Water Protection General Permit for Facilities and Activities of Utility and Public Service Companies Regulated by the Federal Energy Regulatory Commission or the State Corporation Commission and Other Utility Line Activities.

9VAC25-680. Virginia Water Protection General Permit for Linear Transportation Projects.

9VAC25-690. Virginia Water Protection General Permit for Impacts from Development and Certain Mining Activities.

Agency Contact: Debra Harris, Policy and Planning Specialist, Department of Environmental Quality, 629 East Main Street, Richmond, VA 23219, telephone (804) 698-4209, or email debra.harris@deq.virginia.gov.

FORMS (9VAC25-210)

Department of Environmental Quality Water Division Permit Application Fee Form (rev. 10/2014)

~~Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (rev. 3/2014)~~

Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (rev. 5/2017)

Virginia Department of Transportation, Inter-Agency Coordination Meeting Joint Permit Application (eff. 6/2008)

~~Tidewater Joint Permit Application for Projects Involving Tidal Waters, Tidal Wetlands and/or Dunes and Beaches in Virginia (rev. 3/2014)~~

Tidewater Joint Permit Application for Projects Involving Tidal Waters, Tidal Wetlands and/or Dunes and Beaches in Virginia (rev. 5/2017)

Monthly Reporting of Impacts Less than or Equal to One-Tenth Acre Statewide (eff. 8/2007)

FORMS (9VAC25-660)

Department of Environmental Quality Water Division Permit Application Fee Form (rev. 10/2014)

~~Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (rev. 3/2014)~~

Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (rev. 5/2017)

Virginia Department of Transportation, Inter-Agency Coordination Meeting Joint Permit Application (eff. 6/2008)

Monthly Reporting of Impacts Less than or Equal to One-Tenth Acre Statewide (eff. 8/2007)

FORMS (9VAC25-670)

Department of Environmental Quality Water Division Permit Application Fee Form (rev. 10/2014)

~~Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (rev. 3/2014)~~

Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (rev. 5/2017)

Virginia Department of Transportation, Inter-Agency Coordination Meeting Joint Permit Application (eff. 6/2008)

Monthly Reporting of Impacts Less than or Equal to One-Tenth Acre Statewide (eff. 8/2007)

FORMS (9VAC25-680)

Department of Environmental Quality Water Division Permit Application Fee Form (rev. 10/2014)

~~Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (eff. 3/2014)~~

Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (rev. 5/2017)

Virginia Department of Transportation, Inter-Agency Coordination Meeting Joint Permit Application (eff. 6/2008)

Monthly Reporting of Impacts Less than or Equal to One-Tenth Acre Statewide (eff. 8/2007)

FORMS (9VAC25-690)

~~Department of Environmental Quality Water Division Permit Application Fee Form (rev. 10/2014)~~

Department of Environmental Quality Water Division Permit Application Fee Form (rev. 10/2014)

~~Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (rev. 3/2014)~~

Standard Joint Permit Application for Activities in Waters and Wetlands of the Commonwealth of Virginia (rev. 5/2017)

Virginia Department of Transportation, Inter-Agency Coordination Meeting Joint Permit Application (eff. 6/2008)

Monthly Reporting of Impacts Less than or Equal to One-Tenth Acre Statewide (eff. 8/2007)

VA.R. Doc. No. R17-5170; Filed June 13, 2017, 8:55 a.m.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Withdrawal

Title of Regulation: **12VAC30-40. Eligibility Conditions and Requirements (amending 12VAC30-40-10).**

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

The Department of Medical Assistance Services has withdrawn subdivision 3 b (1) of 12VAC30-40-10 from the regulatory action pertaining to the modified adjusted gross income methodology as published in 34:21 VA.R. 2376 June 12, 2017. This subdivision will be designated as "Reserved" in the Virginia Administrative Code when this action becomes effective on July 27, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

VA.R. Doc. No. R17-4396; Filed June 9, 2017, 2:43 p.m.

Emergency Regulation

Title of Regulation: **12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-40).**

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Effective Dates: June 16, 2017, through December 15, 2018.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Preamble:

Section 2.2-4011 of the Code of Virginia states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of § 2.2-4006 A 4 of the Code of Virginia.

Item 306 OO of Chapter 780 of the 2016 Acts of Assembly (the 2016 Appropriation Act) directed the Department of Medical Assistance Services (DMAS) to implement a pricing methodology to modify or replace the current pricing methodology for pharmaceutical products as defined in 12VAC30-80-40. The amendments conform the regulation to these requirements and to the federal drug pricing regulation, which was published at 81 FR 5170, requiring states to pay pharmacies based on the drug's ingredient cost, defined as the actual acquisition cost plus a professional dispensing fee.

12VAC30-80-40. Fee-for-service providers: pharmacy.

~~Payment for pharmacy services (excluding outpatient hospital) shall be the lowest of subdivisions 1 through 5 of this section (except that subdivisions 1 and 2 of this section will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.512(c) if the brand cost is greater than the Centers for Medicare and Medicaid Services (CMS) upper limit of VMAC cost) subject to the conditions, where applicable, set forth in subdivisions 6 and 7 of this section:~~

~~1. The upper limit established by the CMS for multiple source drugs pursuant to 42 CFR 447.512 and 447.514, as determined by the CMS Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.~~

~~2. The methodology used to reimburse for generic drug products shall be the higher of either (i) the lowest Wholesale Acquisition Cost (WAC) plus 10% or (ii) the second lowest WAC plus 6.0%. This methodology shall reimburse for products' costs based on a Maximum Allowable Cost (VMAC) list to be established by the single state agency.~~

~~a. In developing the maximum allowable reimbursement rate for generic pharmaceuticals, the department or its designated contractor shall:~~

~~(1) Identify three different suppliers, including manufacturers that are able to supply pharmaceutical products in sufficient quantities. The drugs considered must be listed as therapeutically and pharmaceutically equivalent in the Food and Drug Administration's most recent version of the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book). Pharmaceutical products that are not available from three different suppliers, including manufacturers, shall not be subject to the VMAC list.~~

~~(2) Identify that the use of a VMAC rate is lower than the Federal Upper Limit (FUL) for the drug. The FUL is a known, widely published price provided by CMS; and~~

~~(3) Distribute the list of state VMAC rates to pharmacy providers in a timely manner prior to the implementation of VMAC rates and subsequent modifications. DMAS shall publish on its website, each month, the information used to set the Commonwealth's prospective VMAC rates, including, but not necessarily limited to:~~

~~(a) The identity of applicable reference products used to set the VMAC rates;~~

~~(b) The Generic Code Number (GCN) or National Drug Code (NDC), as may be appropriate, of reference products;~~

~~(c) The difference by which the VMAC rate exceeds the appropriate WAC price; and~~

~~(d) The identity and date of the published compendia used to determine reference products and set the VMAC rate. The difference by which the VMAC rate exceeds the appropriate WAC price shall be at least or equal to 10% above the lowest published wholesale acquisition cost for products widely available for purchase in the Commonwealth and shall be included in national pricing compendia.~~

~~b. Development of a VMAC rate that does not have a FUL rate shall not result in the use of higher cost innovator brand name or single source drugs in the Medicaid program.~~

~~c. DMAS or its designated contractor shall:~~

~~(1) Implement and maintain a procedure to add or eliminate products from the list, or modify VMAC rates, consistent with changes in the fluctuating marketplace. DMAS or its designated contractor will regularly review manufacturers' pricing and monitor drug availability in the marketplace to determine the inclusion or exclusion of drugs on the VMAC list; and~~

~~(2) Provide a pricing dispute resolution procedure to allow a dispensing provider to contest a listed VMAC rate. DMAS or its designated contractor shall confirm receipt of pricing disputes within 24 hours, via telephone or facsimile, with the appropriate documentation of relevant information, for example, invoices. Disputes shall be resolved within three business days of confirmation. The pricing dispute resolution process will include DMAS' or the contractor's verification of accurate pricing to ensure consistency with marketplace pricing and drug availability. Providers will be reimbursed, as appropriate, based on findings. Providers shall be required to use this dispute resolution process prior to exercising any applicable appeal rights.~~

~~3. The provider's usual and customary charge to the public, as identified by the claim charge.~~

~~4. The Estimated Acquisition Cost (EAC), which shall be based on the published Average Wholesale Price (AWP) minus a percentage discount established by the General Assembly (as set forth in subdivision 7 of this section) or, in the absence thereof, by the following methodology set out in subdivisions a, b, and c of this subdivision.~~

~~a. Percentage discount shall be determined by a statewide survey of providers' acquisition cost.~~

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

~~c. The agency will conduct surveys at intervals deemed necessary by DMAS.~~

~~5. Maximum allowable cost (MAC) methodology for specialty drugs. Payment for drug products designated by DMAS as specialty drugs shall be the lesser of subdivisions 1 through 4 of this section or the following method, whichever is least:~~

~~a. The methodology used to reimburse for designated specialty drug products shall be the WAC price plus the WAC percentage. The WAC percentage is a constant percentage identified each year for all GCNs.~~

~~b. Designated specialty drug products are certain products used to treat chronic, high cost, or rare diseases; the drugs subject to this pricing methodology and their current reimbursement rates are listed on the DMAS website at the following internet address: http://www.dmas.virginia.gov/Content_pgs/pharm-home.aspx.~~

~~c. The MAC reimbursement methodology for specialty drugs shall be subject to the pricing review and dispute resolution procedures described in subdivisions 2 c (1) and 2 c (2) of this section.~~

~~6. Payment for pharmacy services will be as described in subdivisions 1 through 5 of this section; however, payment for legend drugs will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The dispensing fee for brand name and generic drugs is $3.75.~~

~~7. An EAC of AWP minus 13.1% shall become effective July 1, 2011. The dispensing fee for brand name and generic drugs of $3.75 shall remain in effect, creating a payment methodology based on the previous algorithm (least of subdivisions of this section) plus a dispensing fee where applicable.~~

A. Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

1. The national average drug acquisition cost (NADAC) of the drug, the federal upper limit (FUL), or the provider's usual and customary (U&C) charge to the public, as identified by the claim charge; or

2. When no NADAC is available, DMAS shall reimburse at the lowest of the wholesale acquisition cost plus 0%, the FUL, or the provider's U&C charge to the public, as identified by the claim charge.

B. Payment for specialty drugs not dispensed by a retail community pharmacy but dispensed primarily through the mail will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

1. The national average drug acquisition cost (NADAC) of the drug, the federal upper limit (FUL), or the provider's usual and customary (U&C) charge to the public, as identified by the claim charge; or

2. When no NADAC is available, DMAS shall reimburse at the lowest of the wholesale acquisition cost plus 0%; the FUL; or the provider's U&C charge to the public, as identified by the claim charge.

C. Payment for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies) will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

1. The national average drug acquisition cost (NADAC) of the drug; the federal upper limit (FUL); or the provider's usual and customary (U&C) charge to the public, as identified by the claim charge; or

2. When no NADAC is available, DMAS shall reimburse at the lowest of the wholesale acquisition cost plus 0%; the FUL; or the provider's U&C charge to the public, as identified by the claim charge.

D. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers and Centers of Excellence will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

1. The national average drug acquisition cost (NADAC) of the drug, or the provider's usual and customary (U&C) charge to the public, as identified by the claim charge; or

2. When no NADAC is available, DMAS shall reimburse at the lowest of the wholesale acquisition cost plus 0%, or the provider's U&C charge to the public, as identified by the claim charge.

E. Section 340B covered entities and federally qualified health centers (FQHCs) that fill Medicaid member prescriptions with drugs purchased at the prices authorized under § 340B of the Public Health Services Act will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee. Section 340B covered entities that fill Medicaid member prescriptions with drugs not purchased under § 340B of the Public Health Services Act will be reimbursed in accordance with subsection A of this section plus the $10.65 professional dispensing fee as described in subsection I of this section.

F. Drugs acquired through the federal § 340B drug price program and dispensed by § 340B contract pharmacies are not covered.

G. Facilities purchasing drugs through the federal supply schedule (FSS) or drug pricing program under 38 USC § 1826, 42 USC § 256b, or 42 USC §1396-8, other than the § 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee.

H. Facilities purchasing drugs at nominal price (outside of § 340B or FSS) will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee. Nominal price as defined in 42 CFR 447.502 means that a price is less than 10% of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

I. Payment for pharmacy services will be as described in subsections A through H of this section; however, shall include the allowed cost of the drug plus only one professional dispensing fee, as defined at 42 CFR 447.502, per member per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The professional dispensing fee for all covered outpatient drugs shall be $10.65. The professional dispensing fee shall be determined by a cost of dispensing survey conducted at least every five years.

J. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 106% of the average sales price (ASP) as published by the Centers for Medicare and Medicaid Services (CMS). PADs without an ASP on the CMS reference file will be reimbursed at the provider's actual acquisition cost. Covered entities using drugs purchased at the prices authorized under § 340B of the Public Health Services Act for Medicaid members shall bill Medicaid their actual acquisition cost.

K. Payment to Indian Health Service, tribal, and urban Indian pharmacies. DMAS does not have any Indian Health Service, tribal, or urban Indian pharmacies enrolled at this time. Payment for pharmacy services will be defined in a state plan amendment if such entity enrolls with DMAS.

L. Investigational drugs are not a covered service under the DMAS pharmacy program.

~~8.~~ M. Home infusion therapy.

~~a.~~ 1. The following therapy categories shall have a pharmacy service day rate payment allowable: hydration therapy, chemotherapy, pain management therapy, drug therapy, and total parenteral nutrition (TPN). The service day rate payment for the pharmacy component shall apply to the basic components and services intrinsic to the therapy category. Submission of claims for the per diem rate shall be accomplished by use of the CMS 1500 claim form.

~~b.~~ 2. The cost of the active ingredient or ingredients for chemotherapy, pain management and drug therapies shall be submitted as a separate claim through the pharmacy program, using standard pharmacy format. Payment for this component shall be consistent with the current reimbursement for pharmacy services. Multiple applications of the same therapy shall be reimbursed one service day rate for the pharmacy services. Multiple applications of different therapies shall be reimbursed at 100% of standard pharmacy reimbursement for each active ingredient.

~~9.~~ N. Supplemental rebate agreement. The Commonwealth complies with the requirements of § 1927 of the Social

Security Act and Subpart I (42 CFR 447.500 et seq.) of 42 CFR Part 447 with regard to supplemental drug rebates. In addition, the following requirements are also met:

~~a.~~ 1. Supplemental drug rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

~~b.~~ 2. Prior authorization requirements found in § 1927(d)(5) of the Social Security Act have been met.

~~c.~~ 3. Nonpreferred drugs are those that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list (PDL). Nonpreferred drugs will be made available to Medicaid beneficiaries through prior authorization.

~~d.~~ 4. Payment of supplemental rebates may result in a product's inclusion on the PDL.

VA.R. Doc. No. R17-4546; Filed June 19, 2017, 8:32 a.m.

Emergency Regulation

Title of Regulation: **12VAC30-120. Waivered Services (adding 12VAC30-120-600 through 12VAC30-120-690).**

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Effective Dates: June 16, 2017, through December 15, 2018.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Preamble:

Section 2.2-4011 of the Code of Virginia states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of § 2.2-4006 A 4 of the Code of Virginia.

Subdivision 3 of Item 306 JJJ of Chapter 780 of the 2016 Acts of Assembly (the 2016 Appropriation Act) directs the Department of Medical Assistance Services (DMAS) to include all remaining Medicaid populations and services, including long-term care and home and community-based waiver services into cost-effective, managed, and coordinated delivery systems.

Commonwealth Coordinated Care Plus (CCC Plus) is the new statewide Medicaid managed long-term services and supports program that will service approximately 214,000 individuals with complex care needs through an integrated delivery system model across the full continuum of care. Care management is at the heart of the CCC Plus high-touch, person-centered program design. CCC Plus focuses on improving quality, access, and efficiency.

12VAC30-120-600. Definitions.

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

"Action" means, consistent with 42 CFR 438.400, an adverse benefit determination by the participating plan, subcontractor, service provider, or Virginia Department of Medical Assistance Services that constitutes a (i) denial or limited authorization of a service authorization request, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) reduction, suspension, or termination of a previously authorized service; (iii) failure to act on a service request; (iv) denial in whole or in part of a payment for a service; (v) failure by the participating plan to render a decision within the required timeframes; (vi) failure to provide services in a timely manner; (vii) denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities or (viii) denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network.

"Appellant" means an applicant for or recipient of Medicaid benefits who seeks to challenge an action taken by the participating plan, subcontractor, service provider, or DMAS regarding eligibility for services and payment determinations.

"Carved-out services" means the subset of Medicaid covered services for which the plan shall not be fiscally responsible.

"Centers for Medicare and Medicaid Services" or "CMS" means the federal agency of the U.S. Department of Health and Human Services that is responsible for the administration of Titles XVIII, XIX, and XXI of the Social Security Act.

"Commonwealth Coordinated Care" or "CCC" means the program for the Virginia Medicare-Medicaid Financial Alignment Demonstration Model.

"Commonwealth Coordinated Care Plus Program" or "CCC Plus" means the department's mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long-term services and supports (LTSS). The CCC Plus program includes individuals who receive services through nursing facility (NF) care or from four of the department's five home and community-based services (HCBS) § 1915(c) waivers (the Alzheimer's Assisted Living (AAL) Waiver individuals are not eligible for the CCC Plus program).

"Covered services" means the set of required services offered by the participating plan.

"Department of Medical Assistance Services," "department," or "DMAS" means the Virginia Department of Medical Assistance Services, the single state agency for the Medicaid program in Virginia that is responsible for implementation and oversight of CCC Plus.

"Disenrollment" means the process of changing enrollment from one participating plan to another participating plan or the process of being excluded from CCC Plus by the department as described in 12VAC30-120-610.

"Division" or "Appeals Division" means the Appeals Division of the Department of Medical Assistance Services.

"Dual eligible enrollees" means a Medicare enrollee who receives Medicare Parts A, B, and D benefits and also receives full Medicaid benefits.

"Effective date" means the date on which a participating plan's coverage begins for an enrollee.

"Enrollee" means an individual that has enrolled in a participating plan to receive services under this program.

"Enrollee appeal" means an enrollee's request for review of an action.

"Enrollment" means assignment of an individual to a health plan by the department in accordance with the terms of the contract with the participating plan. This does not include attaining eligibility for the Medicaid program.

"Enrollment period" means the time that an enrollee is actually enrolled in a participating plan.

"Expedited appeal" means the process by which the participating plan must respond to an appeal by an enrollee if a denial of care decision and the subsequent internal appeal by a participating plan may jeopardize life, health, or ability to attain, maintain, or regain maximum function.

"External appeal" means an appeal, subsequent to the participating plan internal appeal or reconsideration decision, to the state fair hearing process or internal reconsideration process for adverse decisions. The department's external appeal decision shall be binding upon the participating plan or plans and not subject to further appeal by the participating plan or plans.

"Fee-for-service" or "FFS" means the traditional health care payment system in which physicians and other providers receive a payment for each service they provide.

"Final decision" means a written determination by a department hearing officer from an appeal of an informal evidentiary proceeding that is binding on the department, unless modified during or after the judicial process.

"Handbook" means a document prepared by the MCO and provided to the enrollee that is consistent with the requirements of 42 CFR 438.10 and the CCC Plus contract, and includes information about all the services covered by that plan.

"Hearing" means an informal evidentiary proceeding conducted by a department hearing officer during which an enrollee has the opportunity to present his concerns with or objections to the participating plan's internal appeal decision.

"Hearing officer" means an impartial decision maker who conducts evidentiary hearings for enrollee appeals on behalf of the department.

"Intermediate care facility for individuals with intellectual disabilities" or "ICF/IID" means a facility licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to intellectually disabled individuals who are not in need of skilled nursing care, but who need more intensive training and supervision than would be available in a rooming home, boarding home, or group home. Such facilities must comply with Title XIX standards, provide health or rehabilitative services, and provide active treatment to enrollees toward the achievement of a more independent level of functioning.

"Internal appeal" means an enrollee's initial request to an MCO for review of an action.

"Long-term services and supports" or "LTSS" means a variety of services and supports that (i) help elderly enrollees and enrollees with disabilities who need assistance to perform activities of daily living and instrumental activities of daily living to improve the quality of their lives and (ii) are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

"MCO" means a health plan selected to participate in Virginia's CCC Plus program. "MCO" means the same as "participating plan."

"Medicaid" means the program of medical assistance benefits under Title XIX of the Social Security Act.

"Medically necessary" or "medical necessity" means at item or service provided for the diagnosis or treatment of an enrollee's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12VAC30-130-600 et seq.) and EPSDT criteria (for those younger than 21 years of age) in accordance with 42 CFR 441 Subpart B (§§ 50 through 62) and federal regulations as defined in 42 CFR 438.210 and 42 CFR 440.230.

"Medicare" means Title XVIII of the Social Security Act, the federal health insurance program for people age 65 years or older, people younger than 65 years of age who have certain disabilities, and people with end stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS).

"Member" means the same as "enrollee."

"Money Follows the Person" or "MFP" means a demonstration project administered by DMAS that is designed to create a system of long-term services and supports that better enable enrollees to transition from certain long-term care institutions into the community.

"Network provider" means a doctor, hospital, or other health care provider that participates or contracts with a participating plan and, as a result, agrees to accept a mutually-agreed upon payment amount or fee schedule as payment in full for covered services that are rendered to eligible enrollees.

"Nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing care facility, or nursing facility, whether freestanding or a portion of a

freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the Social Security Act, as amended, and § 32.1-137 of the Code of Virginia.

"Participating plan" means the same as "MCO."

"Plan of care" or "POC" means a plan, primarily directed by the enrollee and family members of the enrollee as appropriate with the assistance of the enrollee's interdisciplinary care team to meet the enrollee's medical, behavioral health, long-term care services and supports, and social needs.

"Previously authorized" means, in relation to continuation of benefits, as described in 42 CFR 438.420, a prior approved course of treatment.

"Primary care provider" or "PCP" means a practitioner who provides preventive and primary medical care and certifies service authorizations and referrals for medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, geriatricians, and specialists who perform primary care functions (such as surgeons) and clinics including local health departments, federally qualified health centers (FQHCs), and rural health clinics (RHCs).

"Program of All-Inclusive Care for the Elderly" or "PACE" means the program in which the PACE provider provides the entire spectrum of health services (preventive, primary, and acute) and long-term services and supports to its enrollees without limit as to duration or cost of services pursuant to 12VAC30-50-320 et seq.

"Provider appeal" means an appeal to the department filed by a Medicaid-enrolled or network service provider that has already provided a service to an enrollee and has received an adverse reconsideration decision regarding service authorization, payment, or audit result.

"Reconsideration" means a provider's request to the MCO for review of an adverse action related to service authorization or payment. The MCO's reconsideration decision is a prerequisite to a provider's filing of an appeal to the DMAS Appeals Division.

"Remand" means the return of a case by the department's hearing officer to the MCO for further review, evaluation, and action.

"Representative" means an attorney or other individual who has been authorized to represent an enrollee pursuant to these regulations.

"Reverse" means to overturn the MCO's internal appeal decision and to direct that the MCO fully approve the amount, duration, and scope of requested services.

"Social Security Act" means the federal act, codified through Chapter 7 of Title 42 of the United States Code that established social insurance programs including Medicare and Medicaid.

"State fair hearing" means the DMAS evidentiary hearing process as administered by the Appeals Division of DMAS.

"Sustain" means to uphold the MCO's appeal decision.

"Withdraw" means a written request from the enrollee or the enrollee's representative for the department to terminate the enrollee appeal.

12VAC30-120-610. CCC Plus mandatory managed care enrollees; enrollment process.

A. The following individuals shall be enrolled in CCC Plus per the CCC Plus § 1915(b) waiver:

1. Dual eligible individuals with Medicare A or B coverage and full Medicaid coverage.

2. Individuals enrolled in the Commonwealth Coordinated Care (CCC) program will transition to CCC Plus in January 2018, which is after the CCC program ends.

3. Non-dual eligible individuals who receive long-term services and supports through an institution, the CCC Plus waiver (formerly known as the EDCD and Technology Assisted waivers), Building Independence waiver, Community Living waiver, and Family and Individual Supports waiver.

Those enrolled in the Building Independence, Community Living, and Family and Individual Supports waivers will continue to receive their LTSS including LTSS related transportation services through Medicaid fee-for-service.

4. Individuals enrolled in the Department's Medallion Health and Acute Care Program (HAP), except individuals in the Alzheimer's Assisted Living (AAL) Waiver; AAL is excluded from CCC Plus.

5. All individuals classified as aged, blind, or disabled (ABD) without Medicare and not receiving LTSS. The majority of these individuals is currently enrolled in Medallion and will transition to CCC Plus effective January 1, 2018.

B. The following individuals shall be excluded from enrollment in CCC Plus:

1. Individuals enrolled in the Alzheimer's Assisted Living Waiver.

2. Individuals enrolled in another DMAS managed care program (e.g., Medallion, FAMIS, and FAMIS MOMS).

3. Individuals enrolled in a PACE program.

4. Newborns whose mothers are CCC Plus enrollees on their date of birth.

5. Individuals who are in limited coverage groups, such as:

a. Dual eligible individuals without full Medicaid benefits, such as:

(1) Qualified Medicare beneficiaries (QMBs);

(2) Special low-income Medicare beneficiaries (SLMBs);

(3) Qualified disabled working individuals (QDWIs); or

(4) Qualifying individuals (QIs) for whom Medicaid pays the Part B premium.

b. Individuals enrolled in Plan First.

c. Individuals enrolled in the Governor's Access Plan.

6. Individuals enrolled in a Medicaid-approved hospice program at the time of enrollment. However, if an individual enters a hospice program while enrolled in CCC Plus, the member will remain enrolled in CCC Plus.

7. Individuals who live on Tangier Island.

8. Individuals younger than 21 years of age who are approved for DMAS psychiatric residential treatment center (RTC) Level C programs as defined in 12VAC30-130-860. Any individual admitted to an RTC Level C program for behavioral health services will be temporarily excluded from CCC Plus until after they are discharged. RTC Level C services may be transitioned to the CCC Plus program in the future.

9. Individuals with end stage renal disease (ESRD) at the time of enrollment into CCC Plus. However, an individual who develops ESRD while enrolled in CCC Plus will remain in CCC Plus.

10. Individuals who are institutionalized in certain state and private ICF/IID and mental health facilities as specified in the CCC Plus contract.

11. Individuals who are patients at nursing facilities operated by the Veterans Administration.

12. Individuals participating in the CMS Independence at Home (IAH) demonstration. However, IAH individuals may enroll in CCC Plus if they choose to disenroll from IAH.

13. Certain individuals in out-of-state placements as specified in the CCC Plus contract.

14. Individuals placed on spenddown. However, spenddown individuals are included if they are residing in a nursing home.

15. Individuals enrolled in the department's Money Follows the Person (MFP) Demonstration project.

16. Incarcerated individuals. Individuals on house arrest are not considered incarcerated.

17. Individuals who may have any insurance purchased through the Health Insurance Premium Payment (HIPP) program.

C. Enrollment in CCC Plus will be mandatory for eligible individuals. The department shall have sole authority and responsibility for the enrollment of individuals into the CCC Plus program and for excluding enrollees from CCC Plus.

D. There shall be no retroactive enrollment for CCC Plus.

E. The MCO shall notify the enrollee of his enrollment in the MCO's plan through a letter submitted simultaneously with the handbook. Upon disenrollment from the plan, the MCO shall notify the enrollee through a disenrollment notice that coverage in the MCO's plan will no longer be effective.

F. The department reserves the right to revise the CCC Plus intelligent default assignment methodology (as described in subsection J of this section) as needed based upon DMAS sole discretion.

G. Eligible individuals as defined in subsection A of this section shall be enrolled in a CCC Plus contracted health plan through a CCC Plus intelligent assignment methodology as defined by DMAS in the CCC Plus contract.

1. The enrollee will be, at a minimum, notified of his assigned MCO, right to select another CCC Plus MCO operating in his locality, CCC Plus service begin date, and instructions for the individual, or his designee, to contact DMAS or its enrollment broker to either:

a. Accept the assigned MCO; or

b. Select a different CCC Plus MCO that is operating in his locality.

2. If an individual does not contact DMAS or its enrollment broker to accept the assigned MCO or select a different CCC Plus MCO operating in his locality, the individual shall be enrolled into the assigned MCO.

3. For the initial 90 calendar days following the effective date of CCC Plus enrollment, the enrollee will be permitted to disenroll from one MCO and enroll in another without cause. This 90-day timeframe applies only to the enrollee's initial start date of enrollment in CCC Plus; it does not reset or apply to any subsequent enrollment periods. After the initial 90-day period following the initial enrollment date, the enrollee may not disenroll without cause until the next annual open enrollment period.

4. Open enrollment is a period of time when individuals are able to change from one MCO to another without cause.

a. Open enrollment will occur at least once every 12 months per 42 CFR 438.56(c)(2) and (f)(1). The open enrollment will occur during October through December with any changes to taking effect the following January 1.

b. Within 60 days prior to the open enrollment effective date, the department will inform enrollees of the opportunity to remain with the current plan or change to another plan without cause. Those individuals who do not choose a new MCO during the open enrollment period shall remain in their current MCO until their next open enrollment effective date.

H. Individuals transferring from CCC and Medallion 3 (other than HAP as described in subdivision A 4 of this section) will transition with a CCC Plus service begin date of January 1, 2018. However, DMAS retains the authority to change this date if deemed necessary by DMAS or CMS. Individuals impacted by a delay will be notified of their new CCC Plus service begin date.

I. DMAS shall utilize an intelligent default assignment process to assign eligible individuals, other than the ABD populations described in subdivision A 5 of this section, to a CCC Plus MCO contracted to operate in their locality. If none of the criteria used in the intelligent default assignment process applies to an individual, he will be randomly assigned to a CCC Plus MCO operating in his locality. The intelligent default assignment process will, at a minimum, take into account:

1. The individuals previous Medicare and Medicaid MCO enrollment within the past two months if known at the time of assignment; and

2. Which MCO their current providers are contracted with. This may include the nursing facility an individual is residing in at the time of assignment, adult day health care for CCC Plus Waiver enrolled members, and an individual's private duty nursing provider.

J. Consistent with 42 CFR 438.56(d), DMAS must permit an enrollee to disenroll at any time for cause.

1. An enrollee may disenroll from his current plan for the following reasons:

a. The enrollee moves out of the MCO's service area;

b. The MCO does not, because of moral or religious objections, cover the service the enrollee seeks;

c. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the individual to unnecessary risk;

d. The enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO and, as a result, would experience a disruption in his residence or employment; and

e. Other reasons as determined by DMAS, including poor quality of care, lack of access to services covered under this MCO, or lack of access to providers experienced in dealing with the enrollee's care needs.

2. The enrollee's request to change from one plan to another outside of open enrollment, or for cause request, may be submitted orally or in writing to the department as provided for in 42 CFR 438.56(d)(1) and cite the reasons why he wishes to disenroll from one plan and enroll in another. The department will review the request in accordance with cause for disenrollment criteria defined in 42 CFR 438.56(d)(2). The department will respond to "for cause" requests, in writing, within 15 business days of the department's receipt of the request. In accordance with 42 CFR 438.56(e)(2), if the department fails to make a determination by the first day of the second month following the month in which the enrollee files the request, the disenrollment request shall be considered approved and effective on the date of approval. Enrollees who are dissatisfied with the department's determination of the enrollee's request to disenroll from one plan and enroll in another for cause shall have the right to appeal through the state fair hearing process at 12VAC30-110-10 et seq.

K. CCC Plus eligible individuals who have been previously enrolled with a CCC Plus MCO and who regain eligibility for the CCC Plus program within 60 calendar days of the effective date of exclusion or disenrollment will be reassigned to the same MCO whenever possible and without going through the selection or assignment process.

12VAC30-120-620. MCO responsibilities; sanctions.

A. The MCO and any of its subcontractors shall abide by all CCC Plus Contract requirements, including:

1. The MCO shall provide medically necessary covered services in accordance with the CCC Plus contract.

a. Each MCO and its subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of service. Each MCO and its subcontractors shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. Each MCO and its subcontractors shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

b. In accordance with § 1932(f) of the Social Security Act (42 USC § 1396a-2), the contractor shall pay all in-network and out-of-network providers (including Native American health care providers) on a timely basis, consistent with the claims payment procedure described in 42 CFR 447.45 and 42 CFR 447.46 and § 1902(a)(37) of the Social Security Act, upon receipt of all clean claims, for covered services rendered to covered members who are enrolled with the contractor at the time the service was delivered. The MCO may deny claims in whole or in part for not meeting payment criteria established by the MCO.

c. Utilization review and audit: MCOs may perform utilization reviews and audits on their network providers. As a result of such a review or audit, an overpayment may be determined.

2. The MCO shall report data to DMAS per CCC Plus contract requirements, which includes data, claims reports, and quality studies performed by the MCO.

3. The MCO shall maintain records, including written policies and procedures, as required by the CCC Plus contract.

4. The MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representative, or the State Medicaid Fraud Control Unit upon request and in the form requested.

5. The MCO shall meet standards specified in the CCC Plus contract for sufficiency of provider networks.

6. The MCO shall conduct monthly checks to screen providers for exclusion.

7. The MCO shall require its providers and subcontractors to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and CHIP programs, as described in 42 CFR 455 Subpart B.

8. In accordance with 42 CFR 447.50 through 42 CFR 447.60, the MCO shall not impose any cost sharing obligations on members except as set forth in 12VAC30-20-150 and 12VAC30-20-160 and as described in the CCC Plus contract.

B. Sanctions shall be the same as those set forth in the CCC Plus contract.

C. As provided in 42 CFR 438.210(a)(5(i), the MCO's medical necessity criteria shall not be more restrictive than the department's criteria.

D. The MCO's coverage rules for contract covered services shall also ensure compliance with federal EPSDT coverage requirements for enrollees younger than 21 years of age.

E. The MCO shall provide services at least in equal amount, duration, and scope as available under the Medicaid fee-for-service program and as described in Attachment 5 of the CCC Plus contract.

12VAC30-120-630. Covered services.

A. The MCO shall, at a minimum, provide all medically necessary Medicaid covered services required under the state plan (12VAC30-50-10 through 12VAC30-50-310, 12VAC30-50-410 through 12VAC30-50-430, and 12VAC30-50-470 through 12VAC30-50-580) and Elderly and Disabled with Consumer Direction waiver regulations (12VAC30-120-924 and 12VAC30-120-927) and the Technology Assisted waiver regulations (12VAC30-120-1720).

B. The following services are not covered by the MCO and shall be provided outside the MCO network:

1. Dental services (12VAC30-50-190);

2. School health services (12VAC30-50-130);

3. Community mental health services (12VAC30-50-130 and 12VAC30-50-226). Effective January 1, 2018, these services shall be covered by the MCO.

4. Preadmission screening (12VAC30-60-303);

5. Individual and Developmental Disability Support waiver services (12VAC 30-120-700 et seq.);

6. Intellectual Disability Waiver (12VAC30-120-1000 et seq.);

7. Day Support Waiver (12VAC30-120-1500 et seq.)

C. The Program of All-Inclusive Care for the Elderly, or PACE, is not available to CCC Plus members.

12VAC30-120-635. Payment rates for MCOs.

The payment rate to MCOs shall be set by negotiated contracts and in accordance with 42 CFR 438.6 Subpart A.

12VAC30-120-640. State fair hearing process.

A. Notwithstanding the provisions of 12VAC30-110-10 through 12VAC30-110-370, the following regulations govern state fair hearings for individuals enrolled in CCC Plus.

B. The Appeals Division maintains an appeals and fair hearings system for enrollees (also referred to as appellants) to challenge appeal decisions rendered by the MCO in response to enrollee appeals of actions related to Medicaid services. Exhaustion of the MCO's appeals process is a prerequisite to requesting a state fair hearing with the department. Appellants who meet the criteria for a state fair hearing shall be entitled to a hearing before a department hearing officer.

C. The MCO shall conduct an internal appeal hearing, pursuant to 42 CFR Part 431 Subpart E and 42 CFR Part 438 Subpart F, and issue a written decision that includes its findings and information regarding the appellant's right to file an appeal with DMAS for a state fair hearing for Medicaid appeals.

D. Enrollees must be notified in writing of the MCO's internal appeals process in accordance with 42 CFR 438.400 et seq.:

1. With the handbook; and

2. Upon receipt of a notice of adverse benefit determination from the MCO.

E. Enrollees must be notified in writing of their right to an external appeal to DMAS upon receipt of the MCO's final internal appeal decision.

F. An appellant shall have the right to representation by an attorney or other individual of his choice at all stages of an appeal.

1. For those appellants who wish to have a representative, a representative shall be designated in a written statement that is signed by the appellant whose Medicaid benefits were adversely affected. If the appellant is physically unable to sign a written statement and proof is submitted to that affect, the department or MCO shall allow a family member or other person acting on the appellant's behalf to be the representative. If the appellant is mentally unable to sign a written statement, the department or MCO shall require written documentation that a family member or other person has been appointed or designated as his legal representative.

2. If the representative is an attorney or a paralegal working under the supervision of an attorney, a signed statement by such attorney or paralegal that he is authorized to represent the appellant prepared on the attorney's letterhead shall be accepted as a designation of representation.

3. An individual of the same law firm as a designated representative shall have the same rights as the designated representative.

4. An appellant may revoke representation by another person at any time. The revocation is effective when the department receives written notice from the appellant.

G. Any communication from an enrollee or his representative that clearly expresses that he wants to present his case to a reviewing authority shall constitute an appeal request.

1. This communication should explain the basis for the appeal of the MCO's internal appeal decision.

2. The enrollee or his representative may examine witnesses or documents, or both, provide testimony, submit evidence, and advance relevant arguments during the hearing.

H. After the MCO's internal appeal process has been exhausted, appeals to the DMAS state fair hearing process shall be made to the DMAS Appeals Division via U.S. mail, fax transmission, telephone, email, in person, or through other commonly available electronic means.

I. Expedited appeals referenced in subsection K of this section may be filed by telephone or any of the methods set forth in subsection H of this section.

J. The enrollee has the right to have his benefits continued during the MCO's appeal or the state fair hearing.

1. All of the following requirements must be met in order for benefits to be continued during the MCO and state fair hearing appeals:

a. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

b. The services were ordered by an authorized provider;

c. The original period covered by the initial authorization has not expired; and

d. The enrollee requests that the benefits be continued.

2. For continuation of benefits for an internal appeal with the MCO, the enrollee or representative must file the appeal before the effective date of action or within 10 calendar days of the mail date of the MCO's notice of action.

3. For continuation of benefits for a state fair hearing, the enrollee, or representative must file the appeal within 10 calendar days of the mail date of the MCO's final appeal decision.

4. The MCO shall also continue benefits for enrollees who initiate a state fair hearing directly because of deemed exhaustion of appeals processes due to failure of the MCO to adhere to the notice and timing requirements in 42 CFR 438.408.

5. If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's adverse benefit determination, the MCO may recover the costs of services furnished to the enrollee while the appeal and the state fair hearing was pending, to the extent they were furnished solely because of the pending appeal.

K. The MCO and the department shall maintain an expedited process for appeals when an appellant's treating provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

1. Resolution of an expedited appeal shall be no longer than 72 hours after the MCO receives the appeal.

2. Enrollees must exhaust the MCO's internal appeals processes prior to filing an expedited appeal request with the department with the exception of those enrollees with direct access to state fair hearings because of deemed exhaustion of appeals processes with the MCO.

3. The MCO and the department may extend the timeframes for resolution of an expedited appeal by up to 14 calendar days if the enrollee or the enrollee's representative requests the extension, or if the MCO or the department:

a. Shows that there is a need for additional information and how the delay is in the enrollee's best interest;

b. Requirements following extension. If the MCO extends the timeframes not at the request of the enrollee, it shall complete the following:

(1) Promptly notify the enrollee of the reason for an extension, and provides the date the extension expires; and

(2) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

12VAC30-120-650. Appeal timeframes.

A. Appeals to the Medicaid state fair hearing process must be filed with the DMAS Appeals Division within 120 days of the date of the MCO's final internal appeal decision, unless the time period is extended by DMAS upon a finding of good cause in accordance with state fair hearing regulations.

B. It is presumed that appellants will receive the MCO's final internal appeal decision five days after the MCO mails it unless the appellant shows that he did not receive the notice within the five-day period.

C. A request for a state fair hearing on the grounds that the MCO has not acted with reasonable promptness in response to an internal appeal request may be filed at any time until the MCO has acted.

D. The date of filing shall be the date the request is postmarked, if mailed, or the date the request is received by the department, if delivered other than by mail.

E. Documents postmarked on or before a time limit's expiration shall be accepted as timely.

F. In computing any time period under these regulations, the day of the act or event from which the designated period of time begins to run shall be excluded and the last day included. If a time limit would expire on a Saturday, Sunday, or state or federal holiday, it shall be extended until the next regular business day.

G. An extension of the 120-day period for filing a request for appeal may be granted for good cause shown. Examples of good cause include the following situations:

1. Appellant was seriously ill and was prevented by illness from contacting DMAS;

2. The MCO's final internal appeal decision was not sent to the appellant. The MCO may rebut this claim by evidence that the decision was mailed to the appellant's last known address or that the decision was received by the appellant.

3. Appellant sent the request for appeal to another government agency or another division within DMAS that is not the Appeals Division in good faith within the time limit; or

4. Unusual or unavoidable circumstances prevented a timely filing.

H. DMAS shall take final administrative action within 90 days from the date the enrollee filed an MCO appeal, not including the number of days the enrollee took to subsequently file for a state fair hearing.

I. Exceptions to standard appeal resolution timeframes. Decisions may be issued beyond the standard appeal resolution timeframes when the appellant or his representative requests or causes a delay. Decisions may also be issued beyond the standard appeal resolution timeframe when any of the following circumstances exist:

1. The appellant or representative requests to reschedule or continue the hearing;

2. The appellant or representative provides good cause for failing to keep a scheduled hearing appointment, and the Appeals Division reschedules the hearing;

3. Inclement weather, unanticipated system outage, or the department's closure that prevents the hearing officer's ability to work;

4. Following a hearing, the hearing officer orders an independent medical assessment as described in 12VAC30-120-670 H 1;

5. The hearing officer leaves the hearing record open after the hearing in order to receive additional evidence or argument from the appellant;

6. The hearing officer receives additional evidence from a person other than the appellant or his representative, and the appellant requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence; or

7. The Appeals Division determines that there is a need for additional information and documents how the delay is in the appellant's best interest.

J. For delays requested or caused by an appellant or his representative the delay date for the decision will be calculated as follows:

1. If an appellant or representative requests or causes a delay within 30 days of the request for a hearing, the 90-day time limit will be extended by the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

2. If an appellant or representative requests or causes a delay within 31 to 60 days of the request for a hearing, the 90-day time limit will be extended by 1.5 times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

3. If an appellant or representative requests or causes a delay within 61 to 90 days of the request for a hearing, the 90-day time limit will be extended by two times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

K. Post hearing delays requested or caused by an appellant or representative (e.g., requests for the record to be left open) will result in a day-for-day delay for the decision date. The department shall provide the appellant and representative with written notice of the reason for the decision delay and the delayed decision date, if applicable.

12VAC30-120-660. Prehearing decisions.

A. If the Appeals Division determines that any of the conditions as described in this subsection exist, a hearing will not be held and the appeal process shall be terminated.

1. A request for appeal may be invalidated if:

a. It was not filed within the time limit imposed by, or extended pursuant to 12VAC30-120-650, and the DMAS Appeals Division sends a letter to the appellant for an explanation as to why the appeal request was not filed timely; and

(1) The appellant did not reply to the request within 10 calendar days for an explanation of why good cause criteria were met for the untimely filing; or

(2) The appellant replied within 10 calendar days of the request, and the DMAS Appeals Division had sufficient

facts to determine that the reply did not meet good cause criteria pursuant to 12VAC30-120-650.

b. The individual who filed the appeal ("filer") is not the appellant or parent of a minor appellant, and the DMAS Appeals Division sends a letter to the filer requesting proof of his authority to appeal on behalf of the appellant; and

(1) The filer did not reply to the request for authorization to represent the appellant within 10 calendar days; or

(2) The filer replied within 10 calendar days of the request, and the DMAS Appeals Division determined that the authorization submitted was insufficient to allow the filer to represent the appellant under the provisions of 12VAC30-120-640.

2. A request for appeal may be administratively dismissed if:

a. The MCO's internal appeals process was not exhausted prior to the enrollee's request for a state fair hearing;

b. The issue of the appeal is not related to the MCO's final internal appeal decision;

c. The action being appealed was not taken by the MCO; or

d. The sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries.

3. An appeal case may be closed if:

a. The Appeals Division schedules a hearing and sends a written schedule letter notifying the appellant or his representative of the date, time, and location of the hearing; the appellant or his representative failed to appear at the scheduled hearing; and the DMAS Appeals Division sends a letter to the appellant for an explanation as to why he failed to appear; and

(1) The appellant did not reply to the request within 10 calendar days for an explanation that met good cause criteria; or

(2) The appellant replied within 10 calendar days of the request, and the DMAS Appeals Division determined that the reply did not meet good cause criteria.

b. The Appeals Division sends a written schedule letter requesting that the appellant or his representative provide a telephone number at which he can be reached for a telephonic hearing, and the appellant or his representative failed to respond within 10 calendar days to the request for a telephone number at which he could be reached for a telephonic hearing.

c. The appellant or his representative withdraws the appeal request. If the appeal request is withdrawn orally, the Appeals Division shall (i) record the individual's statement and telephonic signature and (ii) send the affected individual written confirmation, via regular mail or electronic notification, in accordance with the individual's election.

d. The MCO approves the full amount, duration, and scope of services requested.

e. The evidence in the record shows that the MCO's decision was clearly in error and that the case should be fully resolved in the appellant's favor.

B. Remand to the MCO. If the hearing officer determines from the record, without conducting a hearing, that the case might be resolved in the appellant's favor if the MCO obtains and develops additional information, documentation, or verification, the hearing officer may remand the case to the MCO for action consistent with the hearing officer's written instructions pursuant to 12VAC30-110-210 D.

C. A letter shall be sent to the appellant or his representative that explains the determination made on his appeal.

12VAC30-120-670. Hearing process and final decision.

A. All hearings must be scheduled at a reasonable time, date, and place, and the appellant and his representative shall be notified in writing prior to the hearing.

1. The hearing location will be determined by the Appeals Division.

2. A hearing shall be rescheduled at the appellant's request no more than twice unless compelling reasons exist.

3. Rescheduling the hearing at the appellant's request will result in automatic waiver of the 90-day deadline for resolution of the appeal. The delay date for the decision will be calculated as set forth in 12VAC30-120-650 J.

B. The hearing shall be conducted by a department hearing officer. The hearing officer shall review the complete record for all MCO decisions that are properly appealed; conduct informal, fact-gathering hearings; evaluate evidence presented; research the issues; and render a written final decision.

C. Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeal record shall be made accessible to the appellant and representative at a convenient place and time before the date of the hearing, as well as during the hearing. The appellant and his representative may examine the content of the appellant's case file and all documents and records the department will rely on at the hearing except those records excluded by law.

D. Appellants who require the attendance of witnesses or the production of records, memoranda, papers, and other documents at the hearing may request in writing the issuance of a subpoena. The request must be received by the department at least 10 working days before the scheduled hearing. Such request shall (i) include the witness's or respondent's name, home and work addresses, county or city of work and residence, and (ii) identify the sheriff's office that will serve the subpoena.

E. The hearing officer shall conduct the hearing; decide on questions of evidence, procedure, and law; question witnesses; and assure that the hearing remains relevant to the issue or issues being appealed. The hearing officer shall control the conduct of the hearing and decide who may participate in or observe the hearing.

F. Hearings shall be conducted in an informal, nonadversarial manner. The appellant or his representative shall have the right to bring witnesses, establish all pertinent facts and circumstances; present an argument without undue interference, and question or refute the testimony or evidence, including the opportunity to confront and cross-examine agency representatives.

G. The rules of evidence shall not strictly apply. All relevant, nonrepetitive evidence may be admitted, but the probative weight of the evidence will be evaluated by the hearing officer.

H. The hearing officer may leave the hearing record open for a specified period of time after the hearing in order to receive additional evidence or argument from the appellant or his representative.

1. The hearing officer may order an independent medical assessment when the appeal involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team's decision, and the hearing officer determines that it is necessary to have an assessment by someone other than the person or team who made the original decision (e.g., to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence). A medical assessment ordered pursuant to this regulation shall be at the department's expense and shall become part of the record.

2. The hearing officer may receive evidence that was not presented by either party if the record indicates that such evidence exists, and the appellant or his representative requests to submit it or requests that the hearing officer secure it.

3. If the hearing officer receives additional evidence from an entity other than the appellant or his representative, the hearing officer shall send a copy of such evidence to the appellant and his representative and give the appellant or his representative the opportunity to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence.

4. Any additional evidence received will become a part of the hearing record, but the hearing officer must determine whether or not it will be used in making the decision.

I. After conducting the hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision that either sustains or reverses the MCO's action or remands the case to the MCO for further evaluation consistent with his written instructions. Some decisions may be a combination of these dispositions. The hearing officer's final decision shall be considered as the department's final administrative action pursuant to 42 CFR 431.244(f). The final decision shall include:

1. Identification of the issue or issues;

2. Relevant facts, to include a description of the procedural development of the case;

3. Conclusions of law, regulations, and policy that relate to the issue or issues;

4. Discussions, analysis of the accuracy of the MCO's appeal decision, conclusions, and hearing officer's decision;

5. Further action, if any, to be taken by the MCOs to implement the hearing officer's decision;

6. The deadline date by which further action must be taken; and

7. A cover letter informing the appellant and his representative of the hearing officer's decision. The letter must indicate that the hearing officer's decision is final, and that the final decision may be appealed directly to circuit court.

J. A copy of the hearing record shall be forwarded to the appellant and his representative with the final decision.

K. An appellant who disagrees with the hearing officer's final decision described in this section may seek judicial review pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and Rules of the Supreme Court of Virginia, Part Two A. Written instructions for requesting judicial review must be provided to the appellant or his representative with the hearing officer's decision, and upon request by the appellant or representative.

12VAC30-120-680. Appeals Division records.

A. No person shall take from the department's custody any original record, paper, document, or exhibit that has been certified to the department's Appeals Division except as the Appeals Division Director or his designee authorizes, or as may be necessary to furnish or transmit copies for other official purposes.

B. Information in the appellant's record can be released only to the appellant, his authorized representative, the MCO, other entities for official purposes, and other persons named in a release of information authorization signed by an appellant or his representative.

C. The fees to be charged and collected for any copy of Appeals Division records will be in accordance with Virginia's Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia) or other controlling law.

D. When copies are requested from records in the Appeals Division's custody, the required fee shall be waived if the copies are requested in connection with an enrollee's own appeal.

12VAC30-120-690. Provider appeals.

A. The Appeals Division maintains an appeal process for network and Medicaid-enrolled providers of Medicaid services that have rendered services to enrollees and are requesting to challenge a MCO's reconsideration decision regarding service authorization or payment. The MCO's internal reconsideration process is a prerequisite to filing for an external appeal to the department's appeal process. The appeal process is available to network and Medicaid-enrolled providers that (i) have rendered services and have been denied payment in whole or part for Medicaid covered services; (ii) have rendered services and have been denied authorization for the services; and (iii) have received a notice of program reimbursement or overpayment demand from the department or its contractors. Providers that have had their enrollment in the MCO's network denied or terminated by the MCO do not have the right to an external appeal with the Appeals Division.

B. Department provider appeals shall be conducted in accordance with the department's provider appeal regulations (12VAC30-20-500 et seq.), § 32.1-325 et seq. of the Code of Virginia, and the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

C. The department's external appeal decision shall be binding upon the MCO and not subject to further appeal by the MCO.

D. If the provider is successful in its appeal of a reimbursement issue, then the MCO shall reimburse the provider for the appealed issue.

VA.R. Doc. No. R17-4974; Filed June 19, 2017, 7:48 a.m.

Final Regulation

Titles of Regulations: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (adding 12VAC30-50-600).**

12VAC30-121. Medicare-Medicaid Demonstration Waiver (adding 12VAC30-121-10 through 12VAC30-121-250).

Statutory Authority: § 32.1-325 of the Code of Virginia; §§ 1932 and 1915(c) of the Social Security Act.

Effective Date: August 9, 2017.

Agency Contact: Matthew Behrens, Project Manager, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 625-3673, FAX (804) 786-1680, or email matthew.behrens@dmas.virginia.gov.

Summary:

Item 307 RR of Chapter 806 of the 2013 Acts of Assembly, Item 301 TTT of Chapter 3 of the 2014 Acts of Assembly, Special Session I, and Item 301 TTT of Chapter 665 of the 2015 Acts of Assembly direct the Department of Medical Assistance Services (DMAS) to implement a care coordination program for a Medicare-Medicaid dual eligible enrollee. Item 307 AAAA of Chapter 806 of the 2013 Acts of Assembly, Item 301 HHH of Chapter 3 of the 2014 Acts of Assembly, Special Session I, and Item 301 HHH of Chapter 665 of the 2015 Acts of Assembly direct DMAS to implement a process for administrative appeals of Medicaid/Medicare dual eligible recipients in accordance with the terms of the Memorandum of Understanding between DMAS and the Centers for Medicare and Medicaid Services for the Virginia Medicare-Medicaid Financial Alignment Demonstration Model. Item 307 RRRR of Chapter 806 of the 2013 Acts of Assembly provides for achieving cost savings and standardization of administrative and other processes for providers. The amendments conform to these requirements.

The establishment of Commonwealth Coordinated Care as the mandated care coordination program allows DMAS to combine certain aspects of Medicaid managed care and long-term care and Medicare into one program. The purpose of this regulatory action is to provide integrated care to dual eligible individuals who are currently excluded from participating in managed care programs. This change will enable participants to access their primary and acute medical services, behavioral health services, and long-term care services through a single managed delivery system. The program offers dual eligible individuals care coordination, health risk assessments, interdisciplinary care teams, and plans of care.

Summary of Public Comments and Agency's Response: No public comments were received by the promulgating agency.

Part IX
Commonwealth Coordinated Care Program

12VAC30-50-600. Section 1932 Medicare-Medicaid eligible individuals.

A. Consistent with § 1932(a)(1)(A) of the Social Security Act (Act), the Commonwealth enrolls Medicaid enrollees on a voluntary basis into Medicare-Medicaid plans (MMPs) in the absence of § 1115 or § 1915(b) waiver authority.

B. Consistent with § 1932(a)(1)(B) of the Act, the Commonwealth shall contract with MMPs. The payment method to the contracting entity shall be a capitation method.

C. Enrollment is voluntary in the counties and cities designated by the following regions: (i) Central Virginia, (ii) Northern Virginia, (iii) Tidewater, (iv) Western/Charlottesville, and (v) Roanoke.

D. The Commonwealth assures that all of the applicable requirements of § 1903(m) of the Act for MMPs and MMP contracts are met.

E. The Commonwealth assures that all the applicable requirements of § 1932 of the Act for the state's option to limit freedom of choice by requiring enrollees to receive their benefits through managed care entities will be met. MMPs shall be required to pass readiness reviews prior to enrolling individuals.

F. The Commonwealth assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in § 1905(a)(4)(C) of the Act will be met.

G. The Commonwealth assures that all applicable managed care requirements of 42 CFR Part 438 for MMPs will be met. Enrollees shall be permitted to opt out at any time with or without cause from the program pursuant to 42 CFR 438.56(c).

H. The Commonwealth assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

I. The Commonwealth assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

J. Enrollment process.

1. The Department of Medical Assistance Services (DMAS) shall use a preassignment algorithm, through its Medicaid Management Information System, and a contracted enrollment broker to facilitate the continuity of care for Medicaid individuals by providers that have traditionally served this population.

2. DMAS shall not use a lock in (i.e., restricting a beneficiary's ability to move between health plans except during the designated annual open enrollment period) for managed care.

3. Individuals shall have 60 days to choose a health plan before being automatically assigned.

4. Eligible individuals will receive a notice that indicates to which MMP they have been assigned. The notice will have instructions for the individual to contact the DMAS contracted enrollment facilitator to:

a. Accept the preassigned MMP;

b. Select a different MMP that is operating in their region; or

c. Opt out of the program altogether.

5. If an individual does not select an MMP, he shall be passively enrolled into the preassigned MMP.

6. Enrollees shall be assigned to an MMP based on six months of claims prior to preassignment using the rules in this subdivision in order of priority:

a. Individuals in a nursing facility shall be preassigned to an MMP that includes the individual's nursing facility in its provider network.

b. Individuals in the [~~Elerly~~ Elderly] or Disabled with Consumer Direction Waiver shall be assigned to an MMP that includes the individual's current adult day health care provider in its provider network.

c. If more than one MMP network includes the nursing facility or adult day health care provider used by an individual, the individual will be assigned to the MMP with which he has previously been assigned in the past six months. If he has no history of previous MMP assignment, he shall be randomly assigned to an MMP in which his provider participates.

d. Individuals shall be preassigned to an MMP with whom they have previously been assigned within the past six months.

K. The Commonwealth assures that it has an enrollment system that allows individuals who are already enrolled to be given priority to continue that enrollment if the MMP does not have capacity to accept all who are seeking enrollment under the program.

L. The Commonwealth assures that, pursuant to the choice requirements in 42 CFR 438.52, Medicaid individuals who are enrolled in an MMP will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

M. The Commonwealth shall apply the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the individual is disenrolled solely because he loses Medicaid eligibility for a period of two months or less.

N. The following services shall be excluded from coverage by the MMP in this program:

1. Induced abortions;

2. Targeted case management; and

3. Dental services (see 12VAC30-121-70 for specific coverage).

O. The Commonwealth shall intentionally limit the number of entities it contracts with under the option permitted by § 1932 of the Act. The Commonwealth assures that such limits on the number of contracting entities shall not substantially impair enrollee access to services.

P. DMAS has established an advisory committee that meets quarterly throughout the duration of the program to discuss topics such as program design, educational and outreach materials, and provider and beneficiary issues.

CHAPTER 121
COMMONWEALTH COORDINATED CARE PROGRAM

12VAC30-121-10. Commonwealth Coordinated Care program authority.

A. Medicare authority. The Medicare elements of the Commonwealth Coordinated Care (CCC) program shall operate according to existing Medicare Part C and Part D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in the memorandum of understanding (MOU) between the Centers for Medicare and Medicaid Services (CMS) and the department. As a term and condition of the CCC program, participating plans will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act (the Act) and 42 CFR Parts 422 and 423, as

amended from time to time, except to the extent specified in the MOU for waivers and the three-way contract.

B. Medicaid authority. The Medicaid elements of the CCC program shall operate according to existing Medicaid laws and regulations, including but not limited to all requirements of the § 1915(c) of the Act waivers for individuals enrolled in the Elderly or Disabled with Consumer Direction Waiver, as amended or modified, except to the extent waived as provided for in the MOU. As a term and condition of the CCC program, the Commonwealth and participating plans shall comply with Medicaid managed care requirements under (i) Title XIX of the Act, 42 CFR Part 438 and other applicable regulations, as amended or modified, except to the extent specified in the MOU; and (ii) the three-way contract.

[C. Sunset clause. Consistent with the MOU, the Commonwealth Coordinated Care regulations (12VAC30-121) shall expire effective with the termination of the approved MOU.]

12VAC30-121-20. Definitions.

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

"Action" or "adverse decision" means, consistent with 42 CFR 438.400, a decision by the participating plan, subcontractor, service provider, or Department of Medical Assistance Services that constitutes a denial or limited authorization of a service authorization request, including (i) type or level of service; (ii) reduction, suspension, or termination of a previously authorized service; (iii) failure to act on a service request; (iv) denial in whole or in part of a payment for a covered service; (v) failure by the participating plan to render a decision within the required timeframes; or (vi) denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network.

"Appellant" means an applicant for or recipient of Medicaid benefits who seeks to challenge an action taken by the participating plan regarding eligibility for services and payment determinations.

"Capitation payment" means a payment the department makes periodically to a participating plan on behalf of each enrollee enrolled under a contract with that participating plan for the provision of services under the state plan and waivers, regardless of whether the enrollee receives services during the period covered by the payment.

"Capitation rate" means the monthly amount payable to the participating plan per enrollee for the provision of contract services. The participating plan shall accept the established capitation rates paid each month by the department and CMS as payment in full for all Medicaid and Medicare services to be provided pursuant to the three-way contract and all associated administrative costs, pending final recoupment, reconciliation, sanctions, or payment of quality withhold amounts as detailed in the MOU and the three-way contract.

"Care management" means the collaborative, person-centered process that assists enrollees in gaining access to needed health care services and includes (i) assessing for and planning of health care services; (ii) linking the enrollee to services and supports identified in the plan of care; (iii) working with the enrollee directly for the purpose of locating, developing, or obtaining needed health care services and resources; (iv) coordinating health care services and service planning with other agencies, providers, and family members involved with the enrollee; (v) making collateral contacts to promote the implementation of the plan of care and community integration; (vi) monitoring to assess ongoing progress and ensuring services are delivered; and (vii) education and counseling that guides the enrollee and develops a supportive relationship that promotes the plan of care.

"Centers for Medicare and Medicaid Services" or "CMS" means the federal agency of the U.S. Department of Health and Human Services that is responsible for the administration of Titles XVIII, XIX, and XXI of the Social Security Act.

"Commonwealth Coordinated Care," "CCC," or "CCC program" means the program for the Virginia Medicare-Medicaid Financial Alignment Demonstration Model.

"Covered services" means the set of required services offered by the participating plan as set forth in the three-way contract.

"Cultural competency" means understanding those values, beliefs, and needs that are associated with an enrollee's age, gender identity, sexual orientation, or racial, ethnic, or religious background. Cultural competency (i) includes a set of competencies that are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities and (ii) is based on the premise of respect for the enrollee and his existing cultural differences and on an implementation of a trust-promoting method of inquiry and assistance.

"Demonstration" means the capitated model under the Medicare-Medicaid Financial Alignment Demonstration Model as authorized by the Centers for Medicare and Medicaid Services and as set out in the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) and authorized under § 1115A of the Social Security Act.

"Department of Medical Assistance Services," "department," or "DMAS" means the Virginia Department of Medical Assistance Services, the single state agency for the Medicaid program in Virginia that is responsible for implementation and oversight of the demonstration.

"Disenroll" or "disenrollment" means the process of changing enrollment from one participating plan to another participating plan or opting out of the demonstration

altogether but shall not include ending eligibility in the Medicare or Medicaid programs.

"Division" or "Appeals Division" means the Appeals Division of the Department of Medical Assistance Services.

"Effective date of enrollment" means the date on which a participating plan's coverage begins for an enrollee.

"Elderly or Disabled with Consumer Direction Waiver" or "EDCD Waiver" means, as provided in Part IX (12VAC30-120-900 et seq.) of Waivered Services (12VAC30-120), the CMS-approved waiver that covers a limited range of community support services offered to enrollees who are elderly or have a disability and meet Virginia nursing facility level of care criteria as set out in 12VAC30-60-300, 12VAC30-60-303, and 12VAC30-60-307.

"Enrollee appeal" means an enrollee's request for review of a participating plan's coverage or payment determination. In accordance with 42 CFR 438.400, a Medicaid-based appeal is defined as a request for review of an action, as defined in this section. An appeal is an enrollee's challenge to the actions regarding services, benefits, and reimbursement provided by the participating plan, its service providers, or the Department of Medical Assistance Services. Enrollees or providers or other individuals acting on behalf of enrollees and with the enrollee's written consent may appeal adverse decisions to the participating plan and to DMAS (for Medicaid covered services) after the participating plan's internal appeals process is exhausted.

"Enrollee communications" means the materials designed to communicate to enrollees the plan benefits, policies, processes, and enrollee rights. Enrollee communications includes pre-enrollment, post-enrollment, and operational materials.

"Enrollment" means the completion of approved enrollment forms by or on behalf of an eligible person and assignment of an enrollee to a participating plan by DMAS in accordance with federal law.

"Evidence of coverage" or "EOC" means a document prepared by the Medicare-Medicare plan and provided to the enrollee that is consistent with the requirements of 42 CFR 438.10, 42 CFR 422.11, and 42 CFR 423.128 and includes information about all the services covered by that plan.

"Expedited appeal" means the process by which DMAS must respond to an appeal by an enrollee if a denial of care decision and the subsequent internal appeal by a participating plan may jeopardize life, health, or the ability to attain, maintain, or regain maximum function.

"External appeal" means an appeal, subsequent to the participating plan appeal decision, to the state fair hearing process for Medicaid-based adverse decisions or to the Medicare process for Medicare-based adverse decisions. The department's external appeal decision shall be binding upon the participating plan and not subject to further appeal by the participating plan.

"Fee-for-service" or "FFS" means the traditional health care payment system in which physicians and other providers receive a payment for each service they provide.

"Final decision" means a written determination by a hearing officer that is binding on DMAS, unless modified during or after the judicial process, and that may be appealed to the local circuit court.

"Good cause" means to provide sufficient cause or reason for failing to file a timely appeal or for missing a scheduled appeal hearing.

"Health risk assessment" or "HRA" means a comprehensive assessment of an enrollee's medical, psychosocial, cognitive, and functional status in order to determine his medical, behavioral health, long-term care services and supports, and social needs.

"Hearing" means an informal evidentiary proceeding conducted by a DMAS hearing officer during which an enrollee has the opportunity to present his concerns with or objections to the participating plan's internal appeal decision.

"Hearing officer" means an impartial decision maker who conducts evidentiary hearings for enrollee appeals on behalf of the department.

"Interdisciplinary care team" or "ICT" means a team of professionals who collaborate, either in person or through other means, with the enrollee to develop and implement (employing both medical and social models of care) a plan of care that meets the enrollee's medical, behavioral health, long-term care services and supports, and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and social workers, as may be appropriate for the enrollee's medical diagnoses and health condition, comorbidities, and community support needs.

"Intermediate sanctions" means sanctions that may be imposed on a Medicare-Medicaid plan such as civil money penalties, appointment of temporary management, permission for individuals to terminate enrollment in the Medicare-Medicaid plan without cause, suspension or default of all enrollment of individuals, and suspension of payment to the Medicare-Medicaid plan for individuals enrolled pursuant to 42 USC § 1396u-2(e)(2).

"Internal appeal" means an enrollee's initial request to the participating plan for review of the participating plan's coverage or payment determination.

"Long-term services and supports" or "LTSS" means a variety of services and supports that (i) help elderly enrollees and enrollees with disabilities who need assistance to perform activities of daily living and instrumental activities of daily living to improve the quality of their lives and (ii) are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. Examples of these activities include assistance with bathing, dressing, and other basic activities of

daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation.

"Medicaid" means the program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

"Medically necessary" means (i) for Medicare, services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member and (ii) for Virginia Medicaid, an item or service provided for the diagnosis or treatment of a patient's condition consistent with community standards of medical practice and in accordance with Part IX (12VAC30-130-600 et seq.) of 12VAC30-130. Furthermore, services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Virginia Medicaid.

"Medicare" means Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people younger than 65 years of age who have certain disabilities, and people with end stage renal disease or amyotrophic lateral sclerosis.

"Medicare Part A" means hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

"Medicare Part B" means insurance that helps cover medically necessary services such as doctor's services, outpatient care, durable medical equipment, home health services, other medical services, and some preventive services.

"Medicare Part C" or "Medicare Advantage" means a plan that (i) provides all of an enrollee's Medicare Part A and Medicare Part B coverage; (ii) may offer extra coverage, such as vision, hearing, dental, or health and wellness programs; and (iii) may include Medicare prescription drug coverage (Part D).

"Medicare Part D" means Medicare prescription drug coverage.

"Memorandum of understanding" or "MOU" means the Memorandum of Understanding between the Centers for Medicare and Medicaid Services (CMS) and the Commonwealth of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (5/2013), which is the document that sets out the mutually agreed to understanding of this program between CMS and DMAS.

"Minimum data set" or "MDS" means part of the federally-mandated process for assessing enrollees receiving care in certified skilled nursing facilities in order to record their overall health status, regardless of payer source.

"Money Follows the Person" or "MFP" means a demonstration project administered by DMAS that is designed to create a system of long-term services and supports that better enable enrollees to transition from certain long-term care institutions into the community.

"Network" means doctors, hospitals, or other health care providers that participate or contract with a participating plan and, as a result, agree to accept a mutually-agreed upon payment amount or fee schedule as payment in full for covered services that are rendered to eligible enrollees.

"Nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing care facility, or nursing facility, whether freestanding or a portion of a freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the Social Security Act, as amended, and § 32.1-137 of the Code of Virginia.

"Participating plan," "Medicare-Medicaid plan," or "MMP" means a health plan that is selected to participate in Virginia's Medicare-Medicaid Financial Alignment Demonstration Model and that is a party to the three-way contract with CMS and DMAS.

"Passive enrollment" means an enrollment process through which an eligible enrollee is enrolled by DMAS or its vendor into a participating plan, when not otherwise affirmatively electing one plan following a minimum 60-day advance notification that includes the opportunity to make another enrollment decision or opt out of the demonstration prior to the enrollment effective date.

"Plan of care" or "POC" means a plan, primarily directed by the enrollee and family members of the enrollee as appropriate with the assistance of the enrollee's interdisciplinary care team to meet the enrollee's medical, behavioral health, long-term care services and supports, and social needs.

"Preadmission screening" means the process to (i) evaluate the functional, medical or nursing, and social support needs of enrollees referred for preadmission screening; (ii) assist enrollees in determining what specific services the enrollees need; (iii) evaluate whether a service or a combination of existing community services are available to meet the needs of the enrollees; and (iv) refer enrollees to the appropriate entity for either Medicaid-funded nursing facility services or home and community-based care for those enrollees who meet the criteria for nursing facility level of care.

"Preadmission screening team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to § 32.1-330 of the Code of Virginia.

"Previously authorized" means, in relation to continuation of benefits, as described in 42 CFR 438.420, a prior approved course of treatment. "Previously authorized" is further clarified in 12VAC30-121-150.

"Privacy" means the requirements established in (i) the Health Insurance Portability and Accountability Act of 1996 and implementing regulations, (ii) Medicaid regulations,

including 42 CFR 431.300 through 42 CFR 431.307, and (iii) relevant Virginia privacy laws.

"Provider appeal" means an appeal filed by a Medicare, Medicaid, or other service provider that has already provided a service and has received an action regarding payment or audit result.

"Remand" means the return of a case by the hearing officer to the participating plan for further review, evaluation, and action.

"Remote patient monitoring" means monitoring a patient remotely and is often used for patients with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases, or the need for anticoagulation treatment. Remote patient monitoring must be agreed to by the enrollee. Examples of remote patient monitoring activities include transferring vital signs such as weight, blood pressure, blood sugar, and heart rate from the enrollee to the physician's office.

"Representative" means an attorney or other individual who has been authorized to represent an enrollee pursuant to this chapter.

"Reverse" means to overturn the participating plan's action and internal appeal decision and to direct that the participating plan fully approve the amount, duration, and scope of requested services.

"Secretary" means the Secretary of the U.S. Department of Health and Human Services.

"Social Security Act" means the federal act codified through Chapter 7 of Title 42 of the United States Code that established social insurance programs including Medicare and Medicaid.

"State fair hearing" means the DMAS evidentiary hearing process for enrollees as administered by the Appeals Division of DMAS.

"State Plan for Medical Assistance" or "State Plan" means the comprehensive written statement submitted to CMS by DMAS describing the nature and scope of the Virginia Medicaid program and giving assurance that the program will be administered in conformity with the requirements, standards, procedures, and conditions for obtaining federal financial participation. DMAS has the authority to administer such State Plan for the Commonwealth pursuant to the authority of the § 32.1-325 of the Code of Virginia.

"Sustain" means to uphold the participating plan's appeal decision.

"Targeted case management" or "TCM" means the Medicaid-funded State Plan case management service provided by private providers for enrollees with substance use disorders or developmental disabilities and by community services boards or behavioral health authorities for enrollees with behavioral health disorders or intellectual disabilities. TCM encompasses both referral and transition management and clinical services such as monitoring, self-management support, and medication review and adjustment. TCM is separate from "care management" as defined in the MOU.

"Three-way contract" means the three-way agreement between CMS, DMAS, and a participating plan specifying the terms and conditions pursuant to which a participating plan shall participate in the CCC program.

"Vulnerable subpopulation" means, at a minimum, individuals from the following groups: (i) individuals who are enrolled in the Elderly or Disabled with Consumer Direction Waiver (12VAC30-120-900 et seq.); (ii) individuals who have either intellectual or developmental disabilities, or both; (iii) individuals who have cognitive or memory problems, or both, (e.g., dementia and traumatic brain injury); (iv) individuals with physical or sensory disabilities; (v) individuals who are residing in nursing facilities; (vi) individuals who have serious and persistent mental illness or illnesses; (vii) individuals who have end stage renal disease; and (viii) individuals who have complex or multiple chronic health conditions, or both.

"Withdraw" means the enrollee or the enrollee's representative makes a written request for the department to terminate the appeal process without a final decision on the merits.

12VAC30-121-30. Selected localities.

A. The demonstration shall operate in specific regions within the Commonwealth.

B. The department and CMS will implement the demonstration in Central Virginia, Northern Virginia, Roanoke, Tidewater, and Western/Charlottesville regions.

C. Under the demonstration, DMAS will conduct a regional phase in. Phase I will impact Central Virginia and Tidewater. Phase II will impact Western/Charlottesville, Northern Virginia, and Roanoke.

D. Participating plans must cover all eligible enrollees in all localities within the region or regions in which such plans participate.

12VAC30-121-40. Eligible enrollees.

A. Medicaid-eligible enrollees who meet the following qualifications may be eligible to be enrolled in the demonstration:

1. Individuals who are 21 years of age or older at the time of enrollment;

2. Individuals who are entitled to benefits under Medicare Part A, enrolled under Medicare Part B and Part D, and who are receiving full Medicaid benefits. This includes enrollees participating in the EDCD Waiver and those residing in nursing facilities;

3. Individuals who reside in a program region; and

4. Individuals who do not meet any of the exclusions identified in 12VAC30-121-45.

B. Individuals who have been excluded from the CCC program, for any reason, shall be permitted to opt in to the

CCC program once the reason for their exclusion no longer exists.

12VAC30-121-45. Individuals excluded from enrollment.

Individuals who meet at least one of the following criteria shall be excluded from the CCC program:

1. Individuals who are younger than 21 years of age.

2. Individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements. "Spend down" means when a Medicaid applicant meets all Medicaid eligibility requirements other than income, Medicaid eligibility staff conduct a medically needy calculation that compares the enrollee's income to a medically needy income limit for a specific period of time referred to as the "budget period" (not to exceed six months). When a Medicaid applicant's incurred medical expenses equal the spend down amount, the applicant is eligible for full benefit Medicaid for the remainder of the spend down budget period.

3. Individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full-benefit Medicaid beneficiaries. These individuals may receive Medicaid coverage for the following: (i) Medicare monthly premiums for Medicare Part A, Medicare Part B, or both (carved-out payment); (ii) coinsurance, copayment, and deductible for Medicare-allowed services; and (iii) Medicaid-covered services, including those that are not covered by Medicare. These individuals may include:

a. Qualified Medicare beneficiaries;

b. Special low income Medicare beneficiaries;

c. Qualified disabled working individuals; or

d. Qualifying individuals.

4. Individuals who are inpatients in state mental hospitals, including Catawba Hospital, Central State Hospital, Eastern State Hospital, Hiram W. Davis Medical Center, Northern Virginia Mental Health Institute, Piedmont Geriatric Hospital, Southern Virginia Mental Health Institute, Southwestern Virginia Mental Health Institute, and Western State Hospital.

5. Individuals who are residents of state hospitals, intermediate care facilities for individuals with intellectual disabilities, residential treatment facilities, or long-stay hospitals. Long-stay hospitals are specialty Medicaid facilities that serve enrollees who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that an acute care hospital is designed to provide.

6. Individuals who are participating in federal waiver programs for home and community-based Medicaid coverage other than the EDCD Waiver (e.g., Individual and Family Developmental Disabilities Support, Intellectual Disability, Day Support, Technology Assisted, and Alzheimer's Assisted Living waivers).

7. Individuals receiving hospice services at the time of enrollment. If an enrollee enters hospice while enrolled in the CCC program, he shall be disenrolled from the CCC program. If an enrollee opts out of the CCC program, he shall not be permitted to reenter it. If an enrollee does not opt out but leaves the CCC program due to a CCC program action, he shall be permitted to return to the CCC program upon leaving hospice. However, participating plans shall refer these individuals to the preadmission screening team for additional LTSS if not already in place.

8. Individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment into the CCC program. However, an enrollee who develops ESRD while enrolled in the CCC program shall remain in the CCC program unless he opts out. If he opts out, the enrollee shall not be permitted to opt back into the CCC program.

9. Individuals with other comprehensive group or enrollee health insurance coverage, other than full benefit Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program.

10. Individuals who have a Medicaid eligibility period that is less than three months.

11. Individuals who have a Medicaid eligibility period that is only retroactive.

12. Individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

13. Individuals enrolled in the Money Follows the Person program.

14. Individuals residing outside of the CCC program coverage regions.

15. Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE). However, PACE participants may enroll in the CCC program if they choose to disenroll from their PACE providers.

16. Individuals participating in the CMS Independence at Home demonstration or any other demonstration that bases some or all payment on achievement of Medicare savings.

12VAC30-121-50. Enrollment process.

Individuals who qualify as indicated in 12VAC30-121-40 and are not excluded as provided in 12VAC30-121-45 shall be enrolled as follows, except if they choose to opt out:

1. Enrollees shall be passively assigned to a participating plan based on their previous six months of Medicaid claims history prior to preassignment using the rules in this order of priority:

a. Enrollees in a nursing facility shall be preassigned to a participating plan that includes the enrollee's nursing facility in its provider network.

b. Enrollees in the EDCD Waiver shall be assigned to a participating plan that includes the enrollee's current adult day health care provider in the MMP's existing provider network.

c. If more than one participating plan network includes the nursing facility or adult day health care provider used by an enrollee, the enrollee shall be assigned to the participating plan with which he has previously been assigned in the past six months.

d. If the enrollee has no history of previous participating plan assignment, he shall be randomly assigned to a participating plan in which his provider participates.

e. In the absence of the conditions in subdivisions 1 a through 1 d of this section, enrollees shall be preassigned to a participating plan with whom they have previously been assigned within the past six months. The order of assignment shall be first the Medicare plan and secondly the Medicaid participating plan.

2. Utilizing passive enrollment, eligible enrollees shall be notified of their right to select among contracted participating plans no fewer than 60 days prior to the effective date of enrollment.

3. Eligible enrollees shall receive a notice that indicates the participating plan to which they have been preassigned. The notice shall have instructions for the enrollee to contact the department's contracted enrollment facilitator to (i) accept the preassigned participating plan; (ii) actively select a different participating plan that is operating in the enrollee's region; or (iii) to opt out of the program.

An enrollment facilitator is an independent entity contracted with DMAS that (i) enrolls beneficiaries in the plan, (ii) is responsible for the operation and documentation of a toll-free helpline, (iii) educates enrollees about the plan, (iv) assists with and tracks enrollee grievance resolutions, and (v) may market and perform outreach to potential enrollees.

4. If an enrollee does not select a participating plan, he shall be passively enrolled into the preassigned participating plan.

5. Prior to the effective date of their plan enrollment, enrollees who would be passively enrolled shall have the opportunity to opt out and shall receive sufficient notice and information with which to do so.

6. All enrollment effective dates shall be prospective. Enrollment shall be effective the first day of the month following an enrollee's request to enroll, so long as the request is received on or before five days before the end of the month. Active enrollment requests, including requests to change among participating plans, received later than five days before the end of the month shall become effective the first of the second month following the request. Passive enrollment shall be effective not sooner than 60 days after enrollee notification.

7. Disenrollment from participating plans and transfers between participating plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these enrollees shall continue through the end of the month. All disenrollment requests shall be effective the first day of the month following an enrollee's request to disenroll from the CCC program.

8. CMS and DMAS monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations, and CMS policies for the purpose of identifying any inappropriate or illegal marketing practices. As part of this analysis, CMS and DMAS monitor any unusual shifts in enrollment by enrollees identified for passive enrollment into a particular participating plan to a Medicare Advantage plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS or DMAS, or both, may require corrective action. Any illegal marketing practices shall be referred to appropriate agencies for investigation.

9. As mutually agreed upon in the three-way contract, CMS and DMAS shall utilize an independent third party entity to facilitate all enrollments into the participating plans.

10. Participating plan enrollments, transfers, and opt-outs shall become effective on the same day for both Medicare and Medicaid. For enrollees who lose Medicaid eligibility during a month, coverage and federal financial participation will continue through the end of the month in which Medicaid eligibility is ended.

12VAC30-121-60. (Reserved.)

12VAC30-121-70. Covered services.

A. CMS and DMAS shall contract with participating plans that demonstrate the capacity to provide directly, or by subcontracting with other qualified entities, the full continuum of medically necessary Medicare and Medicaid covered services to enrollees, in accordance with (i) the MOU; (ii) CMS guidance; (iii) the three-way contract; (iv) 42 CFR Part 422, 42 CFR Part 423, and 42 CFR Part 438; (v) the requirements in the State Plan for Medical Assistance, including any applicable State Plan amendments and § 1915(c) of the Act; (vi) the EDCD Waiver (12VAC30-120-900 et seq.); (vii) 42 USC § 1395y; (viii) Part IX (12VAC30-130-600 et seq.) of 12VAC30-130; (ix) the Americans with Disabilities Act; and (x) the Olmstead decision (Olmstead v. L.C. (98-536) 527 U.S. 581 (1999)). Furthermore, as set out in 42 CFR 440.230, services shall be sufficient in amount, duration, and scope to reasonably achieve their purpose. Participating plans shall be required to provide services in a way that preserves all protections to enrollees and provides

enrollees with coverage to at least the same extent provided by Medicare and Medicaid. Where there is overlap between Medicare and Medicaid benefits, coverage and rules shall be delineated in the three-way contract. Participating plans shall be required to abide by the more generous of the applicable Medicare, Medicaid, or the combined Medicare-Medicaid standard.

B. With the exception of those services that are specifically carved out of this program as set out in 12VAC30-121-83, the required covered services shall include:

1. Medicare Part A, Part B, and Part D services.

2. Medically necessary procedures. Participating plans will be responsible for medically necessary procedures, including but not limited to, the following:

a. CPT codes, from the Current Procedural Terminology, Revised 2015, as published by the American Medical Association, billed for dental services performed as a result of a dental accident (i.e., an accident that damages the mouth).

b. Preparation of the mouth for radiation therapy, maxillary or mandibular frenectomy when not related to a dental procedure, orthognathic surgery to attain functional capacity, and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.

c. Anesthesia and hospitalization for medically necessary services.

d. At the option of the MMP, additional flexible dental services for program enrollees.

e. For participants of auxiliary grants, case management services. Although not widely used, this service is included as part of the annual reassessment screening process for assisted living recipients and will be provided under fee-for-service.

3. Acute care services provided under the State Plan for Medical Assistance as found in 12VAC30-50, and further defined by DMAS written regulations, policies, and instructions, except as otherwise modified or excluded in the three-way contract.

4. Covered LTSS provided under the EDCD Waiver, including adult day health care, personal care (agency and consumer-directed options), personal emergency response services with or without medication monitoring, respite care (agency and consumer-directed options), transition coordination, and transition services.

5. The integrated formulary for prescription drugs, including Medicaid-covered drugs that are excluded by Medicare Part D. Participating plans shall also cover drugs covered by Medicare Part A and Part B. In all respects, unless stated otherwise in the MOU or the three-way contract, Medicare Part D requirements continue to apply.

6. Nursing facility services as defined in 42 CFR 440.40. Skilled nursing level care may be provided in a long-term care facility without a preceding acute care inpatient stay for enrollees enrolled in the program when the provision of this level of care can avert the need for an inpatient hospital stay.

7. Participating plans shall be permitted to use and reimburse telehealth for Medicare and Medicaid services as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access, and increase timely interventions. Participating plans shall also encourage the use of telehealth to promote community living and improve access to behavioral health services. Participating plans shall be permitted to use telehealth in rural and urban settings and reimburse for store-and-forward applications. Participating plans shall also have the ability to cover remote patient monitoring. All telehealth and remote patient monitoring activities shall be compliant with Health Insurance Portability and Accountability Act requirements and as further set out in the three-way contract.

For the purposes of this section:

a. "Store-and-forward" means when prerecorded images, such as x-rays, video clips, and photographs, are captured and then forwarded to and retrieved, viewed, and assessed by a provider at a later time. Some common applications include (i) teledermatology, where digital pictures of a skin problem are transmitted and assessed by a dermatologist; (ii) teleradiology, where x-ray images are sent to and read by a radiologist; and (iii) teleretinal imaging, where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy; and

b. "Telehealth" means the real time or near real time two-way transfer of data and information using an interactive audio and video connection for the purposes of medical diagnosis and treatment.

8. Health risk assessments.

a. Each enrollee shall receive and be an active participant in a timely, comprehensive assessment completed by the participating plan's care management team. All health risk assessment tools are subject to approval by DMAS. Assessment domains shall include the following: medical, psychosocial, functional, cognitive, and behavioral health. Relevant and comprehensive data sources, including the enrollee, providers, family, caregivers, and additional significant others as may be designated by the enrollee, shall be used by the participating plans in order to thoroughly complete the assessment.

b. During the first year of the program, any enrollee meeting any one of the following criteria shall receive a health risk assessment to be completed no later than 60 days from the onset of the enrollee's enrollment:

(1) Individuals enrolled in the EDCD Waiver;

(2) Individuals with intellectual or developmental disabilities;

(3) Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);

(4) Individuals with physical or sensory disabilities;

(5) Individuals residing in nursing facilities;

(6) Individuals with serious and persistent mental illnesses;

(7) Individuals with end stage renal disease; and

(8) Individuals with complex or multiple chronic health conditions.

c. During the first year of the program and for all other enrollees, health risk assessments shall be conducted within 90 days of enrollment.

d. Health risk assessments for individuals enrolled in the EDCD Waiver and for individuals residing in nursing facilities shall be conducted face to face. The health risk assessments for individuals residing in nursing facilities shall also incorporate the MDS.

e. During subsequent years of the program, individuals enrolled in the EDCD Waiver shall receive a health risk assessment within 30 days of enrollment and all other enrollees shall receive a health risk assessment within 60 days of enrollment.

12VAC30-121-73. Level of care determinations.

A. Initial level of care (LOC) determinations shall be conducted by hospitals and local preadmission screening teams as defined in § 32.1-330 of the Code of Virginia.

B. Participating plans shall ensure that LOC annual reassessments are conducted timely for EDCD Waiver participants (minimum within 365 days of the last annual reassessment or as the participant's needs change). Participating plans shall conduct annual face-to-face assessments for continued nursing facility LOC eligibility requirements for the EDCD Waiver.

C. The plans shall establish criteria including health status changes (i.e., the triggering events that precipitate a need for reassessment, including a change in the ability to perform activities of daily living and instrumental activities of daily living) for reassessments to be performed prior to the reassessment.

D. The LOC annual reassessment shall include all the elements required by the three-way contract for enrollees who are in the EDCD Waiver.

E. LOC annual reassessments for EDCD Waiver enrollees shall be performed by providers with the following qualifications: (i) a registered nurse (RN) licensed in Virginia with at least one year of experience as an RN; (ii) a social worker licensed in Virginia; or (iii) an individual who holds at least a bachelor's degree in a health or human services field and has at least two years of experience working with individuals who are elderly or have disabilities, or both.

F. Participating plans shall ensure that quarterly and annual assessments are conducted timely for nursing facility residents based on the MDS process and shall work cooperatively with nursing facilities to provide information regarding the completion of the assessments for continued nursing facility placement.

G. Participating plans shall communicate annual LOC reassessment data for EDCD Waiver enrollees and nursing facility residents to DMAS according to requirements in the three-way contract.

12VAC30-121-75. Plans of care.

A. Participating plans shall develop a person-centered plan of care (POC) for each enrollee. The POC shall be tailored to the individual enrollee's needs and be agreed to and signed by the enrollee or the enrollee's employer of record. An employer of record is the person who performs the functions of the employer in the consumer-directed model of service delivery and may be the individual enrolled in the waiver, a family member, caregiver, or other person.

B. Participating plans shall implement a person-centered and culturally competent POC development process. Participating plans shall also develop a process that will incorporate but not duplicate targeted case management for applicable enrollees.

C. During the first year of the CCC program, participating plans shall ensure that plans of care for all enrollees are completed within 90 days of the enrollee's enrollment. Participating plans shall honor all existing plans of care and service authorizations until the authorization ends or 180 days from an enrollee's enrollment, whichever is sooner. For EDCD Waiver individuals, the plan of care shall be developed and implemented by the participating plan no later than the end date of any existing service authorization.

D. During subsequent years of the program, participating plans shall ensure that plans of care are developed within the following timeframes:

1. Within 30 days of enrollment for EDCD Waiver participants;

2. Within 60 days of enrollment for vulnerable subpopulations (excluding EDCD Waiver participants); and

3. Within 90 days of enrollment for all other enrollees.

E. Participating plans shall incorporate information from the Uniform Assessment Instrument and the LOC determinations into the POCs for individuals in the EDCD Waiver.

F. Participating plans shall develop a process for obtaining nursing facility MDS data and incorporating that information into the POC. Participating plans shall ensure that nursing facility residents who wish to move to the community will be referred to the preadmission screening teams or the MFP

program. If the individual enrolls in the MFP program, he will be disenrolled from the CCC program.

G. Participating plans shall develop a process for addressing health, safety (including minimizing risk), and welfare of the enrollee in the POC.

H. The POC shall contain the following:

1. Prioritized list of enrollee's concerns, needs, and strengths;

2. Attainable goals, outcome measures, and target dates selected by the enrollee or caregiver, or both;

3. Strategies and actions, including interventions and services to be implemented, the providers responsible for specific interventions and services, and the frequency of the interventions and strategies;

4. Progress noting success, barriers, or obstacles;

5. Enrollee's informal support network and services;

6. Back up plans as appropriate for EDCD Waiver enrollees using personal care and respite services in the event that the scheduled provider or providers are unable to provide services;

7. Determined need and plan to access community resources and noncovered services;

8. Enrollee choice of services (including consumer direction) and service providers; and

9. Elements included in the DMAS-97AB form, (which can be downloaded from https://www.virginiamedicaid.dmas.virginia.gov/wps/portal) for individuals enrolled in the EDCD Waiver.

I. Participating plans shall ensure that reassessments and POC reviews are conducted:

1. By the POC anniversary for vulnerable subpopulations (excluding EDCD Waiver participants and nursing facility residents) and all other enrollees;

2. By the POC anniversary, not to exceed 365 days for EDCD Waiver enrollees (must be face to face); and

3. Following MDS guidelines and timeframes for quarterly and annual POC development for nursing facility residents.

J. Participating plans shall ensure that POCs are revised based on triggering events, such as hospitalizations or significant changes in health or functional status.

12VAC30-121-78. Interdisciplinary care team.

A. For each enrollee, participating plans shall support an interdisciplinary care team (ICT) to ensure the integration of the enrollee's medical, behavioral health, substance abuse/use, LTSS, and social needs. The team's focus shall be person centered, built on the enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competency, and dignity.

B. Participating plans ICTs shall employ both medical and social models of care, as appropriate for the enrollee's documented needs.

C. Participating plan members of the team shall agree to participate in approved training on the person-centered planning processes, cultural competency, accessibility and accommodations, independent living and recovery, Americans with Disabilities Act/Olmstead requirements, and wellness principles, along with other required training as specified by the Commonwealth. Participating plans shall offer training to additional members of the team such as primary care providers and specialists, as appropriate.

D. If an enrollee is receiving targeted case management services, the participating plans shall develop a mechanism to include the targeted case manager as a member of the ICT.

E. If an enrollee is identified to be eligible to transition into the community through the Department of Justice Settlement Agreement (Case: 3:12-CV-00059-JAG, available at http://www.dbhds.virginia.gov/settlement/FullAgreement.pdf), the participating plan's ICT shall collaborate with the locality's community services board (CSB) or behavioral health authority, as appropriate, and the Department of Behavioral Health and Developmental Services to successfully transition the enrollee into the community. The enrollee's CSB case manager shall participate as a part of the participating plan's ICT to monitor the enrollee's service needs. If the enrollee transitions into either the Individuals with Intellectual Disabilities Waiver or Developmental Disability Waiver, the enrollee shall be disenrolled from the CCC program. If the enrollee transitions to the EDCD Waiver, the enrollee may remain in the CCC program.

12VAC30-121-80. Requirements for care coordination.

A. The participating plan shall provide person-centered care management functions for all enrollees.

B. All enrollees shall have access to the following supports depending on their needs and preferences; however, care management for vulnerable subpopulations shall include the items described in subdivisions 6 through 12 of this subsection:

1. A single, toll-free point of contact for all questions;

2. Ability to develop, maintain, and monitor the POC;

3. Assurance that referrals result in timely appointments;

4. Communication and education regarding available services and community resources;

5. Assistance developing self-management skills to effectively access and use services;

6. Assistance in receiving needed medical and behavioral health services, preventive services, medications, LTSS, social services, and enhanced benefits; this includes (i) setting up appointments, (ii) in-person contacts as appropriate, (iii) strong working relationships between care managers and physicians; (iv) evidence-based enrollee

education programs, and (v) arranging transportation as needed;

7. Monitoring of functional and health status;

8. Seamless transitions of care across specialties and care settings;

9. Assurance that enrollees with disabilities have effective communication with health care providers and participate in making decisions with respect to treatment options;

10. Connecting enrollees to services that promote community living and help avoid premature or unnecessary nursing facility placements;

11. Coordination with social service agencies (e.g., local departments of health, local departments of social services, and community services boards) and referrals for enrollees to state, local, and other community resources; and

12. Collaboration with nursing facilities to promote adoption of evidence-based interventions to reduce avoidable hospitalizations and to include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the nursing facility benefit.

C. Participating plans shall develop innovative arrangements to provide care management such as:

1. Partnering or contracting, or both, with entities, such as community services boards, adult day care centers, and nursing facilities, that currently perform care management and offer support services to individuals eligible for the program;

2. Medical homes;

3. Sub-capitation, such as payment arrangement where the MMP pays its contracted providers on a capitated basis rather than a fee-for-service basis;

4. Shared savings; and

5. Performance incentives.

D. Participating plans and DMAS shall collaborate to avoid duplication of care management services provided under the program.

E. Participating plans shall be required to use one statewide F/EA to manage the F/EA services for individuals using consumer direction. The F/EA, or fiscal/employer agent, is an organization (i) operating under § 3504 of the IRS Code, IRS Revenue Procedure 70-6, and IRS Notice 2003-70 and (ii) that has a separate federal employer identification number used for the sole purpose of filing federal employment tax forms and payments on behalf of program enrollees who are receiving consumer-directed services.

12VAC30-121-83. Carved out services.

A. Carved-out services are the subset of Medicaid and Medicare covered services for which the participating plan shall not be fiscally responsible under the CCC program.

B. The services are carved out services of the CCC program and are provided under the fee-for-service system:

1. Abortions, induced (this service shall be provided under limited circumstances, e.g., when the life of the mother is endangered);

2. Targeted case management services; and

3. Dental services (in limited cases).

12VAC30-121-85. Flexible benefits.

A. Flexible benefits are those that participating plans may elect to offer to their enrollees.

B. Examples of such benefits are (i) annual physical examinations, (ii) meal benefits, (iii) preventive and comprehensive dental services for adults, (iv) eye examinations, (v) prescription eyeglasses, (vi) hearing examinations, (vii) hearing aids, and (viii) reduced or eliminated drug co-pays.

12VAC30-121-90. Capitation payment rates.

A. Capitation rates and payment rules shall be established in the MOU and three-way contract and may be adjusted by state or federal regulatory changes.

B. If other state or federal statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and DMAS to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

C. Any and all costs incurred by the participating plan in excess of the capitation payment shall be borne in full by the plan.

D. Additional costs shall not be balance billed to the plan's enrollees.

E. Out-of-network reimbursement rules.

1. In an urgent or emergency situation, participating plans shall reimburse an out-of-network provider of emergency or urgent care at the Medicare or Medicaid FFS rate applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. For example, where this service would traditionally be covered under Medicare FFS, the participating plan shall pay out-of-network providers the lesser of provider charges or the Medicare FFS.

2. During the 180-day transition period as outlined in the MOU, the participating plan shall honor existing service authorization timeframes and continue to provide access to the same services and providers at the same levels and rates of Medicare or Medicaid FFS payment (not to exceed 180 days) as enrollees were receiving prior to entering the participating plan.

3. Beyond this 180-day period, the participating plan will be required to offer single-case out-of-network agreements to providers that are currently serving enrollees and are

willing to continue serving them at the participating plan's in-network payment rate, but are not willing to accept new patients or enroll in the participating plan's network.

12VAC30-121-100. (Reserved.)

12VAC30-121-110. Cost sharing requirements.

A. For the purposes of this section, "cost sharing" means copayments, coinsurance, or deductibles paid by an enrollee when receiving medical services.

B. Participating plans shall not charge a Medicare Part C or Part D premium nor assess any cost sharing for Medicare Part A and Part B services.

C. For drugs and pharmacy products (including those covered by both Medicare Part D and Medicaid), participating plans shall be permitted to charge co-pays to enrollees currently eligible to make such payments consistent with co-pays applicable for Medicare and Medicaid drugs, respectively. Co-pays charged by participating plans for Part D drugs shall not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

D. Patient pay requirements, which are applicable to long-term care services, shall be detailed in the contract between CMS, DMAS, and the participating plans.

E. Participating plans shall not assess any cost sharing for DMAS services, beyond the pharmacy cost sharing amounts allowed under Medicaid coverage rules.

F. No enrollee may be balance billed by any provider for any reason for covered services or flexible benefits (see 12VAC30-121-90).

12VAC30-121-120. (Reserved.)

12VAC30-121-130. Access standards.

A. Participating plans shall have the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to enrollees, in accordance with the MOU, CMS guidance, and the three-way contract.

B. Network adequacy. State Medicaid standards shall be utilized for long-term services and supports or for other services for which Medicaid is exclusively responsible for payment, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more stringent. Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to the more stringent of the applicable Medicare and Medicaid standards.

C. Participating plans shall ensure that they maintain a network of providers that is sufficient in number, mix of primary care and specialty providers, and geographic distribution to meet the complex and diverse needs of the anticipated number of enrollees in the service area as defined by CMS for Medicare and defined by DMAS for Medicaid.

D. For services for which Medicaid is the traditional primary payer (including LTSS and community mental health and substance abuse services), each enrollee shall have a choice of at least two providers of each covered service type located within no more than 30 minutes travel time from any enrollee in urban areas unless the participating plan has a DMAS-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours).

E. The participating plan shall ensure that each enrollee shall have a choice of at least two providers of each covered service type located within no more than 60 minutes travel time from any enrollee in rural areas unless the participating plan has a DMAS-approved alternative time standard.

F. DMAS shall require contractual agreements between nursing facilities and participating plans. Participating plans shall be required to contract with any nursing facility that is eligible to participate in Medicare and Medicaid and is willing to accept the participating plan payment rates and contract requirements for the time duration of the demonstration period. Participating plans shall make payments for services directly to nursing facilities.

G. For any covered services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, or minimum number of providers or facilities), the participating plan shall meet the Medicare requirements.

12VAC30-121-140. Medicare-Medicaid plans having low performance.

A. As long as the MMP is determined by DMAS to meet all plan selection requirements in the three-way contract, an interested organization that (i) is an outlier in the CMS past performance analysis for the upcoming contract year, (ii) has a low performance indicator (LPI) on the Medicare Plan Finder website for the upcoming year, or (iii) both may still qualify to offer CCC program services.

B. Such MMPs shall not be eligible to receive new enrollees (via passive enrollment) until the MMP is either (i) no longer considered by CMS to be a past performance outlier or (ii) no longer has an LPI on the Medicare Plan Finder.

C. CMS or DMAS, or both, shall determine if an MMP is eligible to accept passive enrollment prior to the scheduled date of execution of the three-way contract.

D. An MMP that is ineligible to receive passive enrollment shall only be able to enroll (i) individuals who are currently enrolled in another Medicare or Medicaid managed care plan sponsored by the same organization and (ii) individuals who opt in to the organization's MMP.

12VAC30-121-145. Sanctions for noncompliance.

A. DMAS may impose intermediate sanctions, which may include any of the types described in subsection C of this section, or terminate the MMP's contract if the MMP:

1. Fails substantially to provide medically necessary items and services that are required under law or under the MMP's contract with DMAS to be provided under the contract;

2. Imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this chapter;

3. Acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this chapter, or engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical conditions or histories indicate a need for substantial future medical services;

4. Misrepresents or falsifies information that is furnished to either:

a. The Secretary or DMAS under this chapter; or

b. To an enrollee, potential enrollee, or a health care provider under this chapter; or

5. Fails to comply with the applicable requirements of 42 USC § 1396b(m)(2)(A)(x).

B. DMAS may also impose such intermediate sanction against an MMP if DMAS determines that the MMP distributed directly or through any agent or independent contractor marketing materials in violation of 12VAC30-121-250.

C. The sanctions shall be as follows:

1. Civil money penalties.

a. Except as provided in subdivision 1 b, 1 c, or 1 d of this subsection, not more than $25,000 for each determination under subsection A of this section.

b. With respect to a determination under subdivision A 3 or A 4 a of this section, not more than $100,000 for each such determination.

c. With respect to a determination under subdivision A 2 of this section, double the excess amount charged in violation, and the excess amount charged shall be deducted from the penalty and returned to the individual concerned.

d. Subject to subsection 1 b of this subsection, with respect to a determination under subdivision A 3 of this section, $15,000 for each individual not enrolled as a result of a practice described in subdivision A 3.

2. The appointment of temporary management.

a. To oversee the operation of the MMP upon a finding by DMAS that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees;

b. To assure the health of the organization's enrollees if there is a need for temporary management while there is an orderly termination or reorganization of the organization; or

c. To make improvements to remedy the violations found under subsection A of this section except that temporary management under this subdivision 2 may not be terminated until DMAS has determined that the MMP has the capability to ensure that the violations shall not recur.

3. Requiring the MMP (i) to permit individuals enrolled with the MMP to terminate enrollment without cause and (ii) to notify such individuals of such right to terminate enrollment.

4. Suspension or default of all enrollment of individuals under this chapter after the date the Secretary or DMAS notifies the MMP of a determination of a violation of any requirement of 42 USC § 1396b(m) or this section.

5. Suspension of payment to the entity under this chapter for individuals enrolled after the date the Secretary or DMAS notifies the MMP of such a determination and until the Secretary or DMAS is satisfied that the basis for such determination has been corrected and is not likely to recur.

12VAC30-121-150. Continuity of care.

A. As provided by the MOU and the three-way contract, participating plans shall be required to provide or arrange for all medically necessary services, whether by subcontract or by single-case agreement, in order to meet the health care and support needs of their enrollees.

B. Participating plans shall allow enrollees to maintain their current Medicaid providers (including out-of-network providers) for up to 180 days from enrollment. Participating plans shall also allow enrollees to maintain their previously authorized Medicaid services, including frequency and payment rate, for the duration of the prior authorization or for 180 days from enrollment, whichever is less. This shall not apply to enrollees residing in a nursing facility on the date of each region's program implementation.

C. Enrollees in nursing facilities at the time of program implementation may remain in the facility, or move to another nursing facility, as long as they continue to meet DMAS criteria for nursing facility care. In order to move to another nursing facility, the enrollee or his family, or both as may be appropriate, has to agree to the move.

D. During the 180-day period specified in subsection B of this section, change from an existing Medicaid provider can only occur in the following circumstances:

1. The enrollee requests a change;

2. The provider chooses to discontinue providing services to an enrollee as currently allowed by Medicare or Medicaid;

3. The participating plan, CMS, or DMAS identifies provider performance issues that affect the enrollee's health and welfare; or

4. The provider is excluded from participation in Medicare and Medicaid under state or federal exclusion requirements pursuant to the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website. Immediately report in writing to DMAS any exclusion information discovered to (i) DMAS, ATTN: Program Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219 or (ii) providerexclusion@dmas.virginia.gov.

E. Out-of-network reimbursement rules. See 12VAC30-121-90 for requirements for out-of-network reimbursement.

12VAC30-121-160. (Reserved.)

12VAC30-121-170. Model of care.

A. For the purposes of this section, "model of care" or "MOC" means a comprehensive plan that (i) describes the plan's population; (ii) identifies measurable goals for providing high quality care and improving the health of the enrolled population; (iii) describes the plan's staff structure and care management roles; (iv) describes the interdisciplinary care team and the system for disseminating the model of care to plan staff and network providers; and (v) contains other information designed to ensure that the plans provide services that meet the needs of enrollees.

B. All participating plans in partnership with contracted providers shall implement an evidence-based model of care. Participating plans shall meet all CMS MOC standards for Special Needs Plans as well as additional requirements established in the contract by the Commonwealth**.** The Virginia-specific MOC elements are in addition to CMS elements; likewise, the CMS and DMAS reviews and approvals are separate processes. Participating plans shall obtain approvals from both CMS and DMAS before a MOC is considered final and approved.

C. Participating plans shall be permitted to cure problems with their MOC submissions after their initial submissions. Participating plans with MOCs scoring below 85% shall have the opportunity to improve their scores based on CMS and DMAS feedback on the elements and factors that require improvement. At the end of the review process, MOCs that do not meet CMS standards for approval will not be eligible for selection as participating plans. CMS standards for approval are issued to the states and made available on the DMAS website at http://www.dmas.virginia.gov/Content_atchs/altc/altc-fp1.pdf.

12VAC30-121-180. (Reserved.)

12VAC30-121-190. State fair hearing process.

A. Notwithstanding the provisions of 12VAC30-110-10 through 12VAC30-110-370, the provisions of this section govern state fair hearings for individuals enrolled in the CCC program.

B. The Appeals Division maintains an appeals and fair hearings system for enrollees (also referred to as appellants) to challenge appeal decisions rendered by participating plans in response to enrollee appeals of actions related to Medicaid services. Exhaustion of the participating plan's appeals process is a prerequisite to filing for a state fair hearing with the department. Appellants who meet criteria for a state fair hearing shall be entitled to a hearing before a department hearing officer.

C. The participating plan shall conduct an internal appeal hearing, pursuant to 42 CFR Part 431 Subpart E, 42 CFR Part 438, and 12VAC30-110-10 through 12VAC30-110-370, and issue a written decision that includes its findings and information regarding the appellant's right to file an appeal with DMAS for a state fair hearing for Medicaid appeals.

D. Enrollees must be notified in writing of the participating plan's internal appeals process:

1. At the time of the request for services;

2. With the evidence of coverage; and

3. Upon receipt of a notice of action from the participating plan.

E. Enrollees must be notified in writing of their right to an external appeal upon receipt of the participating plan's internal appeal decision.

F. An appellant shall have the right to representation by an attorney or other individual of his choice at all stages of an appeal.

1. For those appellants who wish to have a representative, a representative shall be designated in a written statement that is signed by the appellant whose Medicaid benefits were adversely affected. If the appellant is physically unable to sign a written statement, the division shall allow a family member or other person acting on the appellant's behalf to be the representative. If the appellant is mentally unable to sign a written statement, the division shall require written documentation that a family member or other person has been appointed or designated as his legal representative.

2. If the representative is an attorney or a paralegal working under the supervision of an attorney, a signed statement by such attorney or paralegal that he is authorized to represent the appellant prepared on the attorney's letterhead shall be accepted as a designation of representation.

3. A member of the same law firm as a designated representative shall have the same rights as the designated representative.

4. An appellant may revoke representation by another person at any time. The revocation is effective when the department receives written notice from the appellant.

G. Any [~~written~~] communication from an enrollee or his representative that clearly expresses that he wants to present his case to a reviewing authority shall constitute an appeal request.

1. This communication should explain the basis for the appeal of the participating plan's internal appeal decision.

2. The enrollee or his representative may examine witnesses or documents, or both; provide testimony; submit evidence; and advance relevant arguments during the hearing.

H. Appeals to the state fair hearing process shall be made to the DMAS Appeals Division [~~in writing, with the exception of expedited appeals, and may be made~~] via U.S. mail, fax transmission, [~~hand delivery~~ telephone, email], [in person,] or [through other commonly available] electronic [~~transmission~~ means].

I. Expedited appeals referenced in subsection L of this section may be filed by telephone, or any of the methods set forth in subsection H of this section.

J. Participating plans shall continue benefits while the participating plan's appeal or the state fair hearing is pending when all of the following criteria are met:

1. The enrollee or representative files the appeal within 10 calendar days of the mail date of the participating plan's internal appeal decision;

2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. The services were ordered by an authorized provider;

4. The original period covered by the initial authorization has not expired; and

5. The enrollee requests continuation of benefits.

K. After the final resolution and if the final resolution of the appeal is adverse to the enrollee (e.g., participating plan's internal appeal is upheld), the participating plan may recover the costs of services furnished to the enrollee while the appeal was pending, to the extent they were furnished solely because of the pending appeal.

L. The department shall maintain an expedited process for appeals when an appellant's treating provider certifies that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. Expedited appeal decisions shall be issued as expeditiously as the enrollee's health condition requires, but no later than three business days after the agency receives a fair hearing request on an appeal decision to uphold denial of a service that it determines meets the criteria for expedited resolution.

12VAC30-121-195. Appeal timeframes.

A. Appeals to the Medicaid state fair hearing process must be filed with the DMAS Appeals Division within 60 days of the date of the participating plan's internal appeal decision, unless the time period is extended by DMAS upon a finding of good cause in accordance with state fair hearing regulations.

B. It is presumed that appellants will receive the participating plan's internal appeal decision five days after the participating plan mails it unless the appellant shows that he did not receive the notice within the five-day period.

C. A request for appeal on the grounds that the participating plan has not acted with reasonable promptness in response to an internal appeal request may be filed at any time until the participating plan has acted.

D. The date of filing shall be the date the request is postmarked if mailed, or the date the request is received by the department if delivered other than by mail.

E. Documents postmarked on or before a time limit's expiration shall be accepted as timely.

F. In computing any time period under these regulations, the day of the act or event from which the designated period of time begins to run shall be excluded and the last day included. If a time limit would expire on a Saturday, Sunday, or state or federal holiday, it shall be extended until the next regular business day.

G. An extension of the 60-day period for filing a request for appeal may be granted for good cause shown. Examples of good cause include, but are not limited to, the following situations:

1. Appellant was seriously ill and was prevented by illness from contacting DMAS;

2. The participating plan's decision was not sent to the appellant. The plan may rebut this claim by evidence that the decision was mailed to the appellant's last known address or that the decision was received by the appellant;

3. Appellant sent the request for appeal to another government agency or another division within DMAS that is not the Appeals Division in good faith within the time limit; or

4. Unusual or unavoidable circumstances prevented a timely filing.

H. During the first year of the program, appeals shall be heard and decisions issued within 90 days of the postmark date (if delivered by U.S. mail) or receipt date (if delivered by any method other than U.S. mail).

I. The timeframes for issuing decisions will change to 75 days (during the second year of the program), and 30 days (during the third year of the program and thereafter).

J. Exceptions to standard appeal resolution timeframes. Decisions may be issued beyond the standard appeal resolution timeframes when the appellant or his representative requests or causes a delay. Decisions may also be issued beyond the standard appeal resolution timeframe when any of the following circumstances exist:

1. The appellant or representative requests to reschedule or continue the hearing;

2. The appellant or representative provides good cause for failing to keep a scheduled hearing appointment, and the Appeals Division reschedules the hearing;

3. Inclement weather, unanticipated system outage, or the department's closure that prevents the hearing officer's ability to work;

4. Following a hearing, the hearing officer orders an independent medical assessment as described in 12VAC30-121-210;

5. The hearing officer leaves the hearing record open after the hearing in order to receive additional evidence or argument from the appellant;

6. The hearing officer receives additional evidence from a person other than the appellant or his representative and the appellant requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence; or

7. The Appeals Division determines that there is a need for additional information and documents how the delay is in the appellant's best interest.

K. For delays requested or caused by an appellant or his representative the delay date for the decision will be calculated as follows:

1. If an appellant or representative requests or causes a delay within 30 days of the request for a hearing, the 90-day time limit will be extended by the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

2. If an appellant or representative requests or causes a delay within 31 to 60 days of the request for a hearing, the 90-day time limit will be extended by 1.5 times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

3. If an appellant or representative requests or causes a delay within 61 to 90 days of the request for a hearing, the 90-day time limit will be extended by two times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

L. Post hearing delays requested or caused by an appellant or representative (e.g., requests for the record to be left open) will result in a day-for-day delay for the decision date. The department shall provide the appellant and representative with written notice of the reason for the decision delay and the delayed decision date, if applicable.

12VAC30-121-200. Prehearing decisions.

A. If the Appeals Division determines that any of the conditions as described in this subsection exist, a hearing will not be held, and the appeal process shall be terminated.

1. A request for appeal may be invalidated if:

a. It was not filed within the time limit imposed by 12VAC30-121-195 or extended pursuant to 12VAC30-121-195 J, and the hearing officer sends a letter to the appellant for an explanation as to why the appeal request was not filed timely, and

(1) The appellant did not reply to the hearing officer's request within 10 calendar days for an explanation that met good cause criteria, or

(2) The appellant did reply and the hearing officer had sufficient facts to determine that the reply did not meet good cause criteria pursuant to 12VAC30-121-195.

b. The individual who filed the appeal (filer) is not the appellant, or parent of a minor appellant, and the hearing officer sends a letter to the filer requesting proof of his authority to appeal on behalf of the appellant, and

(1) The filer did not reply to the hearing officer's request for authorization to represent the appellant within 10 calendar days, or

(2) The filer did reply and the hearing officer determined that the authorization submitted was insufficient to allow the filer to represent the appellant under the provisions of 12VAC30-121-190 F.

2. A request for appeal may be administratively dismissed if:

a. The participating plan's internal appeals process was not exhausted prior to the enrollee's request for a state fair hearing;

b. The issue of the appeal is not related to the participating plan's internal appeal decision;

c. The action being appealed was not taken by DMAS or the participating plan;

d. The services denied or terminated were Medicare covered services; or

e. The sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries.

3. An appeal case may be closed if:

a. The Appeals Division schedules a hearing and sends a written schedule letter notifying the appellant or his representative of the date, time, and location of the hearing; the appellant or his representative failed to appear at the scheduled hearing; and the hearing officer sends a letter to the appellant for an explanation as to why he failed to appear, and

(1) The appellant did not reply to the hearing officer's request within 10 calendar days for an explanation that met good cause criteria, or

(2) The appellant did reply and the hearing officer determined that the reply did not meet good cause criteria.

b. The Appeals Division sends a written schedule letter requesting that the appellant or his representative provide a telephone number at which he can be reached for a telephonic hearing, and the appellant or his representative failed to respond within 10 calendar days to the hearing officer's request for a telephone number at which he could be reached for a telephonic hearing.

c. The appellant or his representative withdraws the appeal request [~~in writing~~]. [If the appeal request is withdrawn orally, the Appeals Division shall (i) record the individual's statement and telephonic signature and (ii) send the affected individual written confirmation, via regular mail or electronic notification, in accordance with the individual's election.]

d. The participating plan approves the full amount, duration, and scope of services requested.

e. The evidence in the record shows that the participating plan's decision was clearly in error and that the case should be fully resolved in the appellant's favor.

B. The appellant shall have no opportunity to seek judicial review except in cases where the hearing officer receives and analyzes a response from the appellant or representative as described in subdivisions A 1 a (2), A 1 b (2), and A 3 a (2), and subsection C of this section.

C. Remand to the participating plan. If the hearing officer determines from the record, without conducting a hearing, that the case might be resolved in the appellant's favor if the participating plan obtains and develops additional information, documentation, or verification, the hearing officer may remand the case to the participating plan for action consistent with the hearing officer's written instructions pursuant to 12VAC30-121-210 I.

D. A letter shall be sent to the appellant or his representative that explains the determination made on his appeal.

12VAC30-121-210. Hearing process and final decision.

A. All hearings must be scheduled at a reasonable time, date, and place, and the appellant and his representative shall be notified in writing at least 15 days before the hearing.

1. The hearing location will be determined by the Appeals Division.

2. A hearing shall be rescheduled at the appellant's request no more than twice unless compelling reasons exist.

3. Rescheduling the hearing at the appellant's request will result in automatic waiver of the 90-day (or 75-day or 30-day) deadline for resolution of the appeal. The delay date for the decision will be calculated as set forth in 12VAC30-121-195 K.

B. The hearing shall be conducted by one or more hearing officers or other impartial individuals who have not been directly involved in the initial determination of the action in question or in the participating plan's appeal decision process. The hearing officer shall review the complete record for all participating plan decisions that are properly appealed, conduct informal, fact-gathering hearings, evaluate evidence presented, research the issues, and render a written final decision.

C. Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeal record shall be made accessible to the appellant and representative at a convenient place and time before the date of the hearing, as well as during the hearing. The appellant and his representative may examine the content of the appellant's case file and all documents and records the department will rely on at the hearing except those records excluded by law.

D. Appellants who require the attendance of witnesses or the production of records, memoranda, papers, and other documents at the hearing may request in writing the issuance of a subpoena. The request must be received by the department at least 10 working days before the scheduled hearing. Such request shall (i) include the witness's or respondent's name, home and work addresses, county or city of work and residence, and (ii) identify the sheriff's office that will serve the subpoena.

E. The hearing officer shall conduct the hearing; decide on questions of evidence, procedure, and law; question witnesses; and assure that the hearing remains relevant to the issue or issues being appealed. The hearing officer shall control the conduct of the hearing and decide who may participate in or observe the hearing.

F. Hearings shall be conducted in an informal, nonadversarial manner. The appellant or his representative shall have the right to bring witnesses, establish all pertinent facts and circumstances; present an argument without undue interference, and question or refute the testimony or evidence, including the opportunity to confront and cross-examine agency representatives.

G. The rules of evidence shall not strictly apply. All relevant, nonrepetitive evidence may be admitted, but the probative weight of the evidence will be evaluated by the hearing officer.

H. The hearing officer may leave the hearing record open for a specified period of time after the hearing in order to receive additional evidence or argument from the appellant or his representative.

1. The hearing officer may order an independent medical assessment when the appeal involves medical issues, such as a diagnosis, an examining physician's report, or a

medical review team's decision, and the hearing officer determines that it is necessary to have an assessment by someone other than the person or team who made the original decision (e.g., to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence). A medical assessment ordered pursuant to this regulation shall be at the department's expense and shall become part of the record.

2. The hearing officer may receive evidence that was not presented by either party if the record indicates that such evidence exists, and the appellant or his representative requests to submit it or requests that the hearing officer secure it.

3. If the hearing officer receives additional evidence from an entity other than the appellant or his representative, the hearing officer shall send a copy of such evidence to the appellant and his representative and give the appellant or his representative the opportunity to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence.

4. Any additional evidence received will become a part of the hearing record, but the hearing officer must determine whether or not it will be used in making the decision.

I. After conducting the hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision that either sustains or reverses the participating plan's action or remands the case to the participating plan for further evaluation consistent with his written instructions. Some decisions may be a combination of these dispositions. The hearing officer's final decision shall be considered as the department's final administrative action pursuant to 42 CFR 431.244(f). The final decision shall include:

1. Identification of the issue or issues;

2. Relevant facts, to include a description of the procedural development of the case;

3. Conclusions of law, regulations, and policy that relate to the issue or issues;

4. Discussions, analysis of the accuracy of the participating plan's decision, conclusions, and hearing officer's decision;

5. Further action, if any, to be taken by the participating plan to implement the decision;

6. The deadline date by which further action must be taken; and

7. A cover letter informing the appellant and his representative of the hearing officer's decision. The letter must indicate that the hearing officer's decision is final, and that the final decision may be appealed directly to circuit court.

J. A copy of the hearing record shall be forwarded to the appellant and his representative with the final decision.

K. An appellant who disagrees with the hearing officer's final decision described in this section may seek judicial review pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and Rules of the Supreme Court of Virginia, Part Two A. Written instructions for requesting judicial review must be provided to the appellant or his representative with the hearing officer's decision, and upon request by the appellant or representative.

12VAC30-121-220. Division appeal records.

A. No person shall take from the division's custody any original record, paper, document, or exhibit that has been certified to the division except as the Appeals Division director or his designee authorizes, or as may be necessary to furnish or transmit copies for other official purposes.

B. Information in the appellant's record can be released only to the appellant, his authorized representative, the participating plan, other entities for official purposes, and other persons named in a release of information authorization signed by an appellant or his representative.

C. The fees to be charged and collected for any copy of division records will be in accordance with Virginia's Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia) or other controlling law.

D. When copies are requested from records in the division's custody, the required fee shall be waived if the copies are requested in connection with an enrollee's own appeal.

12VAC30-121-230. Provider appeals.

A. The Appeals Division maintains an appeal process for enrolled providers of Medicaid services who have rendered services and are requesting to challenge a participating plan's internal appeal of an adverse decision regarding payment. The participating plan's internal appeal process is a prerequisite to filing for an external appeal to the department's appeal process. The appeal process is available to (i) enrolled Medicaid service providers that have rendered services and have been denied payment in whole or part for Medicaid covered services and (ii) enrolled Medicaid service providers who have received a Notice of Program Reimbursement or overpayment demand from the department or its contractors.

B. Department provider appeals shall be conducted in accordance with the department's provider appeal regulations (12VAC30-20-500 et seq.), § 32.1-325 et seq. of the Code of Virginia, and the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

C. The department's external appeal decision shall be binding upon the participating plan and not subject to further appeal by the participating plan.

D. If the provider is successful in its appeal, then the MMP shall reimburse it for the appealed issue.

12VAC30-121-240. (Reserved.)

12VAC30-121-250. Marketing and enrollee communication standards for participating plans.

A. Participating plans shall be subject to rules governing their marketing and enrollee communications as specified under §§ 1851(h) and 1932(d)(2) of the Social Security Act; 42 CFR 422.111, 42 CFR 422.2260 et seq., 42 CFR 423.120(b) and (c), 42 CFR 423.128, and 42 CFR 423.2260 et seq.; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual).

1. Participating plans shall not be allowed to market directly to potential enrollees. Instead, plans may participate in group marketing events, provide general audience materials (such as general circulation brochures, and media and billboard advertisements), and provide responses to individual-initiated requests for enrollment.

2. Participating plans shall receive prior approval of all marketing and enrollee communications materials except those that are exempt pursuant to 42 CFR 422.2262(b) and 42 CFR 423.2262(b).

3. Participating plans shall not begin marketing activity earlier than 90 days prior to the effective date of enrollment for the contract year.

B. At a minimum, participating plans will provide current and prospective enrollees the following materials, subject to the rules regarding content and timing of enrollee receipt as applicable under § 1851(h) of the Social Security Act, 42 CFR 422.111, 42 CFR 422.2260 et seq., 42 CFR 423.120(b) and (c), 42 CFR 423.128, 42 CFR 423.2260 et seq., 42 CFR 438.10, 42 CFR 438.104, the three-way contract, and the Medicare Marketing Guidelines.

C. Notification of formulary changes. The requirement at 42 CFR 423.120(b)(5) that participating plans provide at least 60 days advance notice regarding Medicare Part D formulary changes also applies to participating plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (12VAC30-121)

Agency or Consumer Direction Provider Plan of Care, DMAS-97A/B (rev. 3/10)

Commonwealth Coordinated Care Enrollment Application Form

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-121)

Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (Commonwealth Coordinated Care), signed May 21, 2013

Medical Marketing Guidelines, Centers for Medicare & Medicaid Services, revised June 17, 2014

VA.R. Doc. No. R15-3786; Filed June 19, 2017, 7:55 a.m.

TITLE 14. INSURANCE

STATE CORPORATION COMMISSION

Proposed Regulation

REGISTRAR'S NOTICE: The State Corporation Commission is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency that by the Constitution is expressly granted any of the powers of a court of record.

Title of Regulation: **14VAC5-170. Rules Governing Minimum Standards for Medicare Supplement Policies (amending 14VAC5-170-30, 14VAC5-170-60, 14VAC5-170-85, 14VAC5-170-150; adding 14VAC5-170-87).**

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

Public Hearing Information: A public hearing will be held upon request.

Public Comment Deadline: August 10, 2017.

Agency Contact: James Young, Policy Advisor, Policy and Compliance Division, Bureau of Insurance, State Corporation Commission, 1300 East Main Street, 6th Floor, Richmond, VA 23219, mailing address: P.O. Box 1157, Richmond, VA 23218, telephone (804) 371-9612, FAX (804) 371994, or email james.young@scc.virginia.gov.

Summary:

The proposed amendments (i) conform the regulations to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which prohibits the sale of Medigap policies that cover Part B deductibles to newly eligible Medicare beneficiaries, defined as those individuals who have attained age 65 years on or after January 1, 2020, or first become eligible for Medicare due to age, disability, or end-stage renal disease on or after January 1, 2020, and (ii) update deductible amounts.

AT RICHMOND, JUNE 20, 2017

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. INS-2017-00141

Ex Parte: In the matter of Amending
the Rules Governing Minimum Standards
for Medicare Supplement Policies

ORDER TO TAKE NOTICE

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

The rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code are set forth in Title 14 of the Virginia Administrative Code. A copy may also be found at the Commission's website: http://www.scc.virginia.gov/case.

The Bureau of Insurance ("Bureau") has submitted to the Commission proposed amendments to rules set forth in Chapter 170 of Title 14 of the Virginia Administrative Code entitled Rules Governing Minimum Standards for Medicare Supplement Policies, 14 VAC 5-170-10 et seq. ("Rules"), which amend the Rules at 14 VAC 5-170-30, 14 VAC 5-170-60, 14 VAC 5-170-85, and 14 VAC 5-170-150, and add a new Rule at 14 VAC 5-170-87.

The amendments to the Rules are necessary to conform to the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), which was signed into law on April 16, 2015. This piece of legislation prohibits the sale of Medigap policies that cover Part B deductibles to "newly eligible" Medicare beneficiaries, defined as those individuals who have attained age 65 on or after January 1, 2020, or first become eligible for Medicare due to age, disability, or end-stage renal disease on or after January 1, 2020. In addition to the changes made pursuant to MACRA, the proposed amendments include updated deductible amounts.

NOW THE COMMISSION is of the opinion that the proposed amendments submitted by the Bureau to amend the Rules at 14 VAC 5-170-30, 14 VAC 5-170-60, 14 VAC 5-170-85, and 14 VAC 5-170-150, and add a new Rule at 14 VAC 5-170-87, should be considered for adoption.

Accordingly, IT IS ORDERED THAT:

(1) The proposal to amend the Rules at 14 VAC 5-170-30, 14 VAC 5-170-60, 14 VAC 5-170-85, and 14 VAC 5-170-150, and add a new Rule at 14 VAC 5-170-87, is attached hereto and made a part hereof.

(2) All interested persons who desire to comment in support of or in opposition to, or request a hearing to consider the amendments to the Rules, shall file such comments or hearing request on or before August 10, 2017, with Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218. Interested persons desiring to submit comments electronically may do so by following the instructions at the Commission's website: http://www.scc.virginia.gov/case. All comments shall refer to Case No. INS-2017-00141.

(3) If no written request for a hearing on the proposal to amend the Rules is received on or before August 10, 2017, the Commission, upon consideration of any comments submitted in support of or in opposition to the proposal, may amend the Rules.

(4) The Bureau forthwith shall provide notice to all health insurance issuers licensed to issue policies of accident and sickness insurance, subscription contracts, or evidences of coverage in this Commonwealth and to all interested persons.

(5) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with the proposal to amend the Rules, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations.

(6) The Commission's Division of Information Resources shall make available this Order and the attached proposed amendment to the Rules on the Commission's website: http://www.scc.virginia.gov/case.

(7) The Bureau shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of Ordering Paragraph (4) above.

(8) This matter is continued.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Kiva B. Pierce, Assistant Attorney General, Division of Consumer Counsel, Office of the Attorney General, 202 N. 9th Street, 8th Floor, Richmond, Virginia 23219-3424; and a copy hereof shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie S. Blauvelt.

14VAC5-170-30. Definitions.

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

"1990 standardized Medicare supplement benefit plan," "1990 standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 30, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date that are not replaced by the issuer at the request of the insured.

"2010 standardized Medicare supplement benefit plan," "2010 standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance

issued with an effective date for coverage on or after June 1, 2010.

"Applicant" means:

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy, the proposed certificateholder.

"Attained age rating" means a premium structure under which premiums are based on the covered individual's age at the time of application of the policy or certificate, and for which premiums increase based on the covered individual's increase in age during the life of the policy or certificate.

"Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in this Commonwealth.

"Certificate" means any certificate delivered or issued for delivery in this Commonwealth under a group Medicare supplement policy.

"Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Community rating" means a premium structure under which premium rates are the same for all covered individuals of all ages in a given area.

"Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual did not have a break in coverage greater than 63 days.

"Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or Part B of Title XVIII of the Social Security Act of 1935 (Medicare) (42 USC § 1395 et seq.);

4. Title XIX of the Social Security Act of 1935 (Medicaid) (42 USC § 1396 et seq.), other than coverage consisting solely of benefits under § 1928;

5. Chapter 55 of Title 10 of the United States Code ~~(CHAMPUS)~~ (TRICARE) (10 USC§§ 1071-1107);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under the Federal Employees Health Benefits Act of 1959 (5 USC §§ 8901-8914);

9. A public health plan as defined in federal regulation; and

10. A health benefit plan under § 5(e) of the Peace Corps Act of 1961 (22 USC § 2504(e)).

"Creditable coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical expense insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

"Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; and

3. Such other similar, limited benefits as are specified in federal regulations.

"Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and

2. Hospital indemnity or other fixed indemnity insurance.

"Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplement health insurance as defined under § 1882(g)(1) of the Social Security Act of 1935 (42 USC § 1395ss);

2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code (10 USC §§ 1071-1107); and

3. Similar supplemental coverage provided to coverage under a group health plan.

"Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in the Employee Retirement Income Security Act of 1974 (29 USC § 1002).

"Insolvency" means when an issuer, duly licensed to transact an insurance business in this Commonwealth in accordance with the provisions of Chapter 10, 41, 42 or 43, respectively, of Title 38.2 of the Code of Virginia, is determined to be insolvent and placed under a final order of liquidation by a court of competent jurisdiction.

"Issue age rating" means a premium structure based upon the covered individual's age at the time of purchase of the

policy or certificate. Under an issue age rating structure, premiums do not increase due to the covered individual's increase in age during the life of the policy or certificate.

"Issuer" includes insurance companies, fraternal benefit societies, corporations licensed pursuant to Chapter 42 of Title 38.2 of the Code of Virginia to offer health services plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this Commonwealth Medicare supplement policies or certificates.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Act (42 USC § 1395 et seq.), as then constituted or later amended.

"Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in § 1859 (42 USC § 1395w-28(b)(1) of the Social Security Act, and includes:

1. Coordinated care plans ~~which~~ that provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

3. Medicare Advantage private fee-for-service plans.

"Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of health service plans or health maintenance organizations, other than a policy issued pursuant to a contract under § 1876 of the federal Social Security Act of 1935 (42 USC § 1395 et seq.) or an issued policy under a demonstration project specified in 42 USC § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan that provides benefits pursuant to an agreement under § 1833(a)(1)(A) of the Social Security Act.

"Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

"Prestandardized Medicare supplement benefit plan," "prestandardized benefit plan" or "prestandardized plan" means a group or individual policy of Medicare supplement insurance issued prior to July 30, 1992.

"Secretary" means the Secretary of the ~~United States~~ U.S. Department of Health and Human Services.

14VAC5-170-60. Minimum benefit standards for prestandardized Medicare supplement benefits plan policies or certificates issued for delivery prior to July 30, 1992.

A. No policy or certificate may be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits ~~which~~ that are not inconsistent with these standards.

B. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for a loss incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

4. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

a. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

b. Be ~~cancelled~~ canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

5. a. Except as authorized by the State Corporation Commission, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

b. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subdivision 5 d of this subsection, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(1) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those

contained in the terminated group Medicare supplement policy; and

(2) An individual Medicare supplement policy ~~which~~ that provides only such benefits as are required to meet the minimum standards as defined in 14VAC5-170-75 C.

c. If membership in a group is terminated, the issuer shall:

(1) Offer the certificateholder the conversion opportunities described in subdivision 5 b of this subsection; or

(2) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

d. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

7. If a Medicare supplement policy is modified to eliminate an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 USC § 1395w-101), the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

C. Minimum benefit standards.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

3. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

5. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

6. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible ~~$100~~ established by the Centers for Medicare and Medicaid Services;

7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

14VAC5-170-85. Standard plans for 2010 standardized Medicare supplement policies delivered on or after June 1, 2010.

A. The following standard plans are applicable to all Medicare supplement benefit plan policies or certificates delivered or issued for delivery in this Commonwealth with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010, remain subject to the requirements of 14VAC5-170-80.

B. 1. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in 14VAC5-170-75 C.

2. If an issuer makes available any of the additional benefits described in 14VAC5-170-75 D, or offers standardized benefit Plans K or L (as described in subdivisions F 8 and F 9 of this section), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subdivision 1 of this subsection, a policy form or certificate form containing either standardized benefit Plan C (as described in subdivision F 3 of this section) or standardized benefit Plan F (as described in subdivision F 5 of this section).

C. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this Commonwealth, except as may be permitted in subsection G of this section and 14VAC5-170-90.

D. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in 14VAC5-170-30. Each benefit shall be structured in accordance with the format provided in 14VAC5-170-75 C and D; or, in the case of plans K or L, in subdivision F 8 or F 9 of this section and list the benefits in the order shown. For purposes of this section, the term "structure, language, and format" means style, arrangement and overall content of a benefit.

E. In addition to the benefit plan designations required in subsection D of this section, an issuer may use other designations to the extent permitted by law.

F. Make-up of 2010 standardized benefit plans:

1. Standardized Medicare supplement benefit Plan A shall include only the basic (core) benefits as defined in 14VAC5-170-75 C.

2. Standardized Medicare supplement benefit Plan B shall include only the basic (core) benefit as defined in 14VAC5-170-75 C, plus 100% of the Medicare Part A deductible as defined in 14VAC5-170-75 D 1.

3. Standardized Medicare supplement benefit Plan C shall include only the basic (core) benefit as defined in 14VAC5-170-75 C, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in 14VAC5-170-75 D 1, 3, 4 and 6, respectively.

4. Standardized Medicare supplement benefit Plan D shall include only the basic (core) benefit as defined in 14VAC5-170-75 C, plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in 14VAC5-170-75 D 1, 3 and 6, respectively.

5. Standardized Medicare supplement benefit Plan F shall include only the basic (core) benefit as defined in 14VAC5-170-75 C, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 14VAC5-170-75 D 1, 3, 4, 5 and 6, respectively.

6. Standardized Medicare supplement benefit Plan F With High Deductible shall include only 100% of covered expenses following the payment of the annual deductible as defined in subdivision 6 b of this subsection.

a. The basic (core) benefit as defined in 14VAC5-170-75 C, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 14VAC5-170-75 D 1, 3, 4, 5 and 6, respectively.

b. The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

7. Standardized Medicare supplement benefit Plan G shall include only the basic (core) benefit as defined in 14VAC5-170-75 C, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 14VAC5-170-75 D 1, 3, 5 and 6, respectively. Effective January 1, 2020, the standardized benefit plans described in 14VAC5-170-87 D 3 (Plan G with High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

8. Standardized Medicare supplement benefit Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

a. Part A hospital coinsurance 61st through 90th days: Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

b. Part A hospital coinsurance, 91st through 150th days: Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

c. Part A hospitalization after 150 days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

d. Medicare Part A deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subdivision 8 j of this subsection;

e. Skilled nursing facility care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under

Medicare Part A until the out-of-pocket limitation is met as described in subdivision 8 j of this subsection;

f. Hospice care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subdivision 8 j of this subsection;

g. Blood: Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subdivision 8 j of this subsection;

h. Part B cost sharing: Except for coverage provided in subdivision 8 i of this subsection, coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subdivision 8 j of this subsection;

i. Part B preventive services: Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

j. Cost sharing after out-of-pocket limits: Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

9. Standardized Medicare supplement benefit Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

a. The benefits described in subdivisions 8 a, b, c and i of this subsection;

b. The benefit described in subdivisions 8 d, e, f, g and h of this subsection, but substituting 75% for 50%; and

c. The benefit described in subdivision 8 j of this subsection, but substituting $2,000 for $4,000.

10. Standardized Medicare supplement benefit Plan M shall include only the basic (core) benefit as defined in 14VAC5-170-75 C, plus 50% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in 14VAC5-170-75 D 2, 3 and 6, respectively.

11. Standardized Medicare supplement benefit Plan N shall include only the basic (core) benefit as defined in 14VAC5-170-75 C, plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in 14VAC5-170-75 D 1, 3 and 6, respectively, with copayments in the following amounts:

a. The lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

b. The lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

G. New or innovative benefits. An issuer may, with the prior approval of the commission, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

14VAC5-170-87. Standard plans for 2020 standardized Medicare supplement policies delivered to individuals newly eligible for Medicare on or after January 1, 2020.

A. This section applies only to individuals who are newly eligible for Medicare on or after January 1, 2020:

1. By reason of attaining age 65 years on or after January 1, 2020; or

2. By reason of entitlement to benefits under part A pursuant to § 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under § 226(a) of the Social Security Act on or after January 1, 2020.

B. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered, or issued for delivery in the Commonwealth as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All such policies must comply with the benefit standards contained in subsection D of this section. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of 14VAC5-170-75 and 14VAC5-170-85.

C. Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020. For purposes of this section, the reference to Plans C or F contained in 14VAC5-170-85 B 2 is deemed a reference to Plan D or G, respectively.

D. The standards and requirements of 14VAC5-170-85 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible

for Medicare on or after January 1, 2020, with the following exceptions:

1. Standardized Medicare supplement benefit Plan D (previously Plan C) shall provide the benefits contained in 14VAC5-170-85 F 3 but shall not provide coverage for 100% or any portion of the Medicare Part B deductible.

2. Standardized Medicare supplement benefit Plan G (previously Plan F) shall provide the benefits contained in 14VAC5-170-85 F 5 but shall not provide coverage for 100% or any portion of the Medicare Part B deductible.

3. Standardized Medicare supplement benefit Plan G with High Deductible (previously Plan F with High Deductible) shall provide the benefits contained in 14VAC5-170-85 F 6 but shall not provide coverage for 100% or any portion of the Medicare Part B deductible; provided further that the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

E. For purposes of 14VAC5-170-105 E, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F with High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G with High Deductible), respectively.

14VAC5-170-150. Required disclosure provisions.

A. General rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age. Medicare supplement policies or certificates which are attained age rated shall include a clear and prominent statement, in at least 14 point type, disclosing that premiums will increase due to changes in age and the frequency under which such changes will occur.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have all premiums made for the policy refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person or persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services and in a type size no smaller than 12 point type. Delivery of the guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application and acknowledgement of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice requirements.

1. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the State Corporation Commission. The notice shall:

a. Include a description of revisions to the Medicare program and a description of each modification made to

the coverage provided under the Medicare supplement policy or certificate; and

b. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

3. Such notices shall not contain or be accompanied by any solicitation.

C. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 USC § 1395w-101).

D. Outline of coverage requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3. The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12 point type. All plans shall be shown on the cover page, and the ~~plan(s)~~ plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed in the following table.

Benefit Chart of Medicare Supplement Plans Sold with Effective Dates on or after June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available.

Some plans may not be available ~~in your state~~.

~~Plans E, H, I and J are no longer available for sale after June 1, 2010. [This sentence shall not appear after June 1, 2011.]~~

Plans C, F, and high deductible F are no longer available for sale to those who are newly eligible, as defined in 14VAC5-170-87, on or after January 1, 2020.

Note that the numerical figures in the following charts, including out-of-pocket limits and deductible amounts, are current as of January 1, 2018, and are subject to change.

Basic benefits:

Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood – First three pints of blood each year.

Hospice – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER

		Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	50% skilled nursing facility coinsurance	75% skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Part B deductible		Part B deductible					
				Part B excess (100%)	Part B excess (100%)				
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency			Foreign travel emergency	Foreign travel emergency
						Out-of-pocket limit ~~$4,620~~ $4,940; paid at 100% after limit reached	Out-of-pocket limit ~~$2,310~~ $2,470; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year ~~$2,000~~ $2,180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed ~~$2,000~~ $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION

Boldface Type

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this Commonwealth. [If the premium is based on attained age of the insured, include the following information:

1. When premiums will change;

2. The current premium for all ages;

3. A statement that premiums for other Medicare Supplement policies that are issue age or community rated do not increase due to changes in your age; and

4. A statement that while the cost of this policy at the covered individual's present age may be lower than the cost of a Medicare supplement policy that is based on issue age or community rated, it is important to compare the potential cost of these policies over the life of the policy.]

DISCLOSURES

Boldface Type

Use this outline to compare benefits and premiums among policies.

~~This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I and J are no longer available for sale after June 1, 2010. [This paragraph shall not appear after June 1, 2011.]~~

READ YOUR POLICY VERY CAREFULLY

Boldface Type

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

Boldface Type

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

Boldface Type

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

Boldface Type

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Boldface Type

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to 14VAC5-170-85.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the State Corporation Commission.]

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✔ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔

Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in 2016[2]					$4,960[2]	$2,480[2]				

[1] Plans F and G also have a high deductible option that require first paying a plan deductible of $2,180 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible Plan G does not cover the Medicare Part B deductible. However, high deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible. High deductible Plan G is the same as high deductible Plan F except that where the annual out-of-pocket expenses are met with Medicare Part A expenses only, any subsequent Medicare Part B deductible expense incurred by the beneficiary after the required annual out-of-pocket expenses is met may not be paid for by the high deductible Plan G.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,260	$0	~~$1,068~~ $1,260 (Part A Deductible)
61st thru 90th day	All but ~~$267~~ $315 a day	~~$267~~ $315 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $630 a day	~~$534~~ $630 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at			

least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $157.50 a day	$0	Up to ~~$133.50~~ $157.50 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ~~$135~~ $147 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,260	~~$1,068~~ $1,260 (Part A Deductible)	$0
61st thru 90th day	All but ~~$267~~ $315 a day	~~$267~~ $315 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $630 a day	~~$534~~ $630 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $157.50 a day	$0	Up to ~~$133.50~~ $157.50 a day
101st day and after	$0	$0	All Costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed ~~$135~~ $147 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,260	~~$,1068~~ $1,260 (Part A Deductible)	$0
61st thru 90th day	All but ~~$267~~ $315 a day	~~$267~~ $315 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $630 a day	~~$534~~ $630 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $157.50 a day	Up to ~~$133.50~~ $157.50 a day	$0
101st day and after	$0	$0	All Costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed ~~$135~~ $147 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	~~$135~~ $147 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$135~~ $147 of Medicare-Approved Amounts*	$0	~~$135~~ $147 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0

Durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	~~$135~~ $147 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,260	~~$1,068~~ $1,260 (Part A Deductible)	$0
61st thru 90th day	All but ~~$267~~ $315 a day	~~$267~~ $315 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $630 a day	~~$534~~ $630 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $157.50 a day	Up to ~~$133.50~~ $157.50 a day	$0
101st day and after	$0	$0	All Costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed ~~$135~~ $147 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same benefits as Plan F after ~~one has~~ you have paid a calendar year ~~$2,000~~ $2,180 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are ~~$2,000~~ $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$2,000~~ $2,180 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$2,000~~ $2,180 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,260	~~$1,068~~ $1,260 (Part A Deductible)	$0
61st thru 90th day	All but ~~$267~~ $315 a day	~~$267~~ $315 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $630 a day	~~$534~~ $630 a day	$0

Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $157.50 a day	Up to ~~$133.50~~ $157.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ~~$135~~ $147 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan F after ~~one has~~ you have paid a calendar year ~~$2,000~~ $2,180 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~$2,000~~ $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$2,000~~ $2,180 DEDUCTIBLE,** PLAN PAYS	IN ~~ADDITION~~ ADDITION TO ~~$2,000~~ $2,180 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved amounts*	$0	~~$135~~ $147 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$135~~ $147 of Medicare-Approved Amounts*	$0	~~$135~~ $147 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$2,000~~ $2,180 DEDUCTIBLE,** PLAN PAYS	IN ~~ADDITON~~ ADDITION TO ~~$2,000~~ $2,180 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	~~$135~~ $147 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G OR HIGH DEDUCTIBLE PLAN G
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,180 DEDUCTIBLE, PLAN PAYS	IN ADDITION TO $2,180 DEDUCTIBLE, YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,288	~~$1,068~~ $1,288 (Part A Deductible)	$0
61st thru 90th day	All but ~~$267~~ $322 a day	~~$267~~ $322 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $644 a day	~~$534~~ $644 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $161 a day	Up to ~~$133.50~~ $161 a day	$0
101st day and after	$0	$0	All Costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G OR HIGH DEDUCTIBLE PLAN G
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed ~~$135~~ $166 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $166 of Medicare-Approved Amounts*	$0	$0	~~$135 (Part B Deductible)~~ $166 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~$135~~ $166 of Medicare-Approved Amounts*	$0	$0	~~$135 (Part B Deductible)~~ $166 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First ~~$135~~ $166 of Medicare-Approved Amounts*	$0	$0	~~$135 (Part B deductible)~~ $166 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~$4,620~~ $4,940 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,260	~~$534~~ $630 (50% of Part A deductible)	~~$534~~ $630 (50% of Part A deductible)♦

61st thru 90th day	All but ~~$267~~ $315 a day	~~$267~~ $315 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $630 a day	~~$534~~ $630 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $157.50 a day	Up to ~~$66.75~~ $78.75 a day (50% of Part A coinsurance)	Up to ~~$66.75~~ $78.75 a day (50% of Part A coinsurance)♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance ♦

***__NOTICE:__ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever the amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

****Once you have been billed ~~$135~~ $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical			

and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts****	$0	$0	~~$135~~ $147 (Part B deductible)****♦
Preventive Benefits for Medicare covered services	Generally ~~75%~~ 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
PART B EXCESS CHARGES			
(Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of ~~$4620)*~~ $4,940)*
BLOOD			
First 3 pints	$0	50%	50%♦
Next ~~$135~~ $147 of Medicare Approved Amounts****	$0	$0	~~$135~~ $147 (Part B deductible)****♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~$4,620~~ $4,940 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*****	$0	$0	~~$135~~ $147 (Part B deductible)♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~$2,310~~ $2,470 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the

calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,260	~~$808.50~~ $945 (75% of Part A deductible)	~~$267~~ $315 (25% of Part A deductible)♦
61st thru 90th day	All but ~~$267~~ $315 a day	~~$267~~ $315 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $630 a day	~~$534~~ $630 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $157.50 a day	Up to ~~$100.13~~ $118.13 a day (75% of Part A coinsurance)	Up to ~~$33.38~~ $39.38 a day (25% of Part A coinsurance)♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charge and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

****Once you have been billed ~~$135~~ $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts****	$0	$0	~~$135~~ $147 (Part B deductible)****♦
Preventive Benefits for Medicare covered services	Generally ~~75%~~ 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of ~~$2,310)*~~ $2,470)*
BLOOD			
First 3 pints	$0	75%	25%♦
Next ~~$135~~ $147 of Medicare Approved Amounts****	$0	$0	~~$135~~ $147 (Part B deductible)♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~$2,310~~ $2,470 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*****	$0	$0	~~$135~~ $147 (Part B deductible)♦
Remainder of Medicare-Approved Amounts	80%	15%	5%♦

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,260	~~$534~~ $630 (50% of Part A deductible)	~~$534~~ $630 (50% of Part A deductible)
61st thru 90th day	All but ~~$267~~ $315 a day	~~$267~~ $315 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $630 a day	~~$534~~ $630 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $157.50 a day	Up to ~~$133.50~~ $157.50 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charge and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed ~~$135~~ $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~$135~~ $147 of Medicare Approved Amounts*	$0	$0	~~$135~~ $147 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$1,068~~ $1,260	~~$1,068~~ $1,260 (Part A deductible)	$0
61st thru 90th day	All but ~~$267~~ $315 a day	~~$267~~ $315 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~$534~~ $630 a day	~~$534~~ $630 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$133.50~~ $157.50 a day	Up to ~~$133.50~~ $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charge and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed ~~$135~~ $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the	Up to$20 per office visit and up to $50 per emergency visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency room visit is covered as a Medicare

		emergency visit is covered as a Medicare Part A expense.	Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~$135~~ $147 of Medicare Approved Amounts*	$0	$0	~~$135~~ $147 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First ~~$135~~ $147 of Medicare-Approved Amounts*	$0	$0	~~$135~~ $147 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

E. Notice regarding policies or certificates ~~which~~ that are not Medicare supplement policies.

1. Any accident and sickness insurance policy or certificate issued for delivery in this Commonwealth to persons eligible for Medicare, other than a Medicare supplement policy, a policy issued pursuant to a contract under § 1876 of the federal Social Security Act (42 USC § 1395 et seq.), a disability income policy, or other policy identified in 14VAC5-170-20 B, shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate

delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subdivision 1 of this subsection shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

F. Notice requirements for attained age rated Medicare supplement policies or certificates. Issuers of Medicare supplement policies or certificates ~~which~~ that use attained age rating shall provide a notice to all prospective applicants at the time the application is presented, and except for direct response policies or certificates, shall obtain an acknowledgement of receipt of the notice from the applicant. The notice shall be in no less than 12 point type and shall contain the information included in Appendix D. The notice shall be provided as part of, or together with, the application for the policy or certificate.

VA.R. Doc. No. R17-5121; Filed June 20, 2017, 1:47 p.m.

VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM

Final Regulation

REGISTRAR'S NOTICE: The Virginia Birth-Related Neurological Injury Compensation Program is claiming an exemption from the Administrative Process Act in accordance with § 38.2-5002.1 of the Code of Virginia, which provides that the procedure for adoption of rules and regulations by the board of directors of the program shall be consistent with the provisions of Article 2 (§ 2.2-4006 et seq.) of the Administrative Process Act.

Title of Regulation: **14VAC10-10. Virginia Birth-Related Neurological Injury Compensation Program Regulations (adding 14VAC10-10-10 through 14VAC10-10-230).**

Statutory Authority: § 38.2-5002.1 of the Code of Virginia.

Effective Date: July 10, 2017.

Agency Contact: George Deebo, Executive Director, Virginia Birth-Related Neurological Injury Compensation Program, 7501 Boulders View Drive, Suite 201, Richmond, VA 23225, telephone (804) 330-2471, FAX (804) 330-3054, or email gdeebo@vabirthinjury.com.

Summary:

The regulation provides the general requirements concerning the Virginia Birth-Related Neurological Injury Compensation Program, including (i) procedures for claims processing, (ii) available benefits for admitted claimants, (iii) procedures for requesting reimbursement or compensation for the types of expenses covered by the benefits, and (iv) procedures for requesting benefits not expressly addressed by the regulations.

CHAPTER 10

VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM REGULATIONS

Part I

General Procedural Requirements

14VAC10-10-10. Payer of last resort.

The Virginia Birth-Related Neurological Injury Compensation Program (Program) is a payer of last resort. Each admitted claimant's primary insurance and other sources of coverage should be billed for covered services before the Program is asked to pay for a service. An admitted claimant may not receive reimbursement or compensation from the Program for expenses for items or services, or for reimbursements, that he has received or is entitled to receive by contract, state law, or federal law, or from another source, except to the extent that it is prohibited by federal law.

14VAC10-10-20. Primary insurance.

A. Medical services that are required to be precertified, preauthorized, or authorized by the admitted claimant's primary insurance provider may not be payable by the Virginia Birth-Related Neurological Injury Compensation Program (Program) if the primary insurance carrier's certification or authorization process has not been satisfied.

B. Admitted claimants must utilize the primary insurer's in-network providers and facilities unless otherwise authorized by the Program. Utilizing non-network or nonparticipating providers or facilities may result in reduced payment or nonpayment of incurred expenses.

14VAC10-10-30. Medical review.

The Virginia Birth-Related Neurological Injury Compensation Program reserves the right to submit requests for services or equipment for independent medical review to determine medical necessity or appropriateness of care prior to authorizing payment.

Part II

Benefits

14VAC10-10-40. Counseling.

The Virginia Birth-Related Neurological Injury Compensation Program will pay for counseling for family members related to the needs of an admitted claimant. After primary insurance, a maximum of $1,500 per calendar year will be paid for this service. Services must be provided by a licensed clinical social worker, counselor, psychologist, or psychiatrist.

14VAC10-10-50. Personal nursing and assistive care.

A. The Virginia Birth-Related Neurological Injury Compensation Program (Program) will pay for appropriate

medically necessary and reasonable nursing care or assistive care as recommended in writing by the admitted claimant's primary care physician.

B. The Program will review or consult periodically with medical professionals concerning the continued appropriateness of the nursing hours.

C. The Program utilizes nursing agencies when available. All nursing agencies utilized by the Program must provide to the Program copies of their employment policies regarding the criminal history records checks and sex offender searches conducted on their employees. All nursing agencies utilized by the Program must provide a certification to the Program for each employee the agencies places for care of admitted claimants that verifies that the named employee has not been convicted of any offense listed as a barrier crime pursuant to § 37.2-314, 37.2-416, or 37.2-506 of the Code of Virginia. No nursing agency shall be reimbursed for any hours worked by an agency employee for which such certification has not been provided to the Program. Signed and dated time sheets and monthly care summaries must be submitted with each request for reimbursement. If an agency is unable to provide care, the Executive Director of the Program is authorized to approve other arrangements.

D. If a nursing agency is not available, or the admitted claimant's parent or legal guardian chooses to employ a relative or legal guardian of the admitted claimant to provide prescribed nursing or attendant care authorized by the admitted claimant's primary care physician or appropriate treating specialist physician, the Program may reimburse the admitted claimant's parent or legal guardian for care providers who are employed by the admitted claimant's family as independent contractors or household employees, as the case may be, upon approval of the Executive Director of the Program. The Program will reimburse admitted claimant families for employment-related taxes such as FICA or unemployment tax, related to the hiring of an independent contractor upon receipt of proper documentation of payment of these taxes. The parent or legal guardian of the admitted claimant must provide a certification to the Program for each independent contractor or household employee who the parent or legal guardian hires for an admitted claimant's care that verifies that the named independent contractor or household employee has not been convicted of any offense listed as a barrier crime pursuant to § 37.2-314, 37.2-416, or 37.2-506 of the Code of Virginia. No parent or legal guardian shall be reimbursed for any hours worked by an independent contractor for which such certification has not been provided to the Program. The parent or legal guardian of the admitted claimant will pay any application fees associated with requesting these background checks of the Virginia State Police. Upon receipt of the certification and a receipt from the Virginia State Police or an authenticated copy of the canceled check, the Program will reimburse those application fees associated with the application of the independent contractor or household employee actually hired. Signed and dated time sheets, signed and dated receipts of payment, and monthly care summaries must be submitted with each request for reimbursement.

E. The Program will not reimburse a care provider for more than a 16-hour shift within a 24-hour period unless there is an emergency and no other care provider is available to care for the admitted claimant. Overtime is not paid unless preauthorized by the Program. The Program will not reimburse for work by a full-time caregiver for more than 40 hours per week unless preauthorized by the Program.

F. The Program will not provide a private duty nurse while an admitted claimant is hospitalized unless the attending physician considers it medically necessary and a written order for private duty nursing is provided to the Program. The Program will pay for a sitter who is not a family member and may not have medical experience while the child is hospitalized, if requested, and with prior approval from the Program and a letter of medical necessity from the attending physician.

G. The Program will provide nurses or caregivers to accompany admitted claimants during school hours provided such care is deemed medically necessary and is not otherwise available. This care counts toward the total approved nursing hours.

H. The Program will reimburse medically necessary care provider expenses if they have not been previously filed with the tax authorities as deductions or credits. If they have been filed with the tax authorities as deductions or credits, then an amended tax report must be filed with the tax authorities and a copy of the amended tax report provided to the Program before the family will be reimbursed for these expenses.

I. The Program may reimburse for medically necessary and reasonable nursing and attendant care that is provided by a relative or legal guardian of an admitted claimant so long as that care is beyond the scope of childcare duties and services normally and gratuitously provided by family members to uninjured children and so long as such care and reimbursement requests are in accordance with other applicable provisions and the following:

1. The relative or legal guardian providing the care must be at least 18 years of age.

2. The parent or legal guardian of the admitted claimant must submit a letter of medical necessity from the admitted claimant's primary care physician or appropriate treating specialist physician that sets forth the number of nursing or attendant care hours needed per day; the physician's assessment regarding the level of care required; and certification that the intended caregiver is appropriately trained, qualified, and physically capable of performing the required home medical and attendant care duties. Medically necessary care to be provided by a relative or legal guardian of an admitted claimant shall be performed only at the direction and control of the admitted claimant's

primary care physician or appropriate treating specialist physician.

3. The parent or legal guardian of the admitted claimant must provide a certification to the Program for each caregiver the parent or legal guardian hires for an admitted claimant's care that verifies that the named caregiver has not been convicted of any offense listed as a barrier crime pursuant to §§ 37.2-314, 37.2-416, or 37.2-506 of the Code of Virginia. No parent or legal guardian shall be reimbursed for any hours worked by a caregiver for whom such certification has not been provided to the Program. The parent or legal guardian of the admitted claimant will pay any application fees associated with requesting these background checks of the Virginia State Police. Upon receipt of the certification and a receipt from the Virginia State Police or an authenticated copy of the canceled check, the Program will reimburse those application fees associated with the application of the caregiver actually hired.

4. Any relative or legal guardian of an admitted claimant providing caregiver services must provide a signed release of liability form to the Program regarding any potential injury sustained during the course of providing services to the admitted claimant.

5. Any parent or legal guardian of an admitted claimant choosing to utilize nursing or attendant care that is provided by a relative or legal guardian in lieu of nursing or other professional caregiver services must provide a signed release of liability form to the Program regarding any potential injury sustained by the admitted claimant during the course of receiving care.

6. Signed and dated time sheets, signed and dated receipts of payment, and monthly care summaries must be submitted with each request for reimbursement.

7. The Program will not reimburse for care provided by a nurse or other professional caregiver and by a relative or legal guardian for the same hours. Hours of care provided by a relative or legal guardian of an admitted claimant cannot be used to supplement hours of care provided by professional caregivers or nursing agencies to the extent that those hours would exceed the total hours deemed medically necessary and authorized by the Program.

8. No more than 12 hours within a 24-hour period may be reimbursed for care provided by any single relative or legal guardian of an admitted claimant.

9. The rate of reimbursement for nursing and attendant care that is provided by a relative or legal guardian of an admitted claimant shall be the average hourly rate for a home health aide (combined all industries) as reported by the Commonwealth of Virginia's Labor Market Data report for the applicable metropolitan statistical area in the most recently published data available. The Program will reimburse an admitted claimant's parent or legal guardian for employment-related taxes, such as FICA or unemployment tax, resulting from that parent or legal guardian's employment of a relative or legal guardian as the admitted claimant's caregiver as set forth in this chapter, upon receipt of proper documentation of payment of these taxes.

10. The Program's Executive Director and staff reserve the right to have reviewed each nursing or attendant care plan or physician order for medical necessity.

J. The Program generally follows Medicaid payment rates depending on the locality or state where the care is delivered.

K. Travel expenses associated with nursing care are reimbursable only if the travel is medically necessary. No travel expenses will be paid for nurses or caregivers accompanying families on vacation or other nonmedically necessary travel. Travel expenses for medically necessary nursing or attendant care during medically necessary travel will only be paid for one person in addition to the admitted claimant. All such payments or reimbursements are made to the parent or guardian of the admitted claimant not to the caregiver.

14VAC10-10-60. Dental care.

The Virginia Birth-Related Neurological Injury Compensation Program will pay for the admitted claimant's dental care costs if they are medically necessary not cosmetic and are not covered by other sources.

14VAC10-10-70. Therapy.

A. The Virginia Birth-Related Neurological Injury Compensation Program (Program) will pay for therapy that is determined to be medically necessary and reasonable and for which there is a letter of medical necessity provided by the admitted claimant's primary care physician or appropriate treating specialist physician.

B. The Program may consult periodically with appropriate medical professionals regarding the necessity for continuing various therapies including behavioral, physical, horseback, and speech therapy.

14VAC10-10-80. Transportation; vans.

A. The Virginia Birth-Related Neurological Injury Compensation Program (Program) will fund the purchase of a van when it becomes medically necessary for wheelchair transportation. Van options for admitted claimants are available from the Program. The Program will have the primary lien on the van's certificate of title, although the van itself will be titled in the name of the admitted claimant's parents or legal guardians. The Program will pay the personal property taxes on and sales taxes resulting from the initial purchase of the medically necessary van and also will pay an amount equal to the uninsured motorist fee, or the insurance premium for the van, whichever is less. Other operating costs, such as city or county decals and tags, maintenance, repairs, and tires will be the responsibility of the parents or guardians. Mileage and other transportation costs will be reimbursed as set out under 14VAC10-10-150. The Program will reimburse

the admitted claimant's family for the cost of insuring the lift and tie downs if an additional cost is incurred for this and a receipt is provided.

B. Vans will be replaced at approximately 100,000 miles. Documentation of the vehicle's service history and condition will be considered in determining the timing of van replacement.

C. In the event a van provided by the Program is no longer necessary for transportation of the admitted claimant, the van must be returned, and the title must be transferred to the Program within three months. The family may purchase the van if an agreeable purchase price is agreed upon with the Executive Director of the Program.

D. All vans returned to the Program should be in good working order and be able to pass a Virginia state inspection. If the van is not in good working order or cannot pass a Virginia state inspection, the admitted claimant's parent or legal guardian must have the defects repaired at his own cost if the expense is not covered by insurance prior to returning the vehicle to the Program.

14VAC10-10-90. Equipment.

A. Equipment documented as medically necessary by the admitted claimant's physician will be provided by the Virginia Birth-Related Neurological Injury Compensation Program (Program). Because there is a gamut of equipment that may be provided, no attempt is made to list all such equipment in this section. Equipment provided to date, however, includes oxygen concentrators, bipap machines, feeding pumps, gait trainers, wheelchairs, Wizard strollers, suction machines, apnea monitors, IV poles, pulse oximeters, therapy balls, therapy mats, Gorilla car seats, wheelchair lifts, and wheelchair tie-downs.

B. All medically necessary equipment (except vans) purchased entirely by the Program remains the property of the Program. Depending upon the type of equipment and its condition, it is expected that equipment will be returned to the Program when no longer required by the admitted claimant. The family may purchase the equipment if a purchase price is agreed upon with the Executive Director of the Program. If the equipment is not purchased entirely by the Program it does not have to be returned to the Program.

14VAC10-10-100. Augmentative communication technology.

A. The Virginia Birth-Related Neurological Injury Compensation Program (Program) will pay for devices, equipment, and computer software for the purpose of aiding in communication of an admitted claimant who otherwise is unable to communicate verbally. The Program may require an evaluation be completed by a Program assigned augmentative communication consultant to ensure the appropriate equipment is recommended or purchased.

B. For all equipment supplied by the Program, it is expected that the admitted claimant and those involved in the care of the admitted claimant will utilize the equipment as intended and invest the time and effort required for the equipment to be utilized successfully.

C. In accordance with the Program's general policy on purchasing medically necessary equipment, all augmentative communication technology equipment remains the property of the Program. If for any reason the equipment no longer is necessary or not utilized by the admitted claimant, it should be returned to the Program. Because the Program is a payer of last resort, all measures for obtaining coverage through primary insurance or other sources must be exhausted before the Program will cover augmentative technology services.

14VAC10-10-110. Privately owned housing assistance.

A. The Virginia Birth-Related Neurological Injury Compensation Program (Program) Board of Directors statutory authority concerns awards for the medical needs of the admitted claimants it serves. However, if an admitted claimant has medically necessary housing needs that can be addressed in the nonrental home currently owned and occupied by the admitted claimant's family or guardian, the board will provide one-time funding for medically necessary modification to, or construction of, an accessible bedroom and bathroom if such modification or construction is feasible and reasonable. This modification or construction must be within the Program's allowable standards for cost, space, and other factors before funding for an accessible bedroom and bathroom will be authorized. The Program's construction manager or other qualified professional will determine the feasibility of these modifications or construction and whether the admitted claimant's needs will be met in the contemplated project.

B. The maximum lifetime housing benefit per admitted claimant for any one or combination of housing benefits (rental or construction) is up to $175,000.

14VAC10-10-120. Rental housing assistance.

A. If the admitted claimant resides in a non-handicapped-accessible rental unit and moves to a handicapped accessible rental unit, the Virginia Birth-Related Neurological Injury Compensation Program (Program) will reimburse the difference between the former monthly rental payment and the cost for the appropriate handicapped accessible rental unit of similar size and quality based on cost per square foot. Any substantial increases in the square footage of the handicapped accessible unit to be reimbursed must be attributable to medically necessary requirements and not exceed the overall guidelines utilized when the Program constructs additional space for an admitted claimant.

B. The handicapped accessible rental unit should meet all applicable regulations of the Americans with Disabilities Act (ADA (42 USC § 1201 et seq.)). Exceptions to meeting the ADA regulations must be approved by the Virginia Birth-Related Neurological Injury Compensation Program's Board of Directors. Prior to providing reimbursement the Program

may require certification of the rental unit's suitability for the admitted claimant or compliance with this policy.

14VAC10-10-130. Funeral expenses.

The Virginia Birth-Related Neurological Injury Compensation Program will pay a maximum of $5,000 for the funeral and burial expenses of an admitted claimant.

14VAC10-10-140. Attorney fees.

Virginia law authorizes payment of reasonable attorney fees incurred in the initial filing of a claim to enter the Virginia Birth-Related Neurological Injury Compensation Program, subject to the approval and award of the Virginia Workers' Compensation Commission.

14VAC10-10-150. Miscellaneous expenses.

A. Transportation. Upon submission of receipts, the Virginia Birth-Related Neurological Injury Compensation Program (Program) will reimburse parking fees associated with medically necessary travel. The Program will reimburse documented mileage for medically necessary travel at the following rates:

1. Mileage will be reimbursed at 50% of the U.S. Internal Revenue Service's mileage rate for vans provided by the Program. Mileage reimbursement typically covers gasoline and other costs of operation. Because the Program provides the van in this instance, the Program's mileage reimbursement is intended only to cover the cost of gasoline associated with medically necessary transportation. Mileage is based on the distance from the home to the appointment location. Verification may be required by the Program.

2. For use of personal vehicles, reimbursement will be at the U.S. Internal Revenue Service's mileage rate. In the event a van provided by the Program is unavailable, the mileage reimbursement allowance provided would be that allowed for vans purchased by the Program. Upon submission of receipts, the Program will reimburse other medically necessary transportation expenses not otherwise reimbursed.

B. Postage. The Program will pay postage for reimbursement requests submitted to the Program and for information requested by the Program.

C. Cell phones. If the Program receives a prescription from the admitted claimant's primary care physician or appropriate treating specialist physician that a cellular telephone is medically necessary, the Program will pay for basic monthly emergency service. If basic emergency service is unavailable, the Program will pay for basic monthly service only. If installation of the cellular telephone is required, the phone must be installed in the vehicle in which the admitted claimant is transported. An admitted claimant's parent or guardian must contact the Program for the current allowable amounts.

D. Diapers. Beginning at age three years, the Program will pay for diapers for an admitted claimant when deemed medically necessary pursuant to the Program's purchasing guidelines. If the parent or guardian of an admitted claimant does not have receipts for the period of time between the child's third birthday and the child's admission into the Program, the parent or guardian may submit the reimbursement request with the prescription and receive reimbursement based upon the Medicaid reimbursement rate.

E. Therapeutic toys. The Program will provide therapeutic toys with documentation of the therapeutic benefit of the toys. These toys are not to exceed $300 per calendar year. Once the admitted claimant has no need for these toys and if the toys are in good condition, the Program will accept their return to be used to stock a lending program. The toys will be sanitized prior to use by other families.

F. Other expenses. The Program may pay other medically necessary expenses of the admitted claimant as determined by the Program's Board of Directors in its discretion. Requests for medically necessary services, etc., that are not addressed in this chapter should be sent to the Executive Director of the Program who will refer these requests to the board for action.

Part III
Other Procedures

14VAC10-10-160. Insurance.

A. Because the Virginia Birth-Related Neurological Injury Compensation Program (Program) is a payer of last resort, it must be provided with a copy of the applicable health insurance policy, if one exists, or a complete description of applicable coverage, before benefits are paid by the Program. It is the responsibility of the parents or guardians to seek benefits for which an admitted claimant is eligible. In addition, the parents or guardians of the admitted claimant must identify a primary care physician.

B. Claimants must utilize the primary insurer's in-network providers and facilities unless otherwise authorized by the Program. Utilizing non-network or nonparticipating providers or facilities may result in reduced payment, nonpayment, or nonreimbursement of incurred expenses.

14VAC10-10-170. Reimbursement.

Although an admitted claimant has been determined eligible for benefits from the Virginia Birth-Related Injury Compensation Program (Program), parents or caregivers must contact the Program before committing to the purchase of equipment or incurring other expenses for which they may seek reimbursement. Failure to do so may jeopardize reimbursement from the Program. In the case of emergency care rendered or sought during nonbusiness hours, the admitted claimant's family is responsible for contacting the Program the next business day for authorization of services for which the Program is expected to pay.

14VAC10-10-180. Claims for reimbursement.

Requests for reimbursement of expenses from medical providers, pharmacies, equipment providers, medically necessary mileage, or other expenses will not be honored if

submitted after one year from the date they are incurred. All reimbursement requests must be accompanied by documentation of medical necessity and receipts from providers. This time limit does not apply to expenses incurred prior to acceptance into the Virginia Birth-Related Neurological Injury Compensation Program (Program). All requests for reimbursement for expenses prior to entry into the Program must be submitted within two years of entry into the Program.

14VAC10-10-190. Requests for authorization; services outside insurance plan covered area or network.

A. In the event it is medically necessary to take an admitted claimant outside the admitted claimant's applicable insurance plan's covered service area or the primary insurance's provider network for evaluation, surgery, etc., it must be ascertained if the primary insurance plan will pay for benefits and if so, what amount it will pay. After this is determined, the Virginia Birth-Related Neurological Injury Compensation Program (Program) must be contacted for authorization prior to seeking services or the Program may determine not to pay any balance remaining on the bill for these services.

B. If an in-network provider is available for a service and an out-of-network provider is utilized, the Program will reimburse or pay only an amount equal to what the Program would have paid if an in-network provider had been utilized.

14VAC10-10-200. Medically necessary travel greater than 100 miles from primary residence.

In the event it is medically necessary to take an admitted claimant outside the local service area (more than 100 miles from the admitted claimant's primary residence) for evaluation, surgery, or other medically necessary care, it must be ascertained prior to the travel if the travel-related expenses will be reimbursed by the Virginia Birth-Related Neurological Injury Compensation Program (Program). If preauthorization is not obtained, the Program may not pay for these travel-related expenses.

14VAC10-10-210. Request for benefits no specifically addressed.

This chapter authorizes the Executive Director of the Virginia Birth-Related Neurological Injury Compensation Program (Program) to provide the benefits described without referral to the Board of Directors of the Program except in exceptional circumstances, and in the executive director's discretion. The board, however, realizes that there may be programs, equipment, or other items, which may be of value to an admitted claimant that this chapter does not address. If the parents or guardians feel a benefit not described in this chapter would be of value to the admitted claimant (the executive director is not authorized to provide those benefits without board approval), the parents or guardians should write the board via the executive director, who will bring these requests to the board at its next meeting.

14VAC10-10-220. Experimental treatment and therapy.

A. Experimental treatments or therapy not typically covered by health insurance, including conductive education, may be covered up to a maximum of $6,000 per year, combined, with written prior authorization from the Executive Director of the Virginia Birth-Related Neurological Injury Compensation Program (Program). The Board of Directors of the Program recognizes that such therapies or treatments may be useful for some admitted claimants and, therefore, grants this discretionary benefit on a case-by-case basis. Because this benefit is not provided expressly by the Virginia Birth-Related Neurological Injury Compensation Act (§ 38.2-5000 et seq. of the Code of Virginia), however, there is no guarantee of coverage for experimental therapy or treatment. This completely discretionary benefit may be rescinded at any time; especially if such rescission is warranted by the Board of Directors fiduciary obligations set forth in § 38.2-5016 F of the Code of Virginia. Upon such rescission, benefits under this policy will terminate immediately and no admitted claimant will have any further recourse or any basis for a claim for further benefits under this policy.

B. A written request for authorization of experimental treatment or therapy must be submitted to the Program in accordance with the following process:

1. A letter of medical necessity from the admitted claimant's physiatrist, neurologist, or other appropriate treating specialist physician, who also regularly treats other patients with cerebral palsy, must be received by the Program. A letter of medical necessity from a physical therapist is not acceptable.

2. The letter of medical necessity must be received in the Program's offices at least 60 days prior to the desired start of treatment.

3. Evidence as to whether the primary insurers or other payers will cover any portion of the cost must be submitted with the request.

4. At the Program's discretion, all requests for experimental treatments or therapies may be reviewed for medical necessity by an objective qualified physician.

C. All other Program regulations regarding therapies, including the travel policy, are applicable to authorized experimental treatments or therapies. These include:

1. Payment for travel, lodging, and meals on a per diem basis based on current Commonwealth of Virginia rates.

2. For travel other than by car or van, prior authorization must be obtained.

D. Written authorization from the Program must be obtained by the admitted claimant prior to any payments or reimbursements being made by the Program.

E. Total combined costs for experimental treatments or therapies, related equipment, and travel expenses during any single calendar year may not exceed $6,000.

F. Following any experimental therapy treatment, a complete and thorough progress report prepared by the treating facility must be submitted to the Program within 60 days of completion of the therapy.

G. No further sessions or treatments will be authorized prior to the Program's receiving such progress reports. The receipt of the reports does not guarantee that further treatments will be authorized.

H. The Program may request an independent progress evaluation by a qualified physician prior to any reauthorization for subsequent treatments. If the admitted claimant's insurance will not cover this evaluation, the Program will pay for the evaluation at usual and customary rates. If the Program pays for the evaluation, that cost will not be considered to be part of the cost of the treatment.

I. A local qualified provider of the experimental therapy or treatment requested should be utilized unless the Program grants an exception for a specific treatment provider.

J. For any therapy or treatment proposed, no more than 100 hours will be authorized upon initial request. Additional authorization may be provided only after the procedures in subsection F of this section have been followed.

K. Nursing, certified nurse aide, or other personal assistance will not be provided for extended experimental therapy sessions of more than two hours per day unless a letter of medical necessity is received by the Program from an appropriate treating specialist physician. The letter must state specifically that a nurse must be present due to specified health risks to the admitted claimant.

L. In determining whether authorization will be granted for experimental therapy or treatment, the Program will consider, including the following:

1. The overall cost associated with the experimental treatment or therapy. The cost for one person to accompany the admitted claimant, if stated to be medically necessary by the treating physician; the duration of the Program; the expected benefits to the admitted claimant; and the availability of the experimental program in Virginia.

2. The report from the admitted claimant's treating physician regarding the medical necessity for the admitted claimant to participate in the experimental program.

3. Whether there is medically recognized proof of results that the experimental therapy or treatment has benefitted other patients in similar circumstances.

4. The expected frequency and duration of the experimental treatment or therapy requested.

5. The Program may require third party medical reviews to evaluate the potential success, safety, or results of the experimental treatment or therapy.

M. The Program encourages families to seek out clinical trials being conducted by accredited medical facilities, medical schools, or other highly regarded and medically accepted facilities or organizations to help establish the medical efficacy of experimental treatments or therapies.

14VAC10-10-230. Disagreements.

A. Disagreements concerning whether a service or item of equipment should be paid for or reimbursed by the Virginia Birth-Related Neurological Injury Compensation Program (Program) may arise. If Program staff and the Program's Executive Director cannot make a determination regarding a request, or cannot resolve a disagreement, then the executive director has been authorized by the Program's Board of Directors to place the admitted claimant's request on the agenda for the board's consideration and determination at its next regular meeting.

B. The parents or guardians, within 30 days of receiving the Program staff's or executive director's written denial of a claim, may submit a written explanation of the dispute, provide documentation supporting the request and demonstrating that procedures for the submission of claims pursuant to this chapter have been followed, and request that the board make a determination regarding the claim at its next regular meeting.

C. The parents or guardians of the admitted claimant may attend a meeting of the board to make a presentation and to provide documentation in support of the request in addition to submitting written materials to the Program.

D. If a dispute is not resolved by the board, a petition of appeal may be filed with the Clerk of the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond, Virginia 23220, within 30 days of receipt of written notification of the board's decision.

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (14VAC10-10)

Certification Regarding Agency Caregiver's Prior Criminal History (filed 6/2017)

Caregiver Timesheet (rev. 10/2014)

Patient Nursing and Caregiver Form (filed 6/2017)

Release and Waiver of Liability, Discharge, Covenant Not to Sue, and Indemnity Agreement of Admitted Claimant (filed 6/2017)

Release and Waiver of Liability, Discharge, Covenant Not to Sue, and Indemnity Agreement by Caregiver (filed 6/2017)

Family Member Caregiver Competency Certification (filed 6/2017)

Certification, Waiver and Release Regarding Family Member Caregiver's Prior Criminal History for Two Parents/Guardians (filed 6/2017)

Certification, Waiver, and Release Regarding Family Member Caregiver's Prior Criminal History for Single Parent/Guardian (filed 6/2017)

Certification, Waiver, and Release by Single Parent/Guardian Regarding Independent Caregiver's Prior Criminal History (filed 6/2017)

Certification, Waiver, and Release by Parents/Guardians Regarding Independent Caregiver's Prior Criminal History (filed 6/2017)

Monthly Care Summary (filed 6/2017)

Sample Van Agreement (filed 6/2017)

Sample Award Disbursement Agreement (Housing Modifications Allowance) (filed 6/2017)

Claim Reimbursement Form (filed 6/2017)

Medical Appointment Verification Forms (rev. 12/2008)

VA.R. Doc. No. R17-5180; Filed June 22, 2017, 6:00 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF ACCOUNTANCY

Final Regulation

REGISTRAR'S NOTICE: The Board of Accountancy is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law where no agency discretion is involved. The Board of Accountancy will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **18VAC5-22. Board of Accountancy Regulations (amending 18VAC5-22-50, 18VAC5-22-70, 18VAC5-22-90, 18VAC5-22-100).**

Statutory Authority: §§ 54.1-4402 and 54.1-4403 of the Code of Virginia.

Effective Date: August 9, 2017.

Agency Contact: Rebekah E. Allen, Board of Accountancy, 9960 Mayland Drive, Suite 402, Henrico, VA 23223, telephone (804) 367-2006, FAX (804) 527-4207, or email rebekah.allen@boa.virginia.gov.

Summary:

Pursuant to Chapter 403 of the 2017 Acts of Assembly, which amends § 54.1-4400 of the Code of Virginia, the amendments (i) remove "using the CPA title" from context of representing oneself to the public or to an employer, (ii) add "on behalf of" in regards to representing oneself to the public through an employer, and (iii) remove the National College as a degree-granting educational institution that meets the licensing requirements.

18VAC5-22-50. Determining whether the principal place of business of a person ~~using the CPA title,~~ or of a firm~~,~~ is in Virginia.

Complying with subdivision A 1 of § 54.1-4409.1, subsection B of § 54.1-4411, or subsection B of § 54.1-4412.1 of the Code of Virginia requires the person or firm to use reasonable judgment in determining whether Virginia is the principal place of business in which ~~the~~:

1. The person provides services to the public ~~using the CPA title~~; or ~~the~~

2. The firm provides attest services or compilation services.

The determination shall be reasonable considering the facts and circumstances and can be based on quantitative or qualitative assessments. The determination shall be reconsidered for changes in facts and circumstances that are not temporary.

18VAC5-22-70. Education.

A. In order for a person to take the CPA examination through Virginia, he must have obtained from one or more accredited institutions ~~or from the National College~~ at least 120 semester hours of education, a baccalaureate or higher degree, and an accounting concentration or equivalent prior to taking any part of the CPA examination.

B. For the purpose of complying with subsection A of this section and with subdivision A 1 a of § 54.1-4409.2 of the Code of Virginia, obtaining an accounting concentration or equivalent requires obtaining at a minimum:

1. 24 semester hours of accounting courses, including courses in auditing, financial accounting, management accounting, and taxation; and

2. 24 semester hours of business courses, no more than six semester hours of which could be considered accounting courses.

Principles or introductory accounting courses cannot be considered in determining whether a person has obtained the 48 minimum number of semester hours required for an accounting concentration or equivalent.

18VAC5-22-90. Continuing professional education.

A. If during the current calendar year a person who holds a Virginia license provided services to the public ~~using the CPA title~~, he shall have obtained at least 120 hours of continuing professional education during the three-calendar-year period ending with the current calendar year. For each of the calendar years in that period, he shall have obtained at least 20 hours of continuing professional education, including an ethics course of at least two hours.

1. If the person also holds the license of another state and Virginia is not the principal place of business in which he provides services to the public ~~using the CPA title~~, the ethics course taken to comply with this subsection either shall conform with the requirements prescribed by the board or shall be an ethics course acceptable to the board of accountancy of another state in which the person holds a license.

2. Otherwise, the ethics course shall conform with the requirements prescribed by the board.

B. If during the current calendar year a person who holds a Virginia license provided services to or on behalf of an employer ~~using the CPA title~~ and did not provide services to the public ~~using the CPA title~~, he shall have obtained a minimum number of hours of continuing professional education determined as follows:

1. If the current calendar year is 2009 or 2010, the person shall have obtained at least 90 hours of continuing professional education during the three-calendar-year period ending with the current calendar year. For each of the calendar years in that period, he shall have obtained at least 15 hours of continuing professional education, including an ethics course of at least two hours.

2. If the current calendar year is 2011 or later, the person shall have obtained at least 120 hours of continuing professional education during the three-calendar-year period ending with the current calendar year. For each of the calendar years in that period, he shall have obtained at least 20 hours of continuing professional education, including an ethics course of at least two hours.

The ethics course taken to comply with this subsection either shall conform with the requirements prescribed by the board or shall be an ethics course acceptable to the board of accountancy of another state in which the person holds a license.

C. If during the current calendar year a person who holds a Virginia license provided services to the public ~~using the CPA title~~ or to or on behalf of an employer ~~using the CPA title~~ and did not hold a Virginia license or the license of another state during one or both of the two preceding calendar years, he shall determine whether he has complied with the requirements of subsection A or B of this section as follows:

1. If the person became licensed during the current calendar year, he shall be considered to have met the requirements of the subsection for the three-calendar-year period ending with the current calendar year.

2. If the person became licensed during the preceding calendar year, he shall be considered to have met the requirements of the subsection for the three-calendar-year period ending with the current calendar year if during the current calendar year he obtained at least the minimum number of hours of continuing professional education required by the subsection for the current calendar year, including an ethics course of at least two hours.

3. If the person became licensed during the calendar year prior to the preceding calendar year, he shall be considered to have met the requirements of the subsection for the three-calendar-year period ending with the current calendar year if during the current calendar year and the preceding calendar year he obtained at least the minimum number of hours of continuing professional education required by the subsection for each of the years, including for each year an ethics course of at least two hours.

D. If during the current calendar year a person who holds a Virginia license did not provide services to the public ~~using the CPA title~~ or to or on behalf of an employer ~~using the CPA title~~, he is not required to have obtained continuing professional education during the three-calendar-year period ending with the current calendar year. However, in order to begin providing those services:

1. He is required to have obtained at least 120 hours of continuing professional education prior to providing the services, including an ethics course of at least two hours.

2. The ethics course shall conform with the requirements prescribed by the board for the calendar year in which the person begins providing the services.

Continuing professional education obtained during the three calendar years prior to the current calendar year and from the start of the current calendar year to when he begins providing the services shall be considered in determining whether the person has complied with the requirements of this subsection.

E. If a person who has not held the license of any state applies for a Virginia license after the end of the calendar year in which he passes the CPA examination, he shall obtain continuing professional education prior to applying for the license, including an ethics course of at least two hours.

1. The required minimum number of hours of continuing professional education shall be 40, 80, or 120 depending on whether he applies for the Virginia license by the end of the first calendar year after the calendar year in which he passes the CPA examination, by the end of the second calendar year, or later.

2. The ethics course shall conform with the requirements prescribed by the board for the calendar year in which the person applies for the license.

Continuing professional education obtained subsequent to passing the CPA examination but during the three calendar years prior to the calendar year in which the person applies for the license and from the start of that calendar year to when he applies for the license shall be considered in determining whether he has complied with this requirement.

F. Continuing professional education acceptable to the board may be obtained through a variety of forums, provided there is a means of demonstrating that the education was obtained. The following forums are acceptable:

1. Attendance at seminars and educational conferences, provided that the instructors have appropriate knowledge of the subject matter and use appropriate teaching materials and that attendance is monitored in a manner that can be verified by the board;

2. Taking courses at an accredited institution for credit;

3. Self-study courses, provided there is a method for determining that the person met the learning objectives;

4. Making a presentation at a professional seminar, educational conference, or in a classroom setting, provided the person has appropriate knowledge of the subject matter and uses appropriate teaching materials; and

5. Writing material that is relevant to providing services to or on behalf of an employer ~~using the CPA title~~ or to the public ~~using the CPA title,~~ that is formally reviewed by an independent party~~,~~ and that is published in a book, magazine, or similar publication that is used by persons who provide services to the public ~~using the CPA title~~ or to or on behalf of an employer ~~using the CPA title~~.

Whether other forums are acceptable shall be determined by the board on a case-by-case basis.

G. In determining whether a person has obtained the required number of hours of continuing professional education:

1. Repeat presentations shall not be considered.

2. No more than 30 hours from preparing for and making presentations shall be considered during each three-calendar-year period.

3. One semester-hour of credit for courses at an accredited institution constitutes 15 hours of continuing professional education, and one quarter-hour of credit constitutes 10 hours of continuing professional education.

H. Depending on the facts and circumstances, the board may waive all or part of the continuing professional education requirement for one or more calendar years or grant additional time for complying with the continuing professional education requirement, provided that the waiver or deferral is in the public interest.

18VAC5-22-100. Experience.

Prior to applying for a license, a person must have been employed in academia, a firm, government, or industry in any capacity involving the substantial use of accounting, financial, tax, or other skills that are relevant, as determined by the board, to providing services to the public ~~using the CPA title~~ or to or on behalf of an employer ~~using the CPA title~~ for a period that is the full-time equivalent of one year. Whether other skills are relevant shall be determined by the board on a case-by-case basis. Self-employment does not meet the definition of experience in § 54.1-4400 of the Code of Virginia.

VA.R. Doc. No. R17-5174; Filed June 20, 2017, 5:51 p.m.

BOARD OF VETERINARY MEDICINE

Emergency Regulation

Title of Regulation: **18VAC150-20. Regulations Governing the Practice of Veterinary Medicine (adding 18VAC150-20-174).**

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

Effective Date: June 26, 2017, through December 25, 2018.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Veterinary Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4468, FAX (804) 527-4471, or email leslie.knachel@dhp.virginia.gov.

Preamble:

Regulations for veterinarians prescribing controlled substances containing opioids are being promulgated as emergency regulations to address the opioid abuse crisis in Virginia. On November 16, 2016, State Health Commissioner Marissa Levine declared the opioid addiction crisis to be a public health emergency in Virginia. In a news conference about the opioid crisis, Governor McAuliffe noted that the declaration would "provide a framework for further actions to fight it, and to save Virginians' lives." One of those "further actions" is adoption of emergency regulations by the Board of Medicine and the Board of Nursing setting out rules for prescribing opioids and buprenorphine and by the Board of Dentistry for prescribing of opioids for acute pain. To ensure that opioids are not being abused and diverted for sale through veterinary prescribing, the Board of Veterinary Medicine has also adopted emergency regulations.

Section 2.2-4011 of the Code of Virginia authorizes an agency to adopt emergency regulations necessitated by an emergency situation upon consultation with the Attorney General, and the necessity for the action is at the sole discretion of the Governor. The declaration by Commissioner Levine is indeed evidence that such an emergency situation exists in the Commonwealth.

The emergency regulations for the management of acute pain include requirements for the evaluation of the patient, limitations on quantity and dosage, and recordkeeping. The regulations also provide requirements for prescribing an opioid beyond 14 days for chronic pain and certain chronic conditions and allow for prescribing of buprenorphine in a dosage, quantity, and formulation appropriate for an animal species and size.

18VAC150-20-174. Prescribing of controlled substances for pain or chronic conditions.

A. Evaluation of the patient and need for prescribing a controlled substance for pain.

1. For the purposes of this section, a controlled substance shall be a Schedules II through V drug, as set forth in the

Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia), which contains an opioid.

2. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. Prior to initiating treatment with a controlled substance, as defined, the prescriber shall perform a history and physical examination appropriate to the complaint and conduct an assessment of the patient's history as part of the initial evaluation.

3. If a controlled substance is necessary for treatment of acute pain, the veterinarian shall prescribe it in the lowest effective dose appropriate to the size and species of the animal for the least amount of time. The dose shall not exceed a seven-day supply, unless extenuating circumstances are clearly documented in the patient's record.

4. The veterinarian may prescribe a controlled substance for an additional seven days if medically necessary and consistent with an appropriate standard of care, and after a reevaluation of the patient as documented in the patient record.

B. In accordance with the accepted standard of care, a veterinarian may prescribe a controlled substance beyond 14 days for management of certain chronic conditions, such as chronic heart failure, chronic bronchitis, osteoarthritis, collapsing trachea, or related conditions. For treatment of chronic pain or a chronic condition with an opioid beyond 14 days, the treatment plan shall include measures to be used to determine progress in treatment, further diagnostic evaluations or modalities that might be necessary, and the extent to which the pain or condition is associated with physical impairment. For any prescribing of a controlled substance beyond 14 days, the patient shall be seen and reevaluated at least every six months, and the justification for such prescribing documented in the patient record.

C. Prior to prescribing or dispensing a controlled substance, the veterinarian shall document a discussion with the owner about the known risks and benefits of opioid therapy, the responsibility for the security of the drug, and proper disposal of any unused drug.

D. Continuation of treatment with controlled substances shall be supported by documentation of continued benefit from the prescribing. If the patient's progress is unsatisfactory, the veterinarian shall assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

E. Prescribing of buprenorphine for out-patient administration shall only occur in accordance with the following:

1. The dosage, quantity, and formulation shall be appropriate for the patient; and

2. The prescription shall not exceed a seven-day supply. Any prescribing beyond seven days shall be consistent with an appropriate standard of care and only after a reevaluation of the patient as documented in the patient record.

F. The medical record for prescribing controlled substances shall include signs or presentation of the pain or condition, a presumptive diagnosis for the origin of the pain or condition, an examination appropriate to the complaint, a treatment plan, and the medication prescribed to include the date, type, dosage, and quantity prescribed.

VA.R. Doc. No. R17-5103; Filed June 16, 2017, 9:35 p.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **22VAC40-41. Neighborhood Assistance Tax Credit Program (amending 22VAC40-41-20).**

Statutory Authority: §§ 58.1-439.20 and 63.2-217 of the Code of Virginia.

Effective Date: August 10, 2017.

Agency Contact: Wanda Stevenson, Neighborhood Assistance Program Technician, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7924, or email wanda.stevenson@dss.virginia.gov.

Background:

The Neighborhood Assistance Act Tax Credit Program (NAP) is a state tax credit program established by the General Assembly in 1981. NAP uses tax credits as an incentive for businesses, trusts, and, with certain restrictions, individuals to make donations to eligible nonprofit organizations whose primary function is providing services to low-income persons.

Summary:

The amendments conform the regulation to Chapter 724 of the 2017 Acts of Assembly to (i) clarify the audit, review, or compilation requirement for organizations to receive tax credits under the Neighborhood Assistance Program and (ii) add a requirement that at least 50% of the neighborhood organization's revenues must be used to provide services to low-income persons.

22VAC40-41-20. Purpose; procedure for becoming an approved organization; eligibility criteria; termination of approved organization; appeal procedure.

A. The purpose of the Neighborhood Assistance Program is to encourage business firms and individuals to make donations to neighborhood organizations for the benefit of low-income persons.

B. Neighborhood organizations that do not provide education services and that wish to become an approved organization must submit an application to the commissioner. Neighborhood organizations that provide education services must submit an application to the Superintendent of Public Instruction. The application submitted to the Superintendent of Public Instruction must comply with regulations or guidelines adopted by the Board of Education. The application submitted to the commissioner must contain the following information:

1. A description of eligibility as a neighborhood organization, the programs being conducted, the low-income persons assisted, the estimated amount that will be donated to the programs, and plans for implementing the programs.

2. Proof of the neighborhood organization's current exemption from income taxation under the provisions of § 501(c)(3) or ~~§~~ 501(c)(4) of the Internal Revenue Code, or the organization's eligibility as a community action agency as defined in the Economic Opportunity Act of 1964 (42 USC § 2701 et seq.) or housing authority as defined in § 36-3 of the Code of Virginia.

3. For neighborhood organizations with total revenues ~~(including the value of all donations)~~ (i) ~~in excess~~ of more than $100,000 ~~for the organization's most recent year ended~~, an audit or review for ~~such year performed by an independent certified public accountant~~ the most recent year or (ii) of $100,000 or less ~~for the organization's most recent year ended~~, a compilation ~~for such year performed by an independent certified public accountant;~~ for the most recent year. ~~a copy of the organization's current federal form 990; a current brochure describing the organization's programs; and a copy of the annual report filed with the Department of Agriculture and Consumer Services' Division of Consumer Protection.~~ The audit, review, or compilation shall be performed by an independent certified public accountant. "Total revenues" means all revenues, including the value of all donations for the organization's most recent year.

4. A copy of the organization's current federal form 990.

5. A current brochure describing the organization's programs.

6. A copy of the annual report filed with the Department of Agriculture and Consumer Services' Division of Consumer Protection.

7. A statement of objective and measurable outcomes that are expected to occur and the method the organization will use to evaluate the program's effectiveness.

C. To be eligible for participation in the Neighborhood Assistance Program, the applicant and any of its affiliates must meet the following criteria:

1. Applicants must have been in operation as a viable entity, providing neighborhood assistance for low-income people, for at least 12 months.

2. Applicants must ~~be able to~~ demonstrate that at least 50% of the ~~total people~~ persons served shall be low-income and at least 50% of the total ~~expenditures were for~~ revenues shall be used to provide services to low-income persons ~~or eligible students with disabilities~~.

3. Applicant's audit must not contain any significant findings or areas of concern for the ongoing operation of the neighborhood organization.

4. Applicants must demonstrate that at least 75% of total revenue received is expended to support their ongoing programs each year.

D. Beginning with tax credit allocations for fiscal year 2016-2017, the applicant and any of its affiliates must meet the following requirements:

1. Affiliates of neighborhood organizations must demonstrate that at least 50% of the persons served are low-income persons;

2. Affiliates of neighborhood organizations must demonstrate that at least 50% of the revenues are used to provide services to such persons;

3. Affiliates must also meet the definition of "neighborhood organization" under § 58.1-439.18 of the Code of Virginia; and

4. Affiliates are not required to submit an audit, review, or compilation, and such reports shall not apply in determining the eligibility of the neighborhood organization submitting a proposal.

E. Requirements in subsection D of this section do not apply to a neighborhood organization submitting a proposal and any of its affiliates, provided that:

1. The neighborhood organization otherwise meets all statutory requirements and regulations;

2. The neighborhood organization received a fiscal year 2013-2014 allocation of neighborhood assistance tax credits; and

3. No affiliate of the neighborhood organization submits a proposal for or receives an allocation of tax credits pursuant to this chapter for the program year for which the neighborhood organization has submitted its proposal.

F. The application period will start no later than March 15 of each year. All applications must be received by the Department of Social Services no later than the first business day of May. An application filed without the required audit,

review, or compilation will be considered timely filed provided that the audit, review, or compilation is filed within 30 days immediately following the deadline.

G. Those applicants submitting all required information and reports and meeting the eligibility criteria described in this section will be determined an approved organization. The program year will run from July 1 through June 30 of the following year.

H. The commissioner may terminate an approved organization's eligibility based on a finding of program abuse involving illegal activities or fraudulent reporting on contributions.

VA.R. Doc. No. R17-5118; Filed June 15, 2017, 10:22 a.m.

Proposed Regulation

Titles of Regulations: **22VAC40-60. Standards and Regulations for Licensed Adult Day Care Centers (repealing 22VAC40-60-10 through 22VAC40-60-1020).**

22VAC40-61. Standards and Regulations for Licensed Adult Day Care Centers (adding 22VAC40-61-10 through 22VAC40-61-560).

Statutory Authority: § 63.2-1733 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: September 8, 2017.

Agency Contact: Annette Kelley, Licensing Consultant, Department of Social Services, 801 East Main Street, Room 1507, Richmond, VA 23219, telephone (804) 726-7632, FAX (804) 726-7132, or email annette.kelley@dss.virginia.gov.

Basis: The State Board of Social Services has the authority to promulgate the regulation under § 63.2-217 of the Code of Virginia, which states that board shall adopt regulations as may be necessary or desirable to carry out the purpose of Title 63.2 of the Code of Virginia. Section 63.2-1733 of the Code of Virginia addresses the board's overall authority to adopt regulations for adult day care centers to protect the health, safety, welfare, and individual rights of participants of adult day care centers and to promote the participants highest level of functioning.

Purpose: The State Board of Social Services requested at the previous periodic review that a comprehensive revision be completed for these regulations within the next review period, as the last comprehensive revision became effective in 2000. The regulation is essential to protect the health, safety, and welfare of adult day care center participants. The new regulation will allow for changes based on better practices, the latest research and improved technology, as well as meeting the increased needs of a population of elderly, infirm, or disabled persons that has become more vulnerable over the years. Current technology and medical practice have allowed individuals to stay in their own homes, or to live with family members, longer, and as a result, there is an increased need for this level of care and socialization.

Substance: New substantive provisions in the regulation include:

22VAC40-61-40: Provides for the development and implementation of an internal quality assurance program.

22VAC40-61-50: Adds to the participant rights and responsibilities to enhance protection for participants.

22VAC40-61-80: Allows for the use of and appropriate management of electronic records.

22VAC40-61-90: Requires incident reporting for any major incidents that may impact the health, safety and welfare of the participants.

22VAC40-61-120: Requires staff to report suspected abuse, neglect, or exploitation.

22VAC40-61-140: Establishes training criteria for staff that provide direct care to participants.

22VAC40-61-150: Increases the number of hours of training for staff to 12 hours per year.

22VAC40-61-160: Adds a requirement for all staff to be certified in first aid and cardiopulmonary resuscitation.

22VAC40-61-180: Removes the tuberculosis testing requirement and establishes the tuberculosis screening requirements established by the Virginia Department of Health.

22VAC40-61-220: Adds requirements for the completion of the participant assessment.

22VAC40-61-230: Adds requirements for the completion of the participant plan of care and items to be included on the plan of care.

22VAC40-61-240: Adds to the information required to be included in the plan of care.

22VAC40-61-250: Adds to the information required to be included in the participant's record.

22VAC40-61-260: Removes the tuberculosis testing requirement and establishes the tuberculosis screening requirements established by the Virginia Department of Health.

22VAC40-61-270: Condenses three discharge related standards into one and clarifies the role of the center, participant, and family in the discharge process.

22VAC40-61-280: Provides for appropriate health monitoring requirements for participants.

22VAC40-61-290: Provides for evidence based infection control practices to be established within the center.

22VAC40-61-300: Provides for supervisory oversight for medication aides and establishes current medication management practices.

22VAC40-61-310: Establishes that chemical and physical restraints are not allowed in adult day care centers.

22VAC40-61-320: Removes extraneous language and clarifies assistance to be provided for activities of daily living.

22VAC40-61-330: Provides for a list of activity categories to be provided for participants and adds that a staff person must be designated to develop activities.

22VAC40-61-340: Adds a provision requiring 45 minutes to consume a meal and extra time to be allowed if a participant requires it.

22VAC40-61-360: Provides for meal planning and menu development requirements.

22VAC40-61-370: Adds a provision that religious dietary practices will be respected.

22VAC40-61-380: Adds that supervision and safety needs of participants are maintained at all times and that all vehicles will have operable heating and air conditioning systems.

22VAC40-61-390: Adds that staff on a field trip will have a means of communicating with staff at the center and that medications will be administered according to regulatory requirements.

22VAC40-61-400: Provides that the center environment must ensure safety of the participant but not inhibit physical, intellectual, emotional, or social stimulation.

22VAC40-61-430: Establishes temperature requirements to be maintained inside the center and adds provisions for emergency heating.

22VAC40-61-460: Clarifies the requirement of maintaining one restroom for every 10 participants that can accommodate human assistance or specialize equipment for toileting.

22VAC40-61-520: Adds requirements for developing and implementing an emergency preparedness and response plan.

22VAC40-61-530: Adds a provision for developing a written plan for fire and emergency evacuation and having such plan approved by the local fire official.

22VAC40-61-540: Provides for additional information to be collected on fire and emergency evacuation drills.

22VAC40-61-550: Removes syrup of ipecac and activated charcoal from the first aid supplies.

22VAC40-61-560: Provides for initial and semi-annual review of the plan for participant emergencies.

Issues: The primary advantage of the proposed regulatory action is the increased protection it provides to participants in adult day care centers. The action is needed to protect the health, safety, and welfare of an increasingly vulnerable population of aged, infirm, or disabled adults. The regulation addresses the care, services, and environment provided by adult day care centers. Additionally, the last comprehensive revision of the adult day care center regulations became effective in 2000.

The new regulation also provides clear criteria for licensees to follow to maintain their licensure and for licensing staff to use in determining compliance with standards and in the implementation of any necessary enforcement action.

In the proposed regulatory action, a fair and reasonable balance has been attempted to ensure adequate protection of participants while considering the cost to centers. Although some requirements have been increased, others have been eliminated or reduced.

Several areas of the proposed regulations have been of particular interest to adult day care center providers, provider associations, advocacy groups, licensing staff, and the general public. These areas have been addressed and include: (1) eliminating some requirements relating to personnel practices that are internal business practices of a center, (2) adding a requirement for an internal review process, (3) expanding participant's rights and responsibilities, (3) allowance for electronic recordkeeping, (4) development of an incident reporting system, (5) addition of training requirements for direct care staff, (6) defining parameters for completion of participant assessments and plans of care, (7) removing requirements for tuberculosis testing and replacing them with requirements for tuberculosis screening, (8) enhancement of the infection control program, (9) adding a provision for a designated staff person to develop activities, and (10) enhanced emergency preparedness requirements.

The regulation takes into consideration differences in care need requirements of those served, that is, those who are ambulatory, nonambulatory, and those needing assistance with activities of daily living. The regulation addresses the needs of the cognitively impaired population, physically disabled participants, and elderly persons. In addition, it takes into consideration the cost constraints of smaller centers.

Because the adult day care industry is so diverse in respect to size, population in care, types of services offered, form of sponsorship, etc., the standards must be broad enough to allow for these differences, while at the same time be specific enough so that providers know what is expected of them.

The new regulation was prepared based on multiple regulatory advisory panel input, recommendations and feedback and recommendations from two adult day care center provider organizations.

The regulatory action poses no disadvantages to the public or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Board of Social Services (Board) proposes to reorganize and amend its regulation that governs licensure of adult day care centers. Specifically, the Board proposes to:

1) Require a tuberculosis (TB) screening rather than requiring a TB antibody test,

2) Remove activated charcoal and syrup of ipecac from the list of required emergency equipment and supplies,

3) Require a new quality self-assessment,

4) Allow facilities to keep electronic records and allow electronic signatures on forms,

5) Require incident reports for any major incidents that negatively affect or threaten the life, health, safety or welfare of day care participants and require a written report of any incident to be sent to the regional licensing office within seven days,

6) Allow individuals who are licensed as assisted living facility administrators to work as adult day care center directors,

7) Require the list of participant rights and responsibilities to be signed by participants or their representatives and also require that a copy of the list be posted in the day care center,

8) Change the length of notification when day care centers are discharging participants from 14 days to 30 days,

9) Prohibit physical and chemical restraints,

10) Require all vehicles used to transport participants to have working heating and cooling systems,

11) Remove the specific number of hours of staff orientation and initial training while retaining the training requirement,

12) Require at least 40 hours of additional training for all direct care staff,

13) Require first aid and CPR training for all direct care staff,

14) Increase annual in-service training required of direct care staff from eight hours to 12 hours,

15) Require medication management training for adult day care center directors unless the center has a staff person who is licensed to administer medication (such as a nurse),

16) Increase continuing training that is required for individuals who administer medication (from a three-hour refresher course every three years to four hours of additional training every year),

17) Require that center activities be managed by a designated person with required training,

18) Require that all adult day care centers have meal and snack menus posted and available for participants and require that menus be retained for two years (rather than the currently required three months),

19) Require that snacks be made available at all times either in plain view or upon request of day care participants and that second helpings of meals and snacks be provided at no extra charge and

20) Require that the religious dietary practices of the participants be respected and followed unless the participant and care provider mutually agree that the "religious dietary practices of the director, staff or licensees" may be imposed.

Result of Analysis. Benefits likely outweigh costs for most proposed regulatory changes. For some proposed regulatory changes, there is insufficient information to ascertain whether benefits outweigh costs. For several proposed changes, costs likely outweigh benefits.

Estimated Economic Impact. Most changes that the Board proposes for this regulation will not change any substantive requirement for regulated entities but, instead, are aimed at reorganizing regulatory requirements in a more logical order and changing language to clarify regulatory requirements. No affected entities will incur costs on account of changes such as these. Interested parties will benefit from the changed structure of the regulation as it will make it both easier to find and read any particular standard. Benefits likely outweigh costs for all reorganizing and clarifying changes.

Current regulation requires employees of adult day care centers to have a TB antibody test no earlier than 30 days before employment and no later than seven days after employment. Because there has been a shortage of serum to conduct antibody tests for several years now, the Virginia Department of Health guidelines now call for a TB screening that assesses risk factors for, and possible exposure to, TB. The Board now proposes to require that employees undergo TB screening instead of requiring a TB antibody test. This change will allow employees undergoing screening (or their employers) to save at least the lab costs that they would have incurred for the antibody test. Additionally, Board staff reports that adult day care centers that have employee medical staff can have those staff perform the TB screenings for newly hired employees thus saving the cost of an office visit to a doctor. Board staff reports that all adult day care centers that receive funds from either the Elderly or Disabled with Consumer Direction (EDCD) waiver program or the Programs of All-Inclusive Care for the Elderly (PACE) program are required to have medical staff (usually a nurse) and that all but 15 of the 73 adult day care centers in the Commonwealth receive funds from one or both of those two programs. Although there is likely a slightly higher risk of missing a non-symptomatic TB case when employees are screened rather than tested, the shortage of serum makes the changing policy necessary. Nonetheless, risk is likely mitigated by screening to the extent that the benefits to this change likely outweigh its costs.

Current regulation requires adult day care centers to have a list of emergency equipment and supplies so that they can render first aid to center participants. The Board now proposes to remove syrup of ipecac and activated charcoal from the list of required supplies. Board staff reports that both of these items[1] are difficult to administer correctly and that Poison Control no longer recommends that they be kept in first aid supplies. This change will save some small initial and ongoing costs for adult day care centers as these items expire and would need to be periodically replaced. The benefits of this change likely outweigh its costs.

Current regulation has provision for adult day care centers to be inspected. The Board now proposes to add a requirement that all centers perform an annual self-assessment. Board staff reports that the proposed regulation is not prescriptive as to how the self-assessment is produced and that the self-assessment will not be used as part of the inspection process. The self-assessment will involve center staff as well as participants and their families or legal representatives and can take many forms from a formal written survey to informal discussions with participants and their families to ask how well the center is providing services. The Board does propose to require that centers prepare and keep a written record of the results of their self-assessments. There will likely be some time costs for staff as well as copying costs associated with this proposed change. Those costs would need to be measured against any improvements in quality of care that might arise as a result of the self-assessment. There is insufficient information to ascertain whether benefits will outweigh costs.

Current regulation requires centers to keep many types of records and reports but does not have provision for any records to be kept in electronic form. The Board now proposes to allow facilities to keep electronic records and allow electronic signatures on forms. These changes will benefit centers as they will be able to store reports and participant records electronically rather that assigning (or paying for) space to physically store them. Centers will also likely save some time costs not spent on copying reports for physical storage and forms to be signed by center participants. There may be some small costs to purchase electronic memory if centers have a large volume of records that they wish to store electronically. Centers will likely not choose to store records electronically unless they expect the costs of doing so to be less than physically storing the same records, thus the benefits of this proposed change likely outweigh its costs for all centers that choose to store records electronically and/or have forms signed electronically.

Current regulation requires that centers keep a written report of all incidents that involve fire, natural disaster or criminal activity; centers are also required to report such incidents to the State Department of Social Services' Division of Licensing Programs within 24 hours. The Board now proposes to require centers to additionally report any major medical incidents and to send a written report of any major incidents of any sort to the Division of Licensing Programs within seven days. Board staff reports that there is no bright line (such as transport of a center participant to a hospital) that would trigger the necessity for reporting. Instead, center directors and staff will have to use their judgment to decide what medical issues would constitute a major incident. Board staff reports that medical incidents that include heart attack, severe head injury or death would qualify as major incidents. This change will presumably benefit center participants as requiring the additional reporting will allow licensing staff to be aware of incidents that might indicate that there are problems with standards of care that might need to be investigated. Centers may incur some time costs because they will have to report a greater number of incidents and because they will have to newly submit reports to the Division of Licensing Programs. Those costs are likely to be minimal since reports can be submitted electronically. Benefits likely outweigh costs for this proposed change.

Current regulation lays out what qualifications the director of an adult day care center must have. The Board now proposes to expand the kinds of qualifications that are allowed for directors to include licensure as an assisted living facility (ALF) administrator. Board staff reports that licensed ALF administrators have training and education requirements that are at least as stringent as other qualification paths. Expanding the list of individuals who may work as a director for an adult day care center will likely benefit center owners as it expands the pool of potential applicants for positions and allows owners a greater range of choices. Because owners will not be forced to hire ALF administrators, they will likely only take advantage of their additional choice if they judge that benefits of doing so will outweigh the costs.

Current regulation lists participant rights and responsibilities. The Board now proposes to require that centers prominently post a copy of participant rights and responsibilities in the center and get participants or their legal representatives to read and sign a copy of the participant rights and responsibilities. Centers will likely incur some small time costs for meeting this requirement and will also incur some copying costs. These costs would need to be measured against any benefit that might accrue to center participants on account of greater understanding of, and access to, their regulatory rights and responsibilities. There is insufficient information to ascertain whether benefits that may accrue to participants would outweigh the small costs that centers would incur.

Currently regulation requires that centers that, for whatever reason, intend to discharge a participant, and no longer offer them care, give that participant (or their legal representative) 14 days' notice of the intended discharge. Current regulation also allows that notification period to be waived and a participant to be discharged immediately if a "participant's condition presents an immediate and serious risk to the health, safety or welfare of the participant or others."[2] The Board now proposes to extend the notification requirement to 30 days. The Board also proposes to revise the language that allows the notification period to be waived to reflect that extension. This change will likely benefit participants who are being discharged for reasons that do not present and immediate and serious risk to anyone's health or safety, and their representatives, as it will give them longer to make alternate arrangements for care. Centers that are discharging participants whose conditions or behaviors do not present an immediate and serious risk, however, will likely be adversely impacted by this change as it will lengthen the time that they have to care for participants when presumably they feel unable or unwilling to provide that care. There is insufficient information to ascertain whether the benefits that would

likely accrue to participants outweigh the adverse impact on centers.

The Board proposes to add definitions for chemical restraint[3] and physical restraint[4] and prohibit both in adult day care centers. This change will likely benefit center participants as the regulatory prohibition will help ensure that they are not chemically or physically restrained to their detriment. Adult day care centers may incur some costs for modifying the adult day care environment on account of this proposed change. Board staff reports that any physical barrier to free movement, even such things as recliners if they restrict a participant's ability to get up, can constitute a physical restraint. That being the case, owners of adult day care centers will likely have to reexamine their center's physical environment to ensure that any furniture meant to increase the comfort of participants does not constitute a physical restraint. There is insufficient information to ascertain whether the benefits of this change will outweigh its costs.

Current regulation includes rules for vehicles that are used to transport participants. The Board proposes to add to these rules a requirement that any vehicle used for transport have working heat and air conditioning. This change may benefit participants, who tend to be older and may be in fragile health, by ensuring that they are not exposed to temperature extremes. Owners of adult day care centers who may have vehicles used for transport that do not have working heat or air conditioning will have to pay to get those systems repaired or installed. Such heating and air conditioning repairs can costs as little as $50 or as much as over $4,000.[5] Alternately, an adult day care center owner could choose to not allow field trips or otherwise provide transportation for participants if he judges the costs of repair too high. There is insufficient information to ascertain whether the benefits of this proposed change would outweigh its costs.

Changes to Training Requirements:

Current regulation requires that new employees of adult day care centers complete 24 hours of staff orientation and initial training that cover specific topics. The Board now proposes to retain the requirement that specific topics be covered in staff orientation and initial training but proposes to remove the hours of training requirement. This change will benefit all adult day care centers as it will give them greater flexibility to accomplish training on the specified topics as efficiently as possible. These centers will likely save costs in staff time if they are able to complete training on required topics in less than 24 hours. No entity is likely to incur costs on account of this proposed change because new staff will still have to be trained on all required topics. Benefits likely outweigh costs for this proposed change.

The Board proposes to newly require that direct care staff complete additional training. This training can take the form of:

1. Certification as a nurse aide issued by the Virginia Board of Nursing (100 hours),

2. Successful completion of Virginia Board of Nursing approved nurse aide education program (100 hours),

3. Successful completion of a personal care aide program that meets EDCD waiver program requirements (40 hours),

4. Successful completion of certain Board approved out-of-state training as a geriatric assistant, home health aide or nurse aide,

5. Successful completion of a 40-hour Assisted Living Facility Direct Care Training curriculum or

6. Successful completion of at least 40 hours of training that covers specified topics listed in the proposed regulation and taught by a licensed health care professional or, if online, accredited by a national association.

Board staff reports that this change is being made at the behest of advisory panel participants from the industry. Board staff further reports that this training is already required for adult day care centers that participate in the EDCD waiver or PACE programs. This means that the 15 adult day care centers that do not participate in those programs would be the only ones affected. Board staff does not have actual enrollment information but does report that impacted centers have a rated participant capacity of between eight and 65 (with 80% having a rated capacity of 45 participants or lower). This means that if these centers only used full time employees at the staff to participant ratios required by regulation, and assuming enrollment matched capacity,[6] approximately 84 direct care staff would have to undergo at least 40 hours of training. If centers employ part time direct care staff, more staff might need this training than is indicated by full time staff analysis. Additionally, any staff turnover that brings in new direct care staff will necessitate those staff also receiving this training.

Board staff reports that the fee for training option 6 in the list above would be $300. Owners of centers or their employees will incur fee costs as well as time costs for time spent in training. Board staff reports that direct care staff may earn between $7.25 per hour and about $12.50 per hour (depending on experience). Using a rough average of $10 per hour, either owners or employees would incur about $400 in time costs in addition to the $300 fee for training. Other training options would be at least as expensive in time and fee costs and might be much more expensive. These costs will have to be borne by either owners of adult day care centers or by the new employees themselves. For owners, particularly owners of small adult day care centers, these costs will constitute a fairly large burden and may be passed on to participants in the form of higher day care prices. If employees have to pay for training, such training will constitute a considerable disincentive to take employment in an adult day care center when other, similarly low paying, jobs are available and would not require the purchase of training. Absent some showing that current training standards

are inadequate to protect the health and safety of center participants, the costs for this proposed change likely outweigh its benefits.

Current regulation requires that at least one direct care staff member trained in cardiopulmonary resuscitation (CPR) and first aid be on premises at all times. The Board now proposes to require all direct care staff be trained in CPR and first aid. To the extent that the current requirement does not allow staff to adequately respond in a timely fashion to participant emergencies, this change may provide a benefit of increased protection of health and safety for center participants. Either center owners or employees who are not currently receiving CPR and first aid training will incur increased costs. Board staff reports that CPR and first aid certification training each cost approximately $50 every three years and that each would require about four hours of staff time. Using a rate of $10 per hour, this means that costs every three years would equal $180 times the number of direct care staff that would newly be required to complete training. Benefits would likely outweigh these costs only if there are incidents where participant health has suffered because there was only one person required to be in the facility that had CPR and first aid training at any given time.

Current regulation requires adult day care center direct care staff to complete eight hours of in-service training per year. The Board does not currently dictate topics for this training but instead requires that it be "relevant to the needs of the population in care." The Board now proposes to require two hours of training in infection control and four hours of training on center participants' mental impairments. The Board also proposes to raise the total number of in-service training hours to 12. Board staff reports that adult day care centers are seeing an increasing number of participants who suffer from age related mental impairments and also report that infection control training is inadequate right now. Given this, training on these topics would likely be beneficial to both center participants and direct care staff who might feel more adequately prepared to meet participant needs. No additional costs are likely to be incurred solely on account of specifying these training topics. Accordingly, benefits likely outweigh costs for those two changes.

The same may not be true, however, for the proposed increase in total in-service hours. Since current training is undirected, training on these two topics could be accomplished within the currently required eight hours of training (which would leave two additional hours for training on topics directed by center owners or directors). Board staff reports that eight hours of training may be inadequate to cover the two proposed topics and general training. Without a showing of other necessary training that would be getting short shrift, however, there may be little benefit to raising total hours of training to 12. The total costs of this change will be mainly time costs but may also include fees if adult day care owners contract with individuals outside of their center to provide specific training. The costs for direct care staff time will be equal the number of extra hours of in-service training required (four) times the wage rate of the employees completing the training (which likely roughly averages about $10 per hour) times the number of direct care staff statewide.[7] Costs for extra training may also include time costs for other center employees who may provide training. The costs associated with adding additional required training hours will likely exceed any benefit if specified training can be completed in the currently required eight total hours without any loss of staff effectiveness.

Current regulation requires:

1. That adult day care centers have a medication management plan,

2. That staff who will be dispensing medication either successfully complete a medication training program developed by the State Department of Social Services and approved by the Board of Nursing or be licensed in Virginia to administer medication and

3. That staff who dispense medication after successfully completing the program developed by the State Department Social Services complete a three-hour refresher course every three years.

The Board now proposes to require the directors of adult day care centers complete medication management training unless they have medical personnel on staff. Board staff reports that adult day care centers that participate in the EDCD waiver or PACE programs are required to have medical personnel (usually a nurse) on staff so only directors of the 15 centers that do not participate in either of these programs, and do not have medical personnel in their employ separate from any reimbursement requirements, will be required to complete medication management training. Board staff reports that the medication management course consists of 32 hours of training and the fee for the course is $300. Owners of affected adult day care centers, or the directors themselves, will incur training costs that include the $300 fee plus the hourly equivalent of their salary times 32. Board staff reports that directors of adult day care centers likely receive rather low compensation but does not have sufficient information to quantify what the average salary would be. Even without salary information it is likely safe to conclude that time costs for each director will likely be at least several hundred dollars.

The Board also proposes to increase periodic retraining for direct care staff who administer medication from three hours every three years to four hours every year. Board staff reports that the medication administration retraining will cost $50 plus time costs of approximately $40 for each person taking the course. Board staff reports that the increased retraining requirement mimics what is required for registered medication aides. Board staff further reports that medication administration and management are areas where many violations are found during inspections of adult day care centers. To the extent that the additional training that the Board proposes to require decreases the number of times that

medications are mishandled or administered incorrectly, center participants are likely to benefit from these changes. However, there is insufficient information to measure those benefits or ascertain whether they would outweigh quantifiable costs.

Current regulation requires that activities of various sorts be planned and that the planning occur under the supervision of the director. Board staff reports that any employee under the supervision of the director can currently plan and manage activities. The Board now proposes to require that activities be managed by a designated staff person who is:

1. A qualified therapeutic recreation specialist or an activities professional,

2. Eligible for certification as therapeutic recreation specialist or activities professional by a recognized accrediting body,

3. A qualified occupational therapist or an occupational therapy assistant or

4. An individual who has one year of full time experience within the last five years in an activities program in an adult care setting.

Board staff reports that this change is being proposed at the behest of advisory panel participants from the industry. This change will limit the flexibility of centers to assign activities planning tasks in the way they best see fit and may additionally cause them to incur costs for obtaining the services of an individual who has one of the listed qualifications (if they do not have such a person employed as direct care staff now). Absent some empirical evidence that current activity planning is deficient in some way that this requirement would address, costs likely outweigh benefits for this proposed change.

Changes to Nutrition Requirements:

Current regulation requires that adult day care centers post menus for snacks and meals and that menus be retained for three months. An exception to this rule is currently allowed for centers that have meals and snacks catered or contract for food services if the contractor refuses to provide menus. The Board proposes to remove this exception. This change will provide a benefit to participants at centers that currently do not post menus as it will allow participants to know which foods will be available to them and plan accordingly (for instance, packing a lunch if they dislike what is being served on any given day). There should be minimal copying costs for contractors attached to this change. There is a possibility, however, that contractors would continue to refuse to provide menus. If this happens, centers may incur additional costs for searching out and hiring a new food service contractor.

The Board also proposes to require that menus be retained for two years. Board staff reports that this change is proposed as part of an effort to harmonize all record retention requirements. Centers may incur some additional storage costs on account of this requirement.

Current regulation requires that centers serve scheduled snacks and meals. The Board now proposes to also require that snacks be available at all times throughout the day and that second servings of meal and snacks be made available at no additional charge to participants. These changes may benefit some center participants who are still hungry after eating meals or snacks but it also might harm some participants who might fill up on additional snacks and then refuse to eat a meal that might provide more balanced nutrition to them. These changes taken together will likely increase food costs for centers and have the potential to more than double those costs. While the Board plans to prohibit centers from charging for additional food beyond the planned meals and snacks, additional food costs will have to be priced into the costs of day care and day care rates are likely to rise. The magnitude of price increases that can be attributed to these changes will likely be dictated by the magnitude of food cost increases that centers experience. Unless current required meals and snacks are leaving participants underfed, costs likely outweigh benefits for these proposed changes.

Finally, the Board proposes to newly require that the religious dietary practices of center participants be "respected and followed" unless the participants and the care provider mutually agree that "the religious dietary practices of the director, staff or licensees" may be imposed. Although Board staff reports that the Board's intention with this change is to ensure that center participants are not forced to eat food that is prohibited by their religion's dietary restrictions, the proposed language as written appears to require that either centers provide food that meets the strictures of any participant's religious dietary restrictions or that participant must agree to have the religious dietary restrictions of the director, staff or licensee imposed on them. As written, this requirement has the potential to increase costs for centers that do not currently consider participants' religions when planning and preparing meals or choosing a food service or caterer. This is particularly true if participants follow religious dietary restrictions that dictate not only what food may be eaten but also how meat animals may be killed, which cuts of meat from those animals may and may not be eaten and how food must be prepared.[8] On the other hand, participants with religious dietary restrictions who have reached an agreement with the center they attend[9] that does not involve the center providing food compliant with their religion or them signing an agreement that allows any diet to be imposed on them will also be worse off on account of this proposed change. This change may also make it more difficult for individuals who have religious dietary restrictions to find placements in secular adult day care centers that do not currently supply meals compliant with the individuals' particular religion. As written the costs of this proposed change likely outweigh its benefits.

Considered in total, increased costs that adult day care centers will likely incur on account of all of these proposed changes may affect the profitability of these businesses. Owners of

centers that are currently only marginally profitable may choose to close their centers if they judge that their capital and effort can be more profitably spent on other endeavors.

Businesses and Entities Affected. These proposed regulatory changes will affect all adult day care centers licensed by the Board as well as all of their staff and all individuals enrolled in those centers. Board staff reports that there are currently 73 such centers in the Commonwealth. Board staff reports that most centers likely qualify as small businesses.

Localities Particularly Affected. No localities are likely to be particularly affected by these proposed regulatory changes.

Projected Impact on Employment. Increased training requirements in this proposed regulation may marginally increase employment for trainers. Proposed requirements for specific certification or experience for designated activities staff will likely allow individuals with specified certifications or experience a competitive advantage over other candidates for employment at adult day care centers. These proposed requirements are unlikely to increase total employment at adult day care centers, however.

Effects on the Use and Value of Private Property. These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

Real Estate Development Costs. These proposed regulatory changes are unlikely to affect real estate development costs in the Commonwealth.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. Small business adult day care centers will likely incur increased food costs on account of these proposed changes. Centers, or their employees, will incur increased costs for various types of training. Several training costs will fall disproportionately on centers that do not participate in the EDCD waiver or PACE programs or on their employees.

Alternative Method that Minimizes Adverse Impact. The adverse impacts of this proposed regulation may be further minimized if increased training and credential requirements that are not specifically addressing identified deficiencies are eliminated. Allowing greater flexibility for providers and participants to mutually agree on provision of food in participant agreements may lower costs and minimize adverse impacts for all parties. For instance, a provider and participant could agree that the participant will bring food that meets religious dietary requirements from home, that the provider will plan on not providing food for that participant and that the provider will decrease day care fees to account for the decreased care costs for that participant.

Adverse Impacts:

Businesses. Adult day care centers will likely incur increased food costs on account of these proposed changes. Centers, or their employees, will incur increased costs for various types of training. Several training costs will fall disproportionately on centers that do not participate in the EDCD waiver or PACE programs or on their employees.

Localities. Localities in the Commonwealth are unlikely to see any adverse impacts on account of these proposed regulatory changes.

Other Entities. No other entities are likely to be adversely affected by these proposed changes.

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[1] Both syrup of ipecac and activated charcoal are used to counteract poisoning.

[2] This waiver language is in 22 VAC 40-60-660 (C) in the regulation to be repealed and in 22 VAC 40-61-270 (E) in the new regulation.

[3] Chemical restraint is defined as a psychopharmacologic drug that is used for discipline or convenience and not required to treat the participant's medical symptoms or symptoms from mental illness or intellectual disability and that prohibits an individual from reaching his highest level of functioning.

[4] Physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the participant's body that the participant cannot remove easily, which restricts freedom of movement or access to his body.

[5] Cost estimates obtained from http://cars.costhelper.com/car-air-conditioning.html and http://www.autotrader.com/car-news/common-problems-and-typical-repair-costs-33197

[6] Enrollment may be lower than capacity at some affected centers.

[7] Board staff does not know how many people are employed statewide as adult day care center direct care staff but does report that, as of October 7, 2016, all adult day care centers statewide had a combined rated participant capacity of 3,991. Using the direct care staff to participant ratio of one to six, there would be slightly over 665 full time equivalent (FTE) direct care staff if enrollment was equal to capacity. In reality enrollment is unlikely to be as high as capacity. If enrollment number are below capacity, fewer than 665 FTE direct care staff would be affected. To the extent that centers have part time direct care staff, a greater number of individuals may be subject to the increased training requirement than the number of FTEs would indicate.

[8] See http://www.jewfaq.org/kashrut.htm for rules for kosher dietary practices. See https://en.wikipedia.org/wiki/Halal for rules for observant Muslim dietary practices. See https://en.wikipedia.org/wiki/Diet_in_Hinduism for an explanation of various Hindu dietary restrictions.

[9] If these participants are bringing meals and snacks from home that comply with their religious dietary restrictions, for instance.

Agency's Response to Economic Impact Analysis:

The Department of Social Services reviewed the economic impact analysis prepared by the Department of Planning and Budget. The agency does not completely concur with the analysis and provides the following comments:

1. Training for direct care staff and medication administration training. The use of the term "additional" in relation to direct care staff training and medication aide annual training can be misinterpreted. The direct care staff training is a new training requirement and the medication aide training is an enhancement of a current training requirement.

2. Participant rights and responsibilities. Currently, adult day care centers (ADCC) providers are not required to inform participants that they have rights and responsibilities as a care recipient. This requirement will allow participants and families to know that they are guaranteed certain, specific protections while they are in care. The cost for printing the rights and responsibilities is minimal, as it should only require one piece of paper front and back. From a practice perspective, the protection afforded the participant and his family outweighs the cost of the printing.

3. Discharge of participants. The increase of the discharge notification period from 14 days to 30 days will not adversely impact the centers by forcing them to care for individuals that "they feel unable or unwilling to provide that care." 22VAC40-61-270 E allows the provider the ability to forgo the 30-day requirement if the participant's condition presents an immediate and serious risk to the health, safety or welfare of the participant or others. In nonemergency situations, this increase in time allows for better planning and service accessibility for the participant/family. Additionally, it protects the participant from being "dumped" from care without an appropriate plan in place. If alternate care is secured and all parties are in agreement, the discharge can take place prior to the 30th day.

4. Restraints. This standard prohibits any use of chemical or physical restraint and thereby requires the provider to address the care needs of each participant and to determine if anything within the center environment poses a restriction to the freedom of movement to an individual. It is not requiring that major changes be made to the center furniture; rather, the provider needs to address the care needs of participants and determine if something presents a physical restraint to an individual participant. For example, if an individual is able to sit in a recliner and get up from the recliner on his own, then the recliner does not present as a physical restraint. However, if the individual cannot get up from the recliner on his own, then the recliner becomes a physical restraint for that individual. The provider would not need to remove all their recliners and replace them with other furniture, they would simply need to ensure that this individual is seated someplace other than the recliner. Prohibiting chemical and physical restraints is a protection for the participant and is part of their participant's rights.

5. Direct care staff qualifications. This standard is attempting to close a care provision gap that is paramount to the protection and safety of the participants in care. Adult day care exists as an alternative to nursing home placement, with a majority of participants meeting nursing home placement criteria. The nursing home requirement for direct care staff is a CNA level trained individual. Currently, in an adult day care center, an individual with no training in providing assistance with care needs to elderly or disabled individuals can be employed as direct care staff. This means that individuals in some ADCCs who meet nursing home level of care are being cared for by staff who are not required to have any training. By not requiring all ADCCs to meet the same training requirement, we are, in effect, allowing some centers to operate at a lower standard than others, regardless if it is a DSS requirement or a DMAS requirement.

6. Staff training. The increase in training hours allows for the fulfillment (in part) of the required topics of training (two-infection control; four-cognitive impairment). Without this minimal increase, staff may be limited to only completing the same required six hours of training every year, with little opportunity to access other training that could vary significantly in topics related to care provision. This would limit staff in expanding their care knowledge base.

7. Activities. One of the main purposes of attending adult day care is to provide activity stimulation throughout the day. The standard does not limit who can fulfill this requirement, but instead, serves to increase the appropriateness and conduct of activities for the center. It also allows for a dedicated staff person to plan, design and implement activities and gives credibility to that individual's knowledge base.

8. Menu and nutrition requirements. In regards to allowing seconds, the standard is not requiring providers to create meals (either by cooking or catered/contracted meal service) that would serve two portions to every individual. However, if there is extra food and an individual requests seconds, the provider should allow the second portion. The same goes for snacks: the standard is not requiring an open snack bar, to be accessed whenever and however a participant chooses. Staff is responsible for monitoring dietary intake and practices of the participants. If a participant is consistently accessing snacks and then not eating his lunch or gaining significant weight, this would be addressed on the care plan and with that participant.

9. Observance of religious dietary practices. This standard is stating that a provider cannot violate a participant's religious dietary practices by forcing them to consume food that they otherwise would not eat. This standard is not intended to address anything past that (such as how meals are prepared, the manner in which animals are killed, or the parts of the animals being consumed). If this is an issue between the center and the participant, it will need to be addressed and an agreement made between the two parties. This standard is about choice. For example, if an individual does not eat pork, and that is on the menu, the center cannot force the individual to eat the pork. The center can choose to provide an alternate meal, the participant can choose to bring their lunch, the participant can choose not to attend that day, the participant can choose not to attend the center altogether, or the center can choose not to accept the participant. If necessary, technical assistance can be provided to adult day care centers to assist in meeting the intent of the standard.

Summary:

The proposed regulatory action repeals the existing Standards and Regulations for Licensed Adult Day Care Centers (22VAC40-60) and replaces it with a new

regulation, Standards and Regulations for Licensed Adult Day Care Centers (22VAC40-61). The proposed new regulation updates standards to (i) reflect changed practices and procedures, (ii) reflect current federal and state law and regulation, and (iii) improve the organization of the regulation and increase clarity and consistency.

CHAPTER 61
STANDARDS AND REGULATIONS FOR LICENSED ADULT DAY CARE CENTERS

Part I
General Provisions

22VAC40-61-10. Definitions.

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

"Activities of daily living" or "ADLs" means bathing, dressing, toileting, transferring, bowel control, bladder control, eating, and feeding. A person's degree of independence in performing these activities is a part of determining required care needs and necessary services.

"Administer medication" means to open a container of medicine or to remove the ordered dosage and to give it to the participant for whom it is ordered in such a manner as is ordered or is appropriate.

"Adult" means any person 18 years of age or older.

"Adult day care center" or "center" means any facility that is either operated for profit or that desires licensure and that provides supplementary care and protection during only a part of the day to four or more aged, infirm, or disabled adults who reside elsewhere, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Behavioral Health and Developmental Services and (ii) the home or residence of an individual who cares for only persons related to him by blood or marriage. Included in this definition are any two or more places, establishments, or institutions owned, operated, or controlled by a single entity and providing such supplementary care and protection to a combined total of four or more aged, infirm, or disabled adults.

"Advance directive" means (i) a witnessed written document, voluntarily executed by the declarant in accordance with the requirements of § 54.1-2983 of the Code of Virginia or (ii) a witnessed oral statement, made by the declarant subsequent to the time he is diagnosed as suffering from a terminal condition and in accordance with the provisions of § 54.1-2983 of the Code of Virginia.

"Ambulatory" means the condition of a participant who is physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as described in 13VAC5-63, the Virginia Uniform Statewide Building Code, without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such participant may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command to evacuate.

"Business entity" means an individual or sole proprietor, association, partnership, limited liability company, business trust, corporation, public agency, or religious organization.

"Chapter" or "this chapter" means these regulations, that is, Standards and Regulations for Licensed Adult Day Care Centers, 22VAC40-61, unless noted otherwise.

"Chemical restraint" means a psychopharmacologic drug that is used for discipline or convenience and not required to treat the participant's medical symptoms or symptoms from mental illness or intellectual disability and that prohibits an individual from reaching his highest level of functioning.

"Communicable disease" means an illness that spreads from one person to another or from an animal to a person.

"CPR" means cardiopulmonary resuscitation.

"Department" means the Virginia Department of Social Services.

"Dietary supplement" means a product intended for ingestion that supplements the diet, is labeled as a dietary supplement, is not represented as a sole item of a meal or diet, and contains a dietary ingredient, for example, vitamins, minerals, amino acid, herbs or other botanicals, dietary substances (such as enzymes), and concentrates, metabolites, constituents, extracts, or combinations of the preceding types of ingredients. "Dietary supplements" may be found in many forms, such as tablets, capsules, liquids, or bars.

"Direct care staff" means supervisors, assistants, aides, or other staff of a center who assist participants in the performance of personal care or ADLs.

"Director" means the qualified person who has been delegated responsibility for the programmatic and administrative functions of the adult day care center.

"Electronic record" means a record created, generated, sent, communicated, received, or stored by electronic means.

"Electronic signature" means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

"Good character and reputation" means findings have been established that the individual (i) maintains business or professional and community relationships that are characterized by honesty, fairness, truthfulness, and dependability and (ii) has a history or pattern of behavior that demonstrates the individual is suitable and able to administer a program for the care, supervision, and protection of adults.

"Legal representative" means a person legally responsible for representing or standing in the place of the participant for the conduct of his affairs. "Legal representative" may include a guardian, conservator, attorney-in-fact under durable power

of attorney, trustee, or other person expressly named by a court of competent jurisdiction or the participant as his agent in a legal document that specifies the scope of the representative's authority to act. A legal representative may only represent or stand in the place of a participant for the function or functions for which he has legal authority to act. A participant is presumed competent and is responsible for making all health care, personal care, financial, and other personal decisions that affect his life unless a representative with legal authority has been appointed by a court of competent jurisdiction or has been appointed by the participant in a properly executed and signed document. A participant may have different legal representatives for different functions. For any given standard, the term "legal representative" applies solely to the legal representative with the authority to act in regard to the function or functions relevant to that particular standard.

"Licensed health care professional" means any health care professional currently licensed by the Commonwealth of Virginia to practice within the scope of his profession, such as a nurse practitioner, registered nurse, licensed practical nurse (nurses may be licensed or hold multistate licensure pursuant to § 54.1-3000 of the Code of Virginia), clinical social worker, dentist, occupational therapist, pharmacist, physical therapist, physician, physician assistant, psychologist, and speech-language pathologist. Responsibilities of physicians referenced in this chapter may be implemented by nurse practitioners or physician assistants in accordance with their protocols or practice agreements with their supervising physicians and in accordance with the law.

"Licensee" means the business entity to whom a license is issued and who is legally responsible for compliance with the laws and regulations related to the center. A license may not be issued in the name of more than one business entity.

"Mandated reporter" means a person specified in § 63.2-1606 of the Code of Virginia who is required to report matters giving reason to suspect abuse, neglect, or exploitation of an adult.

"Mental impairment" means a disability characterized by the display of an intellectual defect, as manifested by diminished cognitive, interpersonal, social, and vocational effectiveness.

"Nonambulatory" means the condition of a participant who by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person.

"Participant" means an adult who takes part in the program of care and receives services from the center.

"Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the participant's body that the participant cannot remove easily, which restricts freedom of movement or access to his body.

"Physician" means an individual licensed to practice medicine or osteopathic medicine in any of the 50 states or the District of Columbia.

"Qualified" means having appropriate training and experience commensurate with assigned responsibilities, or if referring to a professional, possessing an appropriate degree or having documented equivalent education, training, or experience.

"Significant change" means a change in a participant's condition that is expected to last longer than 30 days. "Significant change" does not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclic pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

"Staff" or "staff person" means personnel working at a center who are compensated or have a financial interest in the center, regardless of role, service, age, function, or duration of employment at the center. "Staff" or "staff person" also includes those individuals hired through a contract with the center to provide services for the center.

"Standard precautions" means a set of basic infection prevention practices intended to prevent transmission of infectious diseases from one person to another. These practices are applied to every person at every contact to assure that transmission of disease does not occur.

"Volunteer" means a person who works at the center who is not compensated. "Volunteer" does not include a person who, either as an individual or as part of an organization, is only present at or facilitates group activities on an occasional basis or for special events.

22VAC40-61-20. Requirements of law and applicability.

A. Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia includes requirements of law relating to licensure, including licensure of adult day care centers.

B. This chapter applies to adult day care centers as defined in § 63.2-100 of the Code of Virginia and in 22VAC40-61-10.

C. All programs, processes, plans, policies, or procedures required by this chapter must be in writing and must be implemented.

22VAC40-61-30. Program of care.

There shall be a program of care that:

1. Meets the participants' physical, intellectual, emotional, psychological, and spiritual needs;

2. Promotes the participants' highest level of functioning;

3. Provides protection, guidance, and supervision;

4. Promotes a sense of security, self-worth, and independence;

5. Promotes the participants' involvement with activities and services; and

6. Reduces risk in the caregiving environment.

22VAC40-61-40. Quality assurance.

At least annually, the center shall conduct an internal evaluation of its operation and services. A written report of the evaluation shall be kept on file and shall include:

1. Involvement of the licensee, program director, staff, participants, family members, legal representative, center's advisory body, if any, and other relevant agencies or organizations.

2. Review of the extent to which the program assisted participants and their families or legal representatives.

3. Measurement of the achievement of the program of care as described in 22VAC40-61-30.

4. Outcome measures as designed by the center, which may include client satisfaction and caregiver surveys.

5. Assessment of the relationship of the program to the rest of the community service network.

6. Recommendations for improvement, corrective action of problem areas, and future program directions.

22VAC40-61-50. Participant rights and responsibilities.

A. All participants shall be guaranteed the following:

1. The right to be treated as an adult, with consideration, respect, and dignity, including privacy in treatment and care of personal needs.

2. The right to participate in a program of services and activities designed to interest and engage the participant and encourage independence, learning, growth, awareness, and joy in life.

3. The right to self-determination within the center setting, including the opportunity to:

a. Participate in developing or changing one's plan of care;

b. Decide whether or not to participate in any given activity;

c. Be involved to the extent possible in program planning and operation;

d. Refuse treatment and be informed of the consequences of such refusal; and

e. End participation at the center at any time.

4. The right to a thorough initial assessment, development of an individualized participant plan of care, and a determination of the required care needs and necessary services.

5. The right to be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided.

6. The right to a safe, secure, and clean environment.

7. The right to receive nourishment and assistance with meals as necessary to maximize functional abilities and quality and enjoyment of life.

8. The right to confidentiality and the guarantee that no personal or medical information or photographs will be released to persons not authorized under law to receive it without the participant's written consent.

9. The right to voice or file grievances about care or treatment and to make recommendations for changes in the policies and services of the center, without coercion, discrimination, threats, or reprisal for having voiced or filed such grievances or recommendations.

10. The right to be fully informed, as documented by the participant's written acknowledgment, of all participant rights and responsibilities and of all rules and regulations regarding participant conduct and responsibilities.

11. The right to be free from harm or fear of harm, including physical or chemical restraint, isolation, excessive medication, and abuse or neglect.

12. The right to be fully informed, at the time of acceptance into the program, of services and activities available and related charges.

13. The right to communicate with others and be understood by them to the extent of the participant's capability.

B. The rights of participants shall be printed in at least 14-point type and posted conspicuously in a public place in the center.

C. The center shall make its policies and procedures available and accessible to participants, relatives, agencies, and the general public.

D. Each center shall post the name and telephone number of the appropriate regional licensing administrator of the department; the Adult Protective Services toll-free telephone number; the toll-free telephone number of the Virginia Long-Term Care Ombudsman Program and any local ombudsman program servicing the area; and the toll-free telephone number of the disAbility Law Center of Virginia.

E. The rights and responsibilities of participants shall be reviewed annually with each participant, or, if a participant is unable to fully understand and exercise his rights and responsibilities, the annual review shall include his family member or his legal representative. Evidence of this review shall include the date of the review and the signature of the participant, family member, or legal representative and shall be included in the participant's file.

F. A participant shall be assumed capable of understanding and exercising these rights and responsibilities unless a physician determines otherwise and documentation is contained in the participant's record.

Part II
Administration

22VAC40-61-60. Requirements for licensee.

A. The licensee shall ensure compliance with all regulations for licensed adult day care centers and terms of the license issued by the department; with relevant federal, state, or local laws; with other relevant regulations; and with the center's own policies and procedures.

B. The licensee shall:

1. Be of good character and reputation;

2. Protect the physical and mental well-being of the participants;

3. Keep such records and make such reports as required by this chapter for licensed adult day care centers. Such records and reports may be inspected by the department's representative at any reasonable time in order to determine compliance with this chapter;

4. Meet the qualifications of the director if he assumes those duties;

5. Act in accordance with General Procedures and Information for Licensure (22VAC40-80);

6. Ensure that the current license is posted in the center in a place conspicuous to the participants and the public; and

7. Be responsible for the overall planning of the program and services to be provided by the center, including the following:

a. Develop and keep current a statement of the purpose and scope of the services to be provided by the center, a description of adults who may be accepted into the program as well as those whom the program cannot serve, and policies and procedures under which the center will operate.

b. Appoint and identify in writing a qualified director to be responsible for the day-to-day operation and management of the center. When the business entity is an individual who serves as the director, this shall also be noted in writing.

c. Provide an adequate number of qualified staff capable of carrying out the operation of the program and to develop a staffing plan that includes a staffing schedule.

d. Develop policies and procedures for the selection and supervision of volunteers.

e. Develop a written organizational chart indicating chain of command.

f. Make certain that when it is time to discard records, the records are disposed of in a manner that ensures confidentiality.

22VAC40-61-70. Liability insurance.

The center shall maintain public liability insurance for bodily injury with a minimum limit of at least $1 million for each occurrence or $1 million aggregate. Evidence of insurance coverage shall be made available to the department's representative upon request.

22VAC40-61-80. Electronic records and signatures.

A. Use of electronic records or signatures shall comply with the provisions of the Uniform Electronic Transactions Act (§ 59.1-479 et seq. of the Code of Virginia).

B. In addition to the requirements of the Uniform Electronic Transactions Act, the use of electronic signatures shall be deemed to constitute a signature and have the same effect as a written signature on a document as long as the licensee:

1. Develops and maintains specific policies and procedures for the use of electronic signatures;

2. Ensures that each electronic signature identifies the individual signing the document by name and title;

3. Ensures that the document cannot be altered after the signature has been affixed;

4. Ensures that access to the code or key sequence is limited;

5. Ensures that all users have signed statements that they alone have access to and use the key or computer password for their signature and will not share their key or password with others; and

6. Ensures that strong and substantial evidence exists that would make it difficult for the signer or the receiving party to claim the electronic representation is not valid.

C. A back-up and security system shall be utilized for all electronic documents.

22VAC40-61-90. Incident reports.

A. Each center shall report to the regional licensing office within 24 hours of the occurrence of any major incident that has negatively affected or that threatens the life, health, safety, or welfare of any participant.

B. The report required in subsection A of this section shall include (i) the name of the center, (ii) the name of the participant or participants involved in the incident, (iii) the name of the person making the report, (iv) the date of the incident, (v) a description of the incident, and (vi) the actions taken in response to the incident.

C. The center shall submit a written report of each incident specified in subsection A of this section to the regional licensing office within seven days from the date of the incident. The report shall be signed and dated by the director or his designee and include the following information:

1. Name and address of the center;

2. Name of the participant or participants involved in the incident;

3. Date and time of the incident;

4. Description of the incident, the circumstances under which it happened, and when applicable, extent of injury or damage;

5. Location of the incident;

6. Actions taken in response to the incident;

7. The outcome of the incident;

8. Actions to prevent recurrence of the incident if applicable;

9. Name of staff person in charge at the time of the incident;

10. Names, telephone numbers, and addresses of witnesses to the incident if any; and

11. Name, title, and signature of the person making the report, if other than the director or his designee.

D. The center shall submit to the regional licensing office amendments to the written report when circumstances require, such as when substantial additional actions are taken, when significant new information becomes available, or when there is resolution of the incident after the submission of the report.

E. A copy of the written report of each incident shall be maintained by the center for at least two years.

F. All reports, such as but not limited to, adult protective services, medical, or police, shall be maintained in the participant's record.

Part III
Personnel

22VAC40-61-100. General qualifications.

All staff members shall:

1. Be of good character and reputation;

2. Be competent, qualified, and capable of carrying out assigned responsibilities;

3. Be considerate, understanding, and respectful of the rights, dignity, and sensitivities of persons who are aged, infirm, and disabled;

4. Be clean and well groomed;

5. Be able to speak, read, understand, and write in English as necessary to carry out their job responsibilities;

6. Be able to understand and apply the standards in this chapter as they relate to their respective responsibilities; and

7. Meet the requirements specified in the Regulation for Background Checks for Assisted Living Facilities and Adult Day Care Centers (22VAC40-90).

22VAC40-61-110. Staff orientation and initial training.

A. Prior to working directly with participants, all staff shall receive training in:

1. Participant rights and responsibilities;

2. Their individual responsibilities in the event of fire, including the location and operation of any fire extinguishers, fire alarm boxes, and approved exits;

3. Their individual responsibilities in the event of illness or injuries, including the location and use of the first aid kit and emergency supplies;

4. Their individual responsibilities in the event of emergencies, such as a lost or missing participant, severe weather, and loss of utilities;

5. Infection control;

6. Requirements and procedures for detecting and reporting suspected abuse, neglect, or exploitation of participants and for the mandated reporters, the consequences for failing to make a required report (§ 63.2-1606 of the Code of Virginia); and

7. Confidential treatment of personal information about participants and their families.

B. Staff who work with participants shall receive training in the following areas or topics no later than three weeks after their starting date of employment; part-time staff shall receive the training no later than six weeks after their starting date of employment. The areas or topics to be covered in the staff training shall include:

1. The purpose and goals of the adult day care center;

2. The policies and procedures of the center as they relate to the staff member's responsibilities;

3. Required compliance with regulations for adult day care centers as it relates to their duties and responsibilities;

4. The physical, emotional, and cognitive needs of the center's population;

5. The current participants' strengths and preferences, their individualized plans of care, and their service needs and supports;

6. The schedule of activities;

7. Behavioral interventions, behavior acceptance and accommodation, and behavior management techniques;

8. Interdisciplinary team approach;

9. Implementation of advance directives and Do Not Resuscitate Orders;

10. Risk management; and

11. The needs of participants' family members or caregivers.

C. A supervisor or designated trained staff shall be on the premises and closely oversee the individual's work with participants until training required in subsection B of this section is complete.

22VAC40-61-120. Reports of abuse, neglect, and exploitation.

A. All staff who are mandated reporters under § 63.2-1606 of the Code of Virginia shall report suspected abuse, neglect, or exploitation of participants in accordance with that section.

B. The center shall notify the participant's contact person or legal representative when a report is made as referenced in subsection A of this section, without identifying any confidential information.

22VAC40-61-130. Director.

A. The director, or a designated assistant director who meets the qualifications of the director, shall be responsible for the center's program and day-to-day operations of the center and shall be present at least 51% of the center's weekly hours of operation. The responsibilities of the director shall include the following areas:

1. The content of the program offered to the participants in care.

2. Programmatic functions, including orientation, training, and scheduling of all staff.

3. Management of the supervision provided to all staff.

4. Assignment of a sufficient number of qualified staff to meet the participants' needs for:

a. Adequate nutrition;

b. Health supervision and maintenance;

c. Personal care;

d. Socialization, recreation, activities, and stimulation; and

e. Supervision, safety, and protection.

5. The duties and responsibilities required by this chapter.

B. The director shall meet the following qualifications:

1. Be at least 21 years of age.

2. Have completed, at a minimum, a bachelor's degree from an accredited college or university and two years of experience working with older adults or persons with disabilities. This may be paid full-time employment or its equivalent in part-time employment, volunteer work, or internship. The following qualifications are also acceptable for the director:

a. Current licensure as a nursing home administrator or assisted living facility administrator from the Board of Long-Term Care Administrators; or

b. Current licensure in Virginia as a registered nurse. The requirement for two years of experience working with older adults or persons with disabilities also must be met.

Exception: Any person continuously employed in an adult day care center licensed prior to July 1, 2000, as either a director or assistant director shall have completed at least 48 semester hours or 72 quarter hours of postsecondary education from an accredited college or institution and shall have completed at least two years experience working with older adults or persons with disabilities. This may be paid full-time employment or its equivalent in part-time employment or in volunteer work.

3. The director shall demonstrate knowledge, skills, and abilities in the administration and management of the adult day care program including (i) knowledge and understanding of the population being served by the center, (ii) supervisory and interpersonal skills, (iii) ability to plan and implement the program, and (iv) knowledge of financial management sufficient to ensure program development and continuity.

C. The director shall complete 24 hours of continuing education training annually to maintain and develop skills. At least two of the required hours of training shall focus on infection control and prevention. When adults with mental impairments participate at the center, at least four of the required hours shall focus on topics related to participants' mental impairments. This training shall be in addition to first aid, CPR, orientation, or initial or refresher medication aide training. Documentation of attendance shall be retained at the center and shall include type of training, name of the entity that provided the training, and date and number of hours of training.

22VAC40-61-140. Direct care staff qualifications.

A. All staff persons who work directly with participants and who are counted in the staff-to-participant ratio shall be at least 18 years of age unless certified in Virginia as a nurse aide.

B. Direct care staff shall meet one of the requirements in this subsection. If the staff does not meet the requirement at the time of employment, he shall successfully meet one of the requirements in this subsection within two months of employment. Licensed health care professionals practicing within the scope of their profession are not required to complete the training in this subsection.

1. Certification as a nurse aide issued by the Virginia Board of Nursing.

2. Successful completion of a Virginia Board of Nursing-approved nurse aide education program.

3. Successful completion of a personal care aide training program that meets the requirements of the Elderly or Disabled with Consumer Direction Waiver program for adult day health care as required by the Department of Medical Assistance Services.

4. Successful completion of an educational program for geriatric assistant or home health aide or for nurse aide that is not covered under subdivision 2 of this subsection. The program shall be provided by a hospital, nursing facility, or educational institution and may include out-of-state training. The program must be approved by the department. To obtain department approval:

a. The center shall provide to the department's representative an outline of course content, dates and hours of instruction received, the name of the entity that provided the training, and other pertinent information.

b. The department will make a determination based on the information in subdivision 4 a of this subsection and provide written confirmation to the center when the educational program meets department requirements.

5. Successful completion of the department-approved 40-hour Assisted Living Facility Direct Care Staff Training curriculum.

6. Successful completion of at least 40 hours of training as taught by a licensed health care professional or, if online training is accessed, accredited by a national association. Topics for this training shall include the following:

a. Participant rights;

b. Physical, biological, and psychological aspects of aging;

c. Health care needs such as hypertension, arthritis, diabetes, heart disease, osteoporosis, stroke, incontinence, skin care, etc.;

d. Functional needs, limitations, and disabilities including sensory, physical, and developmental disabilities; mental illness; substance abuse; and aggressive behavior;

e. Dementia and other cognitive impairment;

f. Assistance with activities of daily living;

g. Body mechanics, ambulation, and transfer;

h. Infection control;

i. Meals and nutrition;

j. Activities; and

k. Safety and accident prevention.

C. The center shall obtain a copy of the certificate issued or other documentation indicating that the person has met one of the requirements of subsection B of this section, which shall be part of the staff member's record in accordance with 22VAC40-61-180.

D. All direct care staff who do not meet one of the requirements in subsection B of this section on the date that this chapter becomes effective shall do so within one year after the effective date of this chapter.

22VAC40-61-150. Staff training.

A. Staff who provide direct care to participants shall attend at least 12 hours of training annually.

B. The training shall be relevant to the population in care and shall be provided by a qualified individual through in-service training programs or institutes, workshops, classes, or conferences.

C. At least two of the required hours of training shall focus on infection control and prevention. When adults with mental impairments participate at the center, at least four of the required hours shall focus on topics related to participants' mental impairments.

D. Documentation of the type of training received, the entity that provided the training, number of hours of training, and dates of the training shall be kept by the center in a manner that allows for identification by individual staff person and is considered part of the staff member's record.

E. The required hours of training shall be in addition to first aid, CPR, orientation, or initial or refresher medication aide training.

22VAC40-61-160. First aid and CPR certification.

A. First aid.

1. Each direct care staff member who does not have current certification in first aid as specified in subdivision 2 of this subsection shall receive certification in first aid within 60 days of employment from the American Red Cross, American Heart Association, National Safety Council, American Safety and Health Institute, community college, hospital, volunteer rescue squad, or fire department. The certification must either be in adult first aid or include adult first aid.

2. Each direct care staff member shall maintain current certification in first aid from an organization listed in subdivision 1 of this subsection. To be considered current, first aid certification from community colleges, hospitals, volunteer rescue squads, or fire departments shall have been issued within the past three years. The certification must either be in adult first aid or include adult first aid.

3. A direct care staff member who is a registered nurse or licensed practical nurse does not have to meet the requirements of subdivisions 1 and 2 of this subsection. With current certification, an emergency medical technician, first responder, or paramedic does not have to meet the requirements of subdivisions 1 and 2 of this subsection.

4. There shall be at least one staff person on the premises at all times who has current certification in first aid that meets the specifications of this section, unless the center has an on-duty registered nurse or licensed practical nurse.

B. Cardiopulmonary resuscitation.

1. Each direct care staff member who does not have current certification in CPR as specified in subdivision 2 of this subsection shall receive certification in CPR within 60 days of employment from the American Red Cross, American Heart Association, National Safety Council, American Safety and Health Institute, community college, hospital, volunteer rescue squad, or fire department. The certification must either be in adult CPR or include adult CPR.

2. Each direct care staff member shall maintain current certification in CPR from an organization listed in subdivision 1 of this subsection. To be considered current, CPR certification from community colleges, hospitals, volunteer rescue squads, or fire departments shall have been issued within the past two years. The certification must either be in adult CPR or include adult CPR.

3. There shall be at least one staff person on the premises at all times who has current certification in CPR that meets the specifications of this section.

C. A staff person with current certification in first aid and CPR shall be present for the duration of center-sponsored activities off the center premises.

22VAC40-61-170. Volunteers.

A. Individuals who volunteer at the center shall:

1. Have qualifications appropriate to the services they render; and

2. Be subject to laws and regulations governing confidential treatment of personal information.

B. No volunteer shall be permitted to serve in an adult day care center without the permission or unless under the supervision of a person who has received a criminal record clearance pursuant to § 63.2-1720 of the Code of Virginia.

C. Duties and responsibilities of all volunteers shall be clearly defined in writing.

D. At least one staff member shall be assigned responsibility for overall selection, supervision, and orientation of volunteers.

E. All volunteers shall be under the supervision of a designated staff person when participants are present.

F. Prior to beginning volunteer service, all volunteers shall attend an orientation including information on their duties and responsibilities, participant rights, confidentiality, emergency procedures, infection control, the name of their supervisor, and reporting requirements. All volunteers shall sign and date a statement that they have received and understood this information.

G. Volunteers may be counted in the staff-to-participant ratio if both of the following criteria are met:

1. These volunteers meet the qualifications and training requirements for staff; and

2. For each volunteer, there shall be at least one staff also counted in the staff-to-participant ratio.

22VAC40-61-180. Staff records and health requirements.

A. A record shall be established for each staff member and shall be kept in a locked cabinet or area, or secured electronically, and retained at the center for currently employed staff and for two years after termination of employment, unless otherwise required by other state or federal regulations.

B. All staff records shall be kept confidential.

C. Records shall be updated and kept current as changes occur.

D. Personal and social data to be maintained on staff are as follows:

1. Name;

2. Birth date;

3. Current address and telephone number;

4. Position title and date employed;

5. Last previous employment;

6. An original criminal record report and a sworn disclosure statement;

7. Previous experience or training or both;

8. Documentation of qualifications for employment related to the staff person's position, including any specified relevant information;

9. Verification of current professional license, certification, registration, or completion of a required approved training course;

10. Name and telephone number of a person to contact in an emergency;

11. Documentation of attendance of formal training received after employment, including title of course, location, date, number of contact hours, and name of the entity that provided the training; and

12. Date of termination of employment.

E. The following required health information shall be maintained at the center and be included in the staff record for each staff member and each volunteer who comes in contact with participants.

1. Initial tuberculosis (TB) examination and report.

a. Each staff person shall obtain an evaluation by a qualified licensed practitioner that completes an assessment for tuberculosis in a communicable form no earlier than 30 days before or no later than seven days after employment or contact with participants.

b. The tuberculosis evaluation shall be consistent with the TB risk assessment as published by the Virginia Department of Health, with additional testing, singly or in combination, as deemed necessary.

c. Documentation of this evaluation shall include all pertinent information contained on the "Report of Tuberculosis Screening" form recommended by the Virginia Department of Health. This documentation shall be maintained at the facility.

d. An evaluation shall not be required for an individual who (i) has separated from employment with a facility or center licensed or certified by the Commonwealth of Virginia, (ii) has had a break in service of six months or less, and (iii) submits the original statement of tuberculosis screening to the new employer.

2. Subsequent evaluations for tuberculosis.

a. All staff shall be screened annually in accordance with subsection 1 of this section, with the exception that annual chest x-rays are not required in the absence of symptoms for those with prior positive test results for TB infection (tuberculin skin test or interferon gamma release assay blood test).

b. Any staff person who develops chronic respiratory symptoms of three weeks duration shall be evaluated immediately for the presence of infectious tuberculosis. Any staff suspected of having infectious tuberculosis shall not be allowed to return to work or have any contact with the participants and staff of the center until a

physician has determined that the staff person is free of infectious tuberculosis.

c. Any staff person who comes in contact with a known case of infectious tuberculosis shall be screened as determined appropriate based on consultation with the local health department.

3. The center shall report any active case of tuberculosis developed by a staff member to the local health department.

Part IV
Supervision

22VAC40-61-190. General supervision.

A. During the center's hours of operation, one staff person on the premises shall be in charge of the administration of the center. This person shall be either the director or a staff member appointed by the licensee or designated by the director. This person may not be a volunteer.

B. At least two staff persons shall be on duty at the center and on field trips at all times when one or more participants are present. The use of volunteers as staff shall be in accordance with 22VAC40-61-170 G.

C. The center shall maintain a daily participant attendance log, documenting the name of the participant and his arrival and departure time.

22VAC40-61-200. Staff-to-participant ratio.

A. There shall be at least one staff person on duty providing direct care and supervision for every six participants in care, or portion thereof, whether at the center or on field trips.

B. The staff-to-participant ratio is to be calculated for the center rather than for a room or activity.

C. The number of any additional staff persons required shall depend upon:

1. The program and services the center provides;

2. The assessed functional levels and current needs of the participants; and

3. The size and physical layout of the building.

Part V
Admission, Retention, and Discharge

22VAC40-61-210. Admission policies.

A. The center shall have admission policies, to include admission criteria, that shall be discussed with each person entering the program, his family members, legal representative, or the public, as appropriate. A copy of the admission policies shall be available upon request.

B. Only those persons who meet the admission criteria shall be admitted to the center.

C. All participants shall be 18 years of age or older.

22VAC40-61-220. Assessment procedures.

A. A written assessment of a participant shall be secured or conducted prior to admission by the director, a staff person who meets the qualifications of the director, or a licensed health care professional employed by the center.

B. The assessment shall be based upon the information presented by the participant, family members, friends, legal representative, the report of the required physical examination, and from other care providers.

C. The assessment shall identify the person's abilities and needs to determine if and how the program can serve the participant.

D. The assessment shall include at minimum a description of the participant's:

1. Medical and functional condition, including:

a. Ambulatory ability;

b. Ability to perform activities of daily living; and

c. Health status to include diagnoses and medications.

2. Mental status, including any intellectual, cognitive, and behavioral impairment and known psychiatric or emotional problems;

3. Social environment, including living arrangements and the availability of family, friends, and other people and organizations in the community to provide services to the participant;

4. Economic conditions;

5. Nutrition needs;

6. Communication limitations;

7. Hobbies and interests; and

8. Personal preferences that would enhance the participant's experience at the center.

E. The assessment shall be reviewed and updated at least every six months.

F. A reassessment shall also be made when there are changes to indicate that a participant's needs may no longer be met by the current plan of care or the center's program of care.

G. The initial assessment and any reassessments shall be in writing and completed, signed, and dated by the staff person identified in subsection A of this section. The assessment or reassessment shall also indicate any other individuals who contributed to the development of the plan with a notation of the date of the contribution.

22VAC40-61-230. Participant plan of care.

A. Prior to or on the date of admission, a preliminary multidisciplinary plan of care based upon the assessment shall be developed for each participant. The plan shall be reviewed and updated, if necessary, within 30 days of admission.

B. The plan shall be developed by the director, a staff person who meets the qualifications of the director, or a licensed health care professional employed by the center.

C. The plan shall be developed in conjunction with the participant and, as appropriate, with the participant's family

members, legal representative, direct care staff members, case manager, or health care provider.

D. The plan shall be developed to maximize the participant's level of functional ability and to support the principles of individuality, personal dignity, and freedom of choice. Whenever possible, participants shall be given a choice of options regarding the type and delivery of services. The plan shall include:

1. A description of the identified needs and the date identified;

2. The expected outcome or goal to be achieved in meeting those needs;

3. The activities and services that will be provided to meet those outcomes or goals, who will provide them, and when they will be provided;

4. If appropriate, the time by which the outcome or goals should be achieved; and

5. Date outcome or goal achieved.

E. The plan of care shall be reviewed and updated as significant changes occur and at least every six months.

F. The preliminary plan of care and any updated plans shall be in writing and completed, signed, and dated by the staff person identified in subsection B of this section. The participant, family member, or legal representative shall also sign the plan of care. The plan shall indicate any other individual who contributed to the development of the plan, with a notation of the date of contribution.

22VAC40-61-240. Participant agreement with the center.

A. At or prior to the time of admission, there shall be a written agreement between the participant and the center. The agreement shall be signed and dated by the participant or legal representative and the center representative.

B. The agreement shall specify the following:

1. Services and care to be provided to the participant by the center. Any additional fees for specific services and care shall be identified.

2. Financial arrangement to include:

a. The amount to be paid, frequency of payments, and rules relating to nonpayment.

b. The amount and purpose of an advance payment or deposit payment and the refund policy for such payment.

c. The policy with respect to increases in charges and the length of time for advance notice of intent to increase charges.

d. The refund policy to apply when transfer of ownership, closing of center, or participant discharge occurs.

e. The fee or notification requirement, if any, associated with participant discharge.

f. The provision of a monthly statement or itemized receipt of the participant’s account.

3. Conditions for discharge.

C. A copy of the signed agreement shall be given to the participant or to the legal representative, as appropriate, and a copy shall be kept in the participant's record at the center.

D. The agreement shall be reviewed and updated whenever there is any change in the services or the financial arrangements. The updated agreement shall be signed and dated by the participant or his legal representative and the center representative.

22VAC40-61-250. Participant record.

A. The center shall establish policies and procedures for documentation and recordkeeping to ensure that the information in participant records is accurate, clear, and well organized. The record shall contain all information, reports, and documents required by this chapter and other information relevant to the plan of care.

B. The following personal information shall be kept current for each participant:

1. Full name of participant, address, and telephone number;

2. Date of admission;

3. Birth date;

4. Marital status;

5. Names, addresses, and telephone numbers of at least two family members, friends, or other designated people to be contacted in the event of illness or an emergency;

6. Names, addresses, and telephone numbers of the participant's local primary care provider, personal physician, any other health or social service provider and the name of the preferred hospital in the event of an emergency;

7. Name, address, and telephone number of any legal representative and documentation regarding the scope of their representation;

8. Known allergies, if any;

9. Information regarding an advance directive or Do Not Resuscitate Order, if applicable;

10. Mental health, substance abuse, or behavioral concerns; and

11. A current photograph or narrative physical description of the participant, which shall be updated annually.

C. Participant records shall be retained at the center and kept in a locked area.

D. The center shall assure that all records are kept confidential and that information shall be made available only when needed for care of the participant and in accordance with applicable federal and state laws. All records shall be made available for inspection by the department's representative.

E. If the participant or legal representative consents in writing, records shall be shared with other centers or agencies

for a specific purpose such as care coordination, referral for other services, or upon discharge.

F. Participants shall be allowed access to their own records. A legal representative of a participant shall be provided access to the participant's record or part of the record only as allowed within the scope of his legal authority.

G. The complete participant record shall be retained for at least two years after the participant leaves the center.

22VAC40-61-260. Physical examinations and report.

A. Within the 30 days preceding admission, a participant shall have a physical examination by a licensed physician.

B. The report of the required physical examination shall be on file at the center and shall include:

1. The person's name, address, and telephone number.

2. The date of the physical examination.

3. Height, weight, and blood pressure.

4. Significant medical history.

5. General physical condition, including a systems review as is medically indicated.

6. All diagnoses and significant medical problems.

7. Any known allergies and description of the person's reactions.

8. Any recommendations for care including:

a. A list of all medications including dosages, route, and frequency of administration;

b. Any special diet or any food intolerances;

c. Any therapy, treatments, or procedures the individual is undergoing or should receive and by whom; and

d. Any restrictions or limitations on physical activities or program participation.

9. The participant shall obtain an evaluation by a qualified licensed practitioner that completes an assessment for tuberculosis (TB) in a communicable form no earlier than 30 days before admission. The evaluation for tuberculosis shall be consistent with the TB risk assessment as published by the Virginia Department of Health, with additional testing, singly or in combination, as deemed necessary. Documentation of the TB evaluation is required, which includes the information contained on the form "Report of Tuberculosis Screening" recommended by the Virginia Department of Health. The form shall be signed by the qualified licensed practitioner who performs the evaluation.

10. A statement that specifies whether the individual is considered to be ambulatory or nonambulatory.

11. A statement that specifies whether the individual is or is not capable of self-administering medication.

12. The signature of the examining physician or his designee.

C. Subsequent medical evaluations.

1. Each participant shall annually submit a report of physical examination by a physician including the information required in subdivisions B 1 through B 8 and B 10, B 11, and B 12 of this section.

2. At the request of the licensee or director of the center or the Department of Social Services, a report of examination by a physician shall be obtained when there are indications that the center can no longer provide appropriate or safe care because of changes in the participant's physical or mental health. The written report of the physical examination shall be:

a. Dated;

b. Signed by a physician or the physician's designee; and

c. Used in evaluating the participant's continued suitability for adult day care.

D. Subsequent evaluations for tuberculosis.

1. Any participant who comes in contact with a known case of infectious tuberculosis shall be screened as deemed appropriate in consultation with the local health department.

2. Any participant who develops respiratory symptoms of three or more weeks duration shall be evaluated immediately for the presence of infectious tuberculosis. Any such participant shall not be allowed to return to the program until a physician has determined that the individual is free of infectious tuberculosis.

3. If a participant develops an active case of tuberculosis, the center shall report this information to the local health department.

22VAC40-61-270. Discharge of participants.

A. When actions, circumstances, conditions, or care needs occur that will result in the discharge of a participant, discharge planning shall begin immediately.

B. A written discharge notice shall identify the reasons for discharge and outline the services needed by the participant upon discharge. The discharge notice shall be provided to and discussed with the participant and family members or legal representative.

C. The center shall notify the participant and family members or legal representative at least 30 calendar days prior to the actual discharge date.

D. The center shall develop a policy regarding the number of days notice that is required when a participant wishes to leave the center. Any required notice of intent to leave shall not exceed 30 calendar days.

E. When a participant's condition presents an immediate and serious risk to the health, safety, or welfare of the participant or others and immediate discharge is necessary, the 30-day notification of planned discharge does not apply.

F. The center shall assist the participant, his family members or legal representative, if any, in the discharge or transfer process. The center shall prepare a transfer report for the new program, if requested.

G. The center shall have a process by which participants, family members, or legal representatives can appeal a center-initiated discharge.

Part VI
Programs and Services

22VAC40-61-280. Health care supervision.

A. The center shall develop a policy and procedure for monitoring the health status of participants consistent with the particular characteristics and needs of the population served by the center.

B. The center shall provide supervision of participant schedules, care, and activities including attention to specialized needs, such as prevention of falls and wandering.

C. Each participant shall be continually observed and monitored for changes in health status including physical, social, emotional, and mental functioning. Changes shall be discussed with the participant, family, legal representative, physician, or others as appropriate. Documentation of the change and any notifications shall be made in the participant's record.

D. Measures of health status include:

1. Vital signs;

2. Weight;

3. Meal and fluid intake;

4. Elimination;

5. Skin integrity;

6. Behavior;

7. Cognition;

8. Functional ability; and

9. Special needs.

E. When the center identifies a need for a change in health care services, this shall be discussed with the participant, family, legal representative, physician, or others as appropriate and documented in the participant's record. The care plan shall be updated if necessary.

F. If the participant requires skilled or rehabilitative services, the center shall assist the participant and family in securing such services if necessary.

G. If skilled health care and rehabilitative services are provided at the center, the center shall ensure that such providers are licensed, certified, or registered as required by law. These services shall be provided in accordance with the physician or other health care professional's order.

22VAC40-61-290. Infection control program.

A. The center shall develop and maintain an infection prevention and occupational health program compliant with Occupational Safety and Health Administration regulations designed to provide a safe, sanitary, and comfortable environment for participants, staff, and the public.

B. The center shall develop infection prevention policies and procedures appropriate for the services provided by the center and including the physical plant and grounds. These shall be based upon evidence-based guidelines such as those published by the Centers for Disease Control and Prevention or the Virginia Department of Health and updated as recommendations change and shall include:

1. Standard precautions to include:

a. Hand hygiene;

b. Use of personal protective equipment such as gloves and masks;

c. Safe injection and blood glucose monitoring practices;

d. Safe handling of potentially contaminated equipment or surfaces in the center environment; and

e. Respiratory hygiene and cough etiquette.

2. Specific methods and timeframes to monitor infection prevention practices by staff and volunteers.

3. Parameters for ensuring that staff, volunteers, and participants with communicable disease or infections are prohibited from direct contact with others if contact may transmit disease, in accordance with applicable local, state, and federal regulations.

4. Handling, storing, processing, and transporting linens, supplies, and equipment consistent with current infection prevention methods.

5. Handling, storing, and transporting medical waste in accordance with applicable regulations.

6. Maintaining an effective pest control program.

C. The center shall ensure that at least one staff person with training in infection prevention specific to this setting is employed by or regularly available (e.g., by contract) to manage the center's infection prevention program.

D. All staff and volunteers shall be trained on requirements of the center's infection prevention program according to their job duties during the orientation period and at least annually. Competencies shall be documented following each training and may include a written test, skills demonstration, or other method as appropriate.

E. The center shall ensure that sufficient and appropriate supplies to maintain standard precautions are available at all times, such as gloves, hand hygiene and cleaning products, and any other supplies needed specific to center services.

F. The director shall be responsible for ensuring that any outbreak of disease as defined by the Virginia Department of Health is immediately reported to the local health department and to the regional licensing office.

22VAC40-61-300. Medication management.

A. The center shall have, keep current, and implement a plan for medication management. The center's medication management plan shall address procedures for administering medication and shall include:

1. Standard operating procedures and any general restrictions specific to the center;

2. Methods to ensure an understanding of the responsibilities associated with medication management including the following:

a. Determining that staff who are responsible for administering medications meet the qualification requirements of subdivisions E 7 a and E 7 b of this section;

b. Ensuring that staff who are responsible for administering medications are trained on requirements of the center's medication management plan; and

c. Ensuring that staff who are responsible for administering medications are adequately supervised, including periodic direct observation of medication administration. Supervision shall be provided by (i) an individual employed by the center who is licensed by the Commonwealth of Virginia to administer medications or (ii) the director who has successfully completed a training program as required in subdivisions E 7 a and E 7 b of this section.

3. Methods to ensure that authorizations for the administration of medications are current;

4. Methods to secure and maintain supplies of each participant's prescription medications and any over-the-counter drugs and supplements in a timely manner to avoid missed dosages;

5. Methods for verifying that medication orders have been accurately transcribed to medication administration records (MARs), including within 24 hours of receipt of a new order or a change in an order;

6. Methods for monitoring medication administration and the effective use of the MARs for documentation;

7. Methods to ensure that participants do not receive medications or dietary supplements to which they have known allergies;

8. Methods to ensure accurate accounting for all controlled substances whenever received by center staff, returned to participant, or whenever assigned medication administration staff changes;

9. Procedures for proper disposal of medication; and

10. Procedures for preventing, detecting, and investigating suspected or reported drug diversion.

B. The center shall have readily accessible as reference materials for medication aides, at least one pharmacy reference book, drug guide, or medication handbook for nurses that is no more than two years old.

C. Prescription and nonprescription medications, including sample medications, shall be given to a participant according to the center's medication policies and only with written or verbal authorization from the physician or prescriber, or the physician's authorized agent. For the purposes of this section, an "authorized agent" means an employee of the physician who is under his immediate and personal supervision. Verbal orders shall be reviewed and signed by the physician or prescriber within 10 working days.

D. The center shall maintain a list of all medications, including those taken at home and at the center, for each participant. The center shall attempt to verify and update the list of center-administered medications with the prescribing health care professional at least twice a year. Unsuccessful attempts to verify shall be documented.

E. The following standards shall apply when medications are administered to participants at the adult day care center:

1. All medication shall be in the original container with the prescription label or direction label attached and legible. Sample medications shall remain in the original packaging, labeled by a physician or other prescriber or pharmacist with the participant's name, the name of the medication, the strength, dosage, and route and frequency of administration, until administered.

2. All medication shall be labeled with the participant's name, the name of the medication, the strength and dosage amount, the route of administration, and the frequency of administration.

3. The medication shall be kept in a locked compartment or area, not accessible to participants. The locked compartment or area shall be free from direct sunlight and high temperatures and free from dampness and shall remain darkened when closed.

4. The area in which the medication is prepared shall have sufficient light so that the labels can be read accurately and the correct dosage can be clearly determined.

5. Medication shall be refrigerated, if required. When medication is stored in a refrigerator used for food, the medications shall be stored together in a locked container in a clearly defined area. If a refrigerator is used for medication only, it is permissible to store dietary supplements and foods and liquids used for medication administration.

6. Unless it is contrary to the center's policy, a participant may take his own medication provided that:

a. A physician has deemed the participant capable of administering medication to himself;

b. The physician has given written authorization for the participant to self-administer his medication; and

c. Medications are kept in a safe manner inaccessible to other participants.

7. When the center staff administers medications to participants, the following standards shall apply:

a. Each staff person who administers medication shall be authorized by § 54.1-3408 of the Code of Virginia. All staff responsible for medication administration shall:

(1) Be licensed by the Commonwealth of Virginia to administer medications;

(2) Be a registered medication aide;

(3) Successfully complete a training program approved by the Board of Nursing and accepted in adult day care centers; or

(4) Successfully complete a training program approved by the Board of Nursing for the registration of medication aides that consists of 68 hours of student instruction and training.

b. All staff who administer medications, except those licensed by the Commonwealth, shall complete, on an annual basis, four hours of medication management refresher training on topics specific to the administration of medications in the adult day care center setting.

c. Medications shall remain in the original or pharmacy issued container until administered to the participant by the qualified medication staff. All medications shall be removed from the pharmacy container and be administered by the same qualified person within one hour of the individual's scheduled dosing time.

d. Documentation shall be maintained on the MAR of all medications, including prescription, nonprescription, and sample medication, administered to a participant while at the center. This documentation shall become part of the participant's permanent record and shall include:

(1) Name of participant;

(2) All known allergies;

(3) Diagnosis, condition, or specific indications for which the medication is prescribed;

(4) Date medication prescribed;

(5) Drug product name;

(6) Dosage and strength of medication;

(7) Route of administration;

(8) Frequency of administration;

(9) Date and time given and initials of staff administering the medication;

(10) Date the medication is discontinued or changed;

(11) Any medication errors or omissions;

(12) Notation of any adverse effects or unusual reactions that occur; and

(13) The name, signature, and initials of all staff administering medications. A master list may be used in lieu of this documentation on individual MARs.

F. In the event of an adverse drug reaction or a medication error, the following applies:

1. Action shall be taken as directed by a physician, pharmacist, or a poison control center;

2. The participant's physician and family member or other legal representative shall be notified as soon as possible; and

3. Medication administration staff shall document actions taken in the participant's record.

G. The use of PRN (as needed) medications is prohibited unless one or more of the following conditions exist:

1. The participant is capable of determining when medication is needed;

2. A licensed health care professional administers the medication;

3. The participant's physician has provided detailed written instructions, including symptoms that might indicate the need for the medication, exact dosage, exact timeframes the medication is to be given in a 24-hour period, and directions for what to do if symptoms persist; or

4. The center staff has telephoned the participant's physician prior to administering the medication and explained the symptoms and received a documented verbal order that includes the information in subdivision 3 of this subsection.

H. Any physician ordered treatment provided by staff shall be documented and shall be within the staff's scope of practice.

22VAC40-61-310. Restraints.

The use of chemical or physical restraints is prohibited.

22VAC40-61-320. Assistance with activities of daily living.

A. Dignity, privacy, and confidentiality shall be maintained for participants whenever assistance with activities of daily living (ADLs) is provided.

B. When providing assistance with ADLs, staff shall ensure all necessary supplies and equipment are available and organized to aid in assistance and to maximize the participant's safety.

C. Assistance with eating and feeding.

1. Dining areas shall be supervised by staff whenever meals or snacks are served.

2. Additional staff shall be present in the dining areas to assist participants who cannot eat independently.

3. Self-feeding skills of participants shall be continuously observed and evaluated so that meals and snacks are not missed because of a participant's inability to feed himself.

4. Appropriate adapted utensils, including adapted plates, bowls, and cups with straws and handles, shall be provided for those participants who need them. Information about effective eating adaptations shall be shared with the participant's family. Assistance such as, but not limited to,

opening containers and cutting food shall be provided to those participants who need it.

5. Low-stimulus dining areas shall be provided for participants with cognitive deficits or other conditions that impair concentration.

6. Changes in food and liquid intake shall be documented in the participant's record, and changes shall be made to the care plan to ensure adequate intake. The participant's family shall be notified of such changes.

D. Assistance with ambulation and transfer.

1. The ability of the participant to safely transfer and ambulate shall be continually monitored. Any changes shall be documented in the participant's record and noted on the plan of care.

2. There shall be adequate staff to provide individualized assistance to participants to ambulate to activities, meals, and the restroom if such assistance is needed.

3. The center shall have at least one wheelchair available for emergency use, even if all participants are ambulatory or have their own wheelchairs.

4. Staff shall identify unmet ambulation and transfer needs, including equipment needs and repairs, and shall discuss such needs with the participant, family, legal representative, or physician, as appropriate.

5. Participants who use wheelchairs shall be offered other seating options throughout the day if appropriate.

E. Assistance with toileting.

1. Staff shall develop and follow appropriate toileting procedures for each participant who requires assistance according to that individual's abilities and plan of care.

2. Participants who are at risk of falling or who have other safety risks shall not be left alone while toileting.

3. Staff shall arrange for coverage of program responsibilities when they must leave the group to assist with toileting a participant.

F. Assistance with bathing.

1. A shower chair, bench, or other seating; safety equipment such as grab bars; and nonslip surfaces shall be provided.

2. The participant shall not be left unattended in the shower or bath. If the bathing area is not in sight or sound of other occupied parts of the building, there shall be an emergency call system to summon additional assistance.

G. Assistance with dressing.

1. Assistance shall be provided according to that individual's abilities and plan of care.

2. Extra clothing shall be available for participants who need to change during the day. Each participant may keep a change of clothing at the center, or the center may keep a supply to use as needed.

3. Participants' clothing, equipment, and supplies kept at the center shall be properly labeled and stored to prevent loss.

4. Special attention shall be given to footwear of participants who are at risk of falling. Staff shall encourage family members to provide appropriate shoes and shall document those recommendations in the participant's record.

22VAC40-61-330. Activities.

A. Activities shall be planned to support the plans of care for the participants and shall be consistent with the program statement and the admission policies.

B. Activities shall:

1. Support the physical, social, mental, and emotional skills and abilities of participants in order to promote or maintain their highest level of independence or functioning;

2. Accommodate individual differences by providing a variety of types of activities and levels of involvement; and

3. Offer participants a varied mix of activities including the following categories: physical; social; cognitive, intellectual, or creative; productive; sensory; reflective or contemplative; outdoor; and nature or the natural world. Community resources as well as center resources may be used to provide activities. Any given activity may fall under more than one category.

C. Participation in activities.

1. Participants shall be encouraged but not forced to participate in activity programs offered by the center and the community.

2. During an activity, each participant shall be encouraged but not coerced to join in the activity at his level of functioning, which may include his observation of the activity.

3. If appropriate to meet the needs of the participant with a short attention span, multiple short activities shall be provided.

4. Any restrictions on participation imposed by a physician shall be followed and documented in the participant's record and the plan of care.

D. There shall be a designated staff person who is routinely present in the center and who shall be responsible for managing or coordinating the structured activities program. This staff person shall maintain personal interaction with the participants and familiarity with their needs and interests and shall meet at least one of the following qualifications:

1. Be a qualified therapeutic recreation specialist or an activities professional;

2. Be eligible for certification as a therapeutic recreation specialist or an activities professional by a recognized accrediting body;

3. Be a qualified occupational therapist or an occupational therapy assistant; or

4. Have one year full-time work experience within the last five years in an activities program in an adult care setting.

E. Participants, staff, and family members shall be encouraged to be involved in the planning of the activities.

F. Schedule of activities.

1. There shall be planned activities and programs throughout the day whenever the center is in operation.

2. A written schedule of activities shall be developed on a monthly basis.

3. The schedule shall include:

a. Group activities for all participants or small groups of participants; and

b. The name, type, date, and hour of the activity.

4. If one activity is substituted for another, the change shall be noted on the schedule.

5. The current month's schedule shall be posted in a readily accessible location in the center and also may be made available to participants and their families.

6. The schedule of activities for the preceding two years shall be kept at the center.

7. If a participant requires an individual schedule of activities, that schedule shall be a part of the plan of care.

G. During an activity, when needed to ensure that each of the following is adequately accomplished, there shall be staff persons or volunteers to:

1. Lead the activity;

2. Assist the participants with the activity;

3. Supervise the general area;

4. Redirect any individuals who require different activities; and

5. Protect the health, safety, and welfare of the participants involved in the activity.

H. The staff person or volunteer leading the activity shall have a general understanding of the following:

1. Attention spans and functional levels of each of the participants;

2. Methods to adapt the activity to meet the needs and abilities of the participants;

3. Various methods of engaging and motivating individuals to participate; and

4. The importance of providing appropriate instruction, education, and guidance throughout the activity.

I. Adequate supplies and equipment appropriate for the program activities shall be available in the center.

J. All equipment and supplies used shall be accounted for at the end of the activity so that a safe environment can be maintained.

K. In addition to the required scheduled activities, there shall be unscheduled staff and participant interaction throughout the day that fosters an environment that promotes socialization opportunities for participants.

22VAC40-61-340. Food service.

A. Meals and snacks shall be provided by the center. The center shall (i) prepare the food, (ii) have the food catered, or (iii) utilize a contract food service.

B. When any portion of an adult day care center is subject to inspection by the Virginia Department of Health, the center shall be in compliance with those regulations, as evidenced by an initial and subsequent annual report from the Virginia Department of Health. The report shall be retained at the center for a period of at least two years.

C. If a catering service or contract food service is used, the service shall be approved by the local health department. The center shall be responsible for monitoring continued compliance by obtaining a copy of the Virginia Department of Health approval.

D. The center shall encourage, but not require, participants to eat the meals and snacks provided by the center. If a participant brings food from home, the food shall be labeled with the participant's name, dated, and stored appropriately until meal or snack time. The fact that the participant brought food does not relieve the center of its responsibility to provide meals and snacks.

E. A minimum of 45 minutes shall be allowed for each participant to complete a meal. If a participant needs additional time to finish his meal due to special needs, such additional time shall be provided.

22VAC40-61-350. Serving of meals and snacks.

A. Centers shall serve meals and snacks at appropriate times, depending on the hours of operation. For example, a center open during the hours of 7 a.m. to 1 p.m. must serve a morning snack and a mid-day meal; a center open during the hours of 8 a.m. to 5 p.m. must serve a morning snack, a mid-day meal, and an afternoon snack; a center open during the hours of 2 p.m. to 6 p.m. must serve an afternoon snack; a center open after 6 p.m. must serve an evening meal. Centers open after 9 p.m. shall serve an evening snack. Snacks shall also be available throughout the day.

B. There shall be at least two hours between scheduled snacks and meals.

C. Adequate kitchen facilities and equipment shall be provided for preparation and serving of meals and snacks or for the catering of meals.

D. Sufficient working refrigeration shall be available to store perishable food and medicine.

22VAC40-61-360. Menu and nutrition requirements.

A. Food preferences of participants shall be considered when menus are planned.

B. Menus for meals and snacks for the current week shall be dated and posted in an area conspicuous to participants.

1. Any menu substitutions or additions shall be recorded on the posted menu.

2. Menus shall be kept at the center for two years.

C. Minimum daily menu.

1. Unless otherwise ordered in writing by the participant's physician, the daily menu, including snacks, for each participant shall meet the current guidelines of the U.S. Department of Agriculture food guidance system or the dietary allowances of the Food and Nutritional Board of the National Academy of Sciences, taking into consideration the age, sex and activity of the participant.

2. Other foods may be added to enhance the meals or meet individual participant needs.

3. Second servings and snacks shall be available at no additional charge.

4. Drinking water shall be available at all times.

D. When a diet is prescribed for a participant by his physician or other prescriber, it shall be prepared and served according to the physician's or other prescriber's orders.

E. A current copy of a diet manual containing acceptable practices and standards for nutrition shall be available to staff responsible for food preparation and meal planning.

22VAC40-61-370. Observance of religious dietary practices.

A. The participant's religious dietary practices shall be respected and followed.

B. Religious dietary practices of the director, staff, or licensee shall not be imposed upon participants unless mutually agreed upon in the admission agreement.

22VAC40-61-380. Transportation services.

A. Centers that provide participant transportation directly or by contract shall ensure that the following requirements are met:

1. The vehicle shall be accessible and appropriate for the participants being transported. Vehicles shall be equipped with a ramp or hydraulic lift to allow entry and exit if there are participants who remain in their wheelchairs during transport.

2. The vehicle's seats shall be attached to the floor, and wheelchairs shall be secured when the vehicle is in motion.

3. Arrangement of wheelchairs and other equipment in the vehicle shall not impede access to exits.

4. The vehicle shall be insured for at least the minimum limits established by law and regulation.

5. All vehicles shall have working heat and air conditioning systems.

6. The vehicle shall meet the safety standards set by the Department of Motor Vehicles and shall be kept in satisfactory condition to ensure the safety of participants.

B. Centers that provide participant transportation directly or by contract shall ensure that during transportation the following requirements are met:

1. The driver has a valid Virginia driver's license to operate the type of vehicle being used.

2. Virginia statutes regarding safety belts are followed.

3. Every person remains seated while the vehicle is in motion.

4. Doors are properly closed and locked while the vehicle is in motion.

5. Supervision and safety needs of participants are maintained at all times.

6. The following information is maintained in vehicles used for transportation:

a. The center's name, address, and phone number;

b. A list of the names of the participants being transported;

c. A list of the names, addresses, and telephone numbers of participants' emergency contact persons; and

d. A first aid kit containing the supplies as listed in 22VAC40-61-550.

7. The driver, another staff person, or a volunteer in the vehicle is current in first aid and CPR training.

8. There shall be a means of communication between the driver and the center.

C. If staff or volunteers supply personal vehicles, the center shall be responsible for ensuring that the requirements of subsections A and B of this section are met.

22VAC40-61-390. Field trips.

A. Any center that takes participants on field trips shall develop a policy that addresses the following:

1. A communication plan between staff at the center and staff who are accompanying participants on a field trip;

2. Maintenance of staff-to-participant ratio at both the center and on the field trip as required by 22VAC40-61-200;

3. Provision of adequate food and water for participants during field trips;

4. Safe storage of food to prevent food-borne illnesses; and

5. Medication administration that meets the requirements of 22VAC40-61-300.

B. Before leaving on a field trip, a list of participants taking the trip and a schedule of the trip's events and locations shall be left at the center and shall be accessible to staff.

C. A wheelchair that is available for emergency use shall be taken on field trips.

D. The requirements of 22VAC40-61-380 apply when participants are transported on field trips.

Part VII
Buildings and Grounds

22VAC40-61-400. Physical environment.

A center must provide an environment that ensures the safety and well-being of the participants but is not so restrictive as to inhibit physical, intellectual, emotional, or social stimulation.

22VAC40-61-410. Maintenance of buildings and grounds.

A. The interior and exterior of all buildings shall be maintained in good repair, kept clean and free of rubbish, and free from safety hazards.

B. All buildings shall be well-ventilated and free from foul, stale, and musty odors.

C. Adequate provisions for the collection and legal disposal of garbage, ashes, and waste material shall be made.

D. Buildings shall be kept free of infestations of insects and vermin. The grounds shall be kept free of insect and vermin breeding places.

E. Cleaning products, pesticides, and all poisonous or harmful materials shall be stored separately from food and shall be kept in a locked place when not in use.

F. All furnishings, fixtures, and equipment, including furniture, window coverings, sinks, toilets, bathtubs, and showers, shall be kept clean and in good repair and condition.

G. Grounds shall be properly maintained to include mowing of grass and removal of snow and ice.

H. A safe area for participant discharge and pick-up shall be available.

I. Adequate outdoor lighting shall be provided to ensure safe ambulation and the safety of participants during arrival and departure.

J. All interior and exterior stairways and ramps shall have a nonslip surface or carpet that shall be secured to the stairways or ramps.

K. Sturdy handrails shall be provided on all stairways, ramps, and elevators and at all changes in floor level.

L. All interior and exterior stairways, changes in floor level, and ramps shall be indicated by a warning strip or contrast in color.

22VAC40-61-420. Lighting.

A. All areas of the center shall be adequately lighted for the safety and comfort of the participants.

B. Artificial lighting shall be powered by electricity.

C. Glare shall be kept at a minimum in rooms used by participants. When necessary to reduce glare, coverings shall be used for windows and lights.

D. If used, fluorescent lights shall be replaced if they flicker or make noise.

F. Flashlights or battery lanterns in working order shall be available at all times for emergency lighting.

G. Open flame lighting is prohibited.

22VAC40-61-430. Heating and cooling.

A. Heat shall be supplied from a central heating plant or an electrical heating system in accordance with the Virginia Uniform Statewide Building Code (13VAC5-63).

B. Provided their installation or operation has been approved by the state or local building or fire authorities, space heaters, such as but not limited to gas stoves, wood burning stoves, coal burning stoves, and oil heaters, or portable heating units either vented or unvented may be used only to provide or supplement heat in the event of a power failure or similar emergency. These appliances shall be used in accordance with the manufacturer's instructions. When any of these heating sources are used, care shall be taken to protect participants from injuries.

C. The temperature of the center shall be maintained at a level safe and suitable for the participants in accordance with the following:

1. The inside temperature shall be between 70°F and 84°F. This standard applies unless otherwise mandated by federal or state authorities.

2. Fans and air conditioners shall be placed to avoid direct drafts on participants and to prevent safety hazards. Any electric fans shall be screened and placed for the protection of the participants.

3. The center shall develop a plan to protect participants from heat-related and cold-related illnesses in the event of a loss of heat or cooling due to emergency situations or malfunctioning or broken equipment.

4. At least one movable thermometer shall be available in each building for measuring temperatures in individual rooms that do not have a fixed thermostat that shows the temperature in the room.

22VAC40-61-440. General areas.

A. Any center licensed after July 1, 2000, shall provide at least 50 square feet of indoor floor space for each participant, in addition to hallways, office space, bathrooms, storage space, or other rooms or areas that are not normally used for program activities; otherwise the square footage shall be 40 square feet.

B. There shall be sufficient and suitable space for planned program activities that may be interchangeable or adaptable for a variety of activities, including meals.

1. There shall be at least one room with sufficient space for the participants to gather together for large group activities.

2. There shall be rooms or areas appropriate for small group activities and individual activities.

3. An area shall be available and accessible so that participants shall have opportunities for supervised outdoor

activities. The area shall be equipped with appropriate seasonal outdoor furniture.

C. Furnishings.

1. The furniture shall be sturdy, safe, and appropriate for participants in care.

2. All centers shall have:

a. At least one chair for each participant and each staff person, excluding any people who remain in wheelchairs throughout the day;

b. Table space adequate for all participants to take part in activities at the same time; and

c. Recliners, lounge chairs, rockers, or other seating to allow participants to relax and rest.

22VAC40-61-450. Privacy space.

Space shall be available to allow privacy for participants during interviews, visits, telephone conversations, counseling, therapy, and other similar activities.

22VAC40-61-460. Restroom facilities.

A. There shall be a minimum of one toilet that is suitable to accommodate a participant who needs human assistance or specialized equipment available for every 10 participants, or portion thereof. For restrooms that have multiple stalls, only the toilets that accommodate a person who needs human assistance or specialized equipment shall be counted in the total required number of toilets.

B. Restrooms that are equipped with only one toilet may be used by either men or women.

C. Restrooms equipped with more than one toilet shall have each toilet enclosed.

D. Restrooms that are equipped with multiple stalls must be designated for men or for women.

E. Sturdy grab bars or safety frames shall be installed beside all toilets used by participants.

F. There shall be a minimum of one sink for every two toilets and the sinks shall be located close enough to toilets to encourage washing of hands after each toileting procedure.

G. There shall be an ample supply of hot and cold running water from an approved source available to the participants at all times.

H. Hot water at taps available to participants shall be maintained within a temperature range of 105°F to 120°F.

I. There shall be an adequate supply of toilet tissue, liquid soap, disposable hand towels, or air dryers and disposable gloves in each restroom at all times.

J. If bathing facilities are provided there shall be:

1. Handrails by bathtubs;

2. Handrails in stall showers; and

3. A bench for use in the shower and a bench for use in dressing, if necessary.

22VAC40-61-470. Dining area.

A. Dining areas shall have a sufficient number of sturdy tables and chairs to serve all participants, either all at one time or in shifts.

B. If the center is licensed for nonambulatory participants, the dining area shall be large enough to provide sufficient table space and floor space to accommodate participants in wheelchairs or other assistive equipment.

22VAC40-61-480. Rest area.

A. A separate room or area shall be available for participants who become ill, need to rest, or need to have privacy. The separate room or area shall be equipped with one bed, comfortable cot, or recliner for every 12 participants.

B. Additional beds, comfortable cots, or recliners shall be available based on participant needs to accommodate rest periods. In centers that are open for evening or night care, beds shall be available for participants who need them.

C. A minimum of one pillow covered with (i) a pillow case, (ii) two sheets, and (iii) one blanket, spread, or covering per bed or cot shall be provided.

D. All sheets and pillow cases shall be laundered after each use.

E. Additional covering or blankets and pillows shall be available as necessary for recliners.

22VAC40-61-490. Storage.

A. Sufficient space shall be provided to store coats, sweaters, umbrellas, toilet articles, and other personal possessions of participants and staff.

B. Sufficient space shall be available for equipment, materials, and supplies used at the center.

22VAC40-61-500. Telephones.

A. Each building shall have at least one operable, nonpay telephone easily accessible to staff. There shall be additional telephones or extensions as may be needed to summon help in an emergency, including one that will operate during power outages.

B. Participants shall have reasonable access to a nonpay telephone on the premises.

22VAC40-61-510. Fire safety: compliance with state regulations and local fire ordinances.

A. The center shall comply with the Virginia Statewide Fire Prevention Code (13VAC5-51) as determined by at least an annual inspection by the appropriate fire official. Reports of the inspections shall be retained at the center for at least two years.

B. An adult day care center shall comply with any local fire ordinance.

Part VIII
Emergency Preparedness

22VAC40-61-520. Emergency preparedness and response plan.

A. The center shall develop an emergency preparedness and response plan that shall address:

1. Documentation of initial and annual contact with the local emergency coordinator to determine (i) local disaster risks, (ii) community wide plans to address different disasters and emergency situations, and (iii) assistance, if any, that the local emergency management office will provide to the center in an emergency.

2. Analysis of the center's potential hazards, including severe weather, biohazard events, fire, loss of utilities, flooding, work place violence or terrorism, severe injuries, or other emergencies that would disrupt normal operation of the center.

3. Emergency management policies and procedures for the provision of:

a. Administrative direction and management of response activities;

b. Coordination of logistics during the emergency;

c. Communications;

d. Life safety of participants, staff, volunteers, and visitors;

e. Property protection;

f. Continued services to participants;

g. Community resource accessibility; and

h. Recovery and restoration.

4. Emergency response procedures for assessing the situation; protecting participants, staff, volunteers, visitors, equipment, medications, and vital records; and restoring services. Emergency response procedures shall address:

a. Alerting emergency personnel and center staff;

b. Warning and notification of participants, including sounding of alarms when appropriate;

c. Providing emergency access to secure areas and opening locked doors;

d. Conducting evacuations and sheltering in place, as appropriate, and accounting for all participants;

e. Locating and shutting off utilities when necessary;

f. Maintaining and operating emergency equipment effectively and safely;

g. Communicating with staff and community emergency responders during the emergency;

h. Conducting relocations to emergency shelters or alternative sites when necessary and accounting for all participants; and

i. Strategies for reunification of participants with their family or legal representative.

5. Supporting documents that would be needed in an emergency, including emergency call lists, building and site maps necessary to shut off utilities, and as applicable, memoranda of understanding with relocation sites and list of major resources such as suppliers of emergency equipment.

B. Staff and volunteers shall be knowledgeable in and prepared to implement the emergency preparedness plan in the event of an emergency.

C. The center shall develop and implement an orientation and semi-annual review on the emergency preparedness and response plan for all staff, participants, and volunteers with emphasis placed on an individual's respective responsibilities, except that for participants, the orientation and review may be limited to only subdivisions 1 and 2 of this subsection. The review shall be documented by signing and dating. The orientation and review shall cover responsibilities for:

1. Alerting emergency personnel and sounding alarms;

2. Implementing evacuation, shelter in place, and relocation procedures;

3. Using, maintaining, and operating emergency equipment;

4. Accessing emergency medical information, equipment, and medications for participants;

5. Locating and shutting off utilities; and

6. Utilizing community support services.

D. The center shall review the emergency preparedness plan annually or more often as needed, document the review by signing and dating the plan, and make necessary revisions. Such revisions shall be communicated to staff, participants, and volunteers and incorporated into the orientation and semi-annual review.

E. In the event of a disaster, fire, emergency, or any other condition that may jeopardize the health, safety, and welfare of participants, the center shall take appropriate action to protect the participants and to remedy the conditions as soon as possible.

F. After the disaster or emergency is stabilized, the center shall:

1. Notify family members and legal representatives; and

2. Report the disaster or emergency to the regional licensing office as specified in 22VAC40-61-90.

22VAC40-61-530. Fire and emergency evacuation plan.

A. The center shall have a plan for fire and emergency evacuation that is to be followed in the event of a fire or other emergency. The plan shall be approved by the appropriate fire official.

B. A fire and emergency evacuation drawing showing primary and secondary escape routes, areas of refuge, assembly areas, telephones, fire alarm boxes, and fire extinguishers shall be posted in a conspicuous place.

C. The telephone numbers for the fire department, rescue squad or ambulance, police, and Poison Control Center shall be posted by each telephone shown on the fire and emergency evacuation plan.

D. Staff and volunteers shall be fully informed of the approved fire and emergency evacuation plan, including their duties, and the location and operation of fire extinguishers, fire alarm boxes, and any other available emergency equipment.

22VAC40-61-540. Fire and emergency evacuation drills.

A. Fire and emergency evacuation drill frequency and participation shall be in accordance with the current edition of the Virginia Statewide Fire Prevention Code (13VAC5-51).

B. Additional fire and emergency evacuation drills shall be held when there is any reason to question whether the requirements of the approved fire and emergency evacuation plan can be met.

C. Each required fire and emergency evacuation drill shall be unannounced.

D. Immediately following each required fire and emergency evacuation drill, there shall be an evaluation of the drill by the staff in order to determine the effectiveness of the drill. The licensee or director shall immediately correct any problems identified in the evaluation and document the corrective action taken.

E. A record of the required fire and emergency evacuation drills shall be kept in the center for two years. Such record shall include:

1. Identity of the person conducting the drill;

2. The date and time of the drill;

3. The method used for notification of the drill;

4. The number of staff participating;

5. The number of participants participating;

6. Any special conditions simulated;

7. The time it took to complete the drill;

8. Weather conditions; and

9. Problems encountered, if any.

22VAC40-61-550. Emergency equipment and supplies.

A. Each building of the center and all vehicles being used to transport participants shall contain a first aid kit which shall include:

1. Scissors;

2. Tweezers;

3. Gauze pads;

4. Adhesive tape;

5. Adhesive bandages in assorted sizes;

6. Triangular bandages;

7. Flexible gauze;

8. Antiseptic cleansing solution;

9. Antibacterial ointment;

10. Bee sting swabs or preparation;

11. Ice pack or ice bag;

12. Thermometer;

13. Small operable flashlight;

14. Single use gloves, such as surgical or examining gloves; and

15. The first aid instructional manual.

B. The first aid kit shall be located in a designated place that is easily accessible to staff but not accessible to participants.

C. The first aid kit shall be checked at least annually and contents shall be replaced before expiration dates and as necessary.

D. Emergency equipment shall be available for use in the event of loss of utilities such as, but not limited to, a working flashlight, extra batteries, a portable radio, and a telephone or other communication device.

E. A plan shall be in place to provide an emergency meal and a supply of water to all participants in the event that meals are not able to be prepared or participants are required to shelter in place for a period of time.

22VAC40-61-560. Plan for participant emergencies.

A. The center shall have a plan for participant emergencies that includes:

1. Procedures for handling medical emergencies, including identifying the staff person responsible for (i) calling the rescue squad, ambulance service, participant's physician, or Poison Control Center and (ii) providing first aid and CPR when indicated.

2. Procedures for handling mental health emergencies such as, but not limited to, catastrophic reaction or the need for a temporary detention order.

3. Procedures for making pertinent medical information and history available to the rescue squad and hospital, including a copy of the current medical administration record, advance directives, and Do Not Resuscitate Orders.

4. Procedures to be followed in the event that a participant is missing, including (i) involvement of center staff, appropriate law-enforcement agency, and others as needed; (ii) areas to be searched; (iii) expectations upon locating the participant such as medical attention; and (iv) documentation of the event.

5. Procedures to be followed in the event of a vehicle emergency to include notifying the center or emergency personnel, telephone numbers for vehicle repair, and options for alternate transportation. Procedures to be followed in the event that a participant's scheduled transportation does not arrive or the participant is stranded at the center shall also be developed. The center shall ensure that these procedures are in place for transportation

provided by both the center and contracted services if appropriate.

6. Procedures for notifying the participant's family, and legal representative.

7. Procedures for notifying the regional licensing office as specified in 22VAC40-61-90.

B. If the center serves participants who wander, a door bell or alarm shall be installed or attached to alert staff to wandering participants.

C. Staff shall be trained on all requirements of subsection A of this section during orientation and during a semi-annual review.

D. The plan for participant emergencies shall be readily available to all staff, family members, and legal representatives.

NOTICE: The following form used in administering the regulation was filed by the agency. The form is not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of the form with a hyperlink to access it. The form is also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (22VAC40-61)

Report of Tuberculosis Screening, Virginia Department of Health (rev. June 2017)

VA.R. Doc. No. R16-4545; Filed June 19, 2017, 10:16 a.m.

BOARD OF ACCOUNTANCY

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board of Accountancy is conducting a periodic review and small business impact review of **18VAC5-11, Public Participation Guidelines**. The review of this regulation will be guided by the principles in Executive Order 17 (2014).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins July 10, 2017, and ends July 31, 2017.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Rebekah E. Allen, Enforcement Director, Board of Accountancy, 9960 Mayland Drive, Suite 402, Henrico, VA 23233, telephone (804) 367-2006, FAX (804) 527-4207, or email rebekah.allen@boa.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

AIR POLLUTION CONTROL BOARD

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Air Pollution Control Board conducted a small business impact review of **9VAC5-5, Public Participation Guidelines**, and determined that this regulation should be retained in its current form. The Air Pollution Control Board is publishing its report of findings dated June 9, 2017, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

The current regulation continues to be needed. The regulation explains how the public will be notified, explains how input will be sought, explains the use of advisory panels, and details the public participation process during regulatory actions. The regulation is explanatory in nature and does not place any additional regulatory burden on the regulated community including small businesses.

Contact Information: Melissa Porterfield, Office of Regulatory Affairs, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238, FAX (804) 698-4019, or email melissa.porterfield@deq.virginia.gov.

STATE CORPORATION COMMISSION

AT RICHMOND, JUNE 8, 2017

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. PUR-2017-00076

Ex Parte: In the matter of revising
the Commission's Rules Governing
Enhanced 911 (E-911) Service

ORDER INITIATING RULEMAKING PROCEEDING

On June 23, 2004, the State Corporation Commission ("Commission") adopted Rules Governing Enhanced 911 (E-911) Service, 20 VAC 5-425-10 et seq. ("E-911 Rules") in Case No. PUC-2003-00103.[1] The Commission initiated the E-911 rulemaking in response to complaints received from Public Safety Answering Point ("PSAP")[2] administrators and local governments regarding the quality of E-911 service and billing issues associated therewith.[3] At that time, the Commission noted that the reliability and accuracy of the E-911 service was essential to protecting the public safety and health of many Virginia citizens.[4] Given the passage of time since the Commission established the E-911 Rules in 2004, the Commission has concluded that it is appropriate to revisit the E-911 Rules and to make modifications, if necessary, due to changes in applicable laws and technological changes in the telecommunications industry.

NOW THE COMMISSION, upon consideration of this matter, is of the opinion and finds that a rulemaking proceeding should be initiated to determine whether, and the extent to which, any of the Commission's E-911 Rules should be revised. In this regard, we will direct the Commission's Staff ("Staff") to solicit comments from, and schedule a meeting or meetings (as necessary) with, stakeholders and persons having an interest in the Commission's E-911 Rules and the provision of E-911 service in the Commonwealth of Virginia. We expect our Staff to develop, with appropriate input from stakeholders and interested persons, a proposal for any revisions, if necessary, to the current E-911 Rules.

Accordingly, IT IS ORDERED THAT:

(1) This matter is docketed and assigned Case No. PUR-2017-00076.

(2) The Commission's Division of Public Utility Regulation hereby is directed to undertake such actions as necessary to facilitate a review of the Commission's E-911 Rules as discussed above.

(3) The Staff shall prepare and file a report on its findings and recommendations in this proceeding, which shall include any proposed revisions to the current E-911 Rules that are developed with appropriate input from stakeholders and other interested persons.

(4) This matter is continued.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to all local exchange carriers certificated in Virginia as set out in Appendix A; all interexchange carriers certificated in Virginia as set out in Appendix B; the chairman of the board of supervisors and county attorney of each county and upon the mayor or manager (or equivalent official) and city or town attorney of every city and town in the Commonwealth of Virginia as set out in Appendix C; and C. Meade Browder, Jr., Senior Assistant Attorney General, Office of the Attorney General, Division of Consumer Counsel, 202 N. 9th Street, 8th Floor, Richmond, Virginia 23219-3424. A copy hereof also shall be provided to the Commission's Office of General Counsel and Division of Public Utility Regulation.

[1] Commonwealth of Virginia, ex rel. State Corporation Commission, Ex Parte: In the matter of establishing rules governing the provision of enhanced 911 service by local exchange carriers, Case No. PUC-2003-00103, 2004 S.C.C. Ann. Rept. 201, Order Adopting Rules (June 23, 2004).

[2] A PSAP is a communications operation or facility operated by or on behalf of a governmental entity that is equipped and staffed on a 24-hour basis to receive and process telephone calls for emergency assistance from an individual who dials the digits 9-1-1. See, e.g., §§ 56-484.12 and 56-484.19 of the Code of Virginia.

[3] See Commonwealth of Virginia, ex rel. State Corporation Commission, Ex Parte: In the matter of establishing rules governing the provision of enhanced 911 service by local exchange carriers, Case No. PUC-2003-00103, Order For Notice and Comment or Requests for Hearing (Aug. 1, 2003).

[4] See id.

CRIMINAL JUSTICE SERVICES BOARD

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Criminal Justice Services and the Criminal Justice Services Board are conducting a periodic review and small business impact review of **6VAC20-20, Rules Relating to Compulsory Minimum Training Standards for Law-Enforcement Officers**. The review of this regulation will be guided by the principles in Executive Order 17 (2014).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins July 10, 2017, and ends September 10, 2017.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Barbara Peterson-Wilson, Law Enforcement Program Coordinator, Department of Criminal Justice Services, 1100 Bank Street, Richmond, VA 23219, telephone (804) 225-4503, FAX (804) 786-0410, or email barbara.peterson-wilson@dcjs.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Port Conway Solar, LLC Notice of Intent for Small Renewable Energy (Solar) Project Permit by Rule - King George County

Port Conway Solar LLC, has provided to the Department of Environmental Quality a notice of intent to submit the necessary documentation for a permit by rule for a small renewable energy project (solar) in King George County pursuant to § 10.1-1197.6 B 1 of the Code of Virginia and 9VAC15-60. The project will have a maximum capacity of 20 megawatts alternating current and will utilize traditional photovoltaic solar modules that rotate throughout the day to track the sun. The project is located in King George County, along Port Conway Road in the general vicinity of Dogue, Virginia. The project will be sited across roughly 250 acres and across multiple parcels.

Contact Information: Mary E. Major, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4426, FAX (804) 698-4510, or email mary.major@deq.virginia.gov.

Westmoreland Solar, LLC Notice of Intent for Small Renewable Energy (Solar) Project Permit by Rule - Westmoreland County

Westmoreland Solar LLC, provided to the Department of Environmental Quality a notice of intent to submit the

necessary documentation for a permit by rule for a small renewable energy project (solar) in Westmoreland County, Virginia, pursuant to § 10.1-1197.6 B 1 of the Code of Virginia and 9VAC15-60. The project will be located on roughly 114 acres of agricultural land west of Routes 205 and 628, and in the general vicinity of Oak Grove, Virginia. The project is anticipated to have a nameplate capacity of 20 megawatts alternating current and will be comprised of approximately 77,580 solar panels.

Contact Information: Mary E. Major, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4426, FAX (804) 698-4510, or email mary.major@deq.virginia.gov.

Public Comment Opportunity - Stafford Regional Airport - Proposed Runway Extension and Airport Development Project

Purpose of notice: The Department of Environmental Quality (DEQ) seeks public comment on an environmental assessment for a proposed runway extension and airport development project at the Stafford Regional Airport in Stafford County, Virginia.

Public comment period: June 16, 2017, through August 4, 2017.

Type of response: Environmental assessment.

DEQ is reviewing an environmental assessment for a proposed runway extension and other improvements as a component of the airport's license modification application. The purpose of the environmental assessment is to determine if a runway extension and additional development at the airport would significantly impact socioeconomic and environmental resources within the proposed project area.

Name of agency proposing the project: The Stafford Regional Airport Authority has submitted a license modification application to the Federal Aviation Administration and Virginia Department of Aviation.

Project description: The plans to construct airport improvements as specified in the 2013 Stafford Regional Airport Master Plan Update (AMPU) and as shown on the conditionally approved 2016 Airport Layout Plan (ALP). The proposed action includes the following project elements:

- Extend Runway 15-33 by 1,000 feet
- Extend the existing 35-foot wide parallel taxiway by 1,000 feet
- Construct one 350-foot long by 35-foot wide connector taxiway
- Construct one 100-foot long by 35-foot wide connector taxiway
- Construct two 150-foot by 120-foot asphalt blast pads
- Relocate the localizer antenna, localizer equipment shelter, and airport perimeter road 1,000 feet northwest of their current location
- Rehabilitate the existing 5,000-foot asphalt runway, taxiways, and apron
- Reinstate northern traffic pattern for Runway 15-33
- Relocate the Automated Weather Observing System and Runway 33 glideslope antenna
- Construct a 48-foot wide by 750-foot long emergency access road
- Acquire in fee simple approximately 105 acres of land
- Release approximately 14.75 acres of airport property to Stafford County Economic Development Authority
- Acquire approximately 91 acres of avigation easements
- Relocate approximately 820,000 cubic yards of soil on airport property
- Construct approximately 13,000 square yards of additional apron
- Construct two 10-unit T-hangars and associated taxilanes
- Construct approximately 8,800 square yards of additional automobile parking spaces
- Construct one 100-foot by 150-foot hangar, one 120-foot by 100-foot hangar, three 120-foot by 120-foot hangars, one 100-foot by 190-foot flight school, and four 60-foot by 60-foot box hangars
- Construct a 1,200-square foot maintenance equipment storage shed
- Relocate the airport security perimeter fence, precision approach path indicator lights, and windsock
- Install one additional 12,000-gallon Jet-A-fuel tank and associated fuel delivery loop road
- Remove approximately 162 acres of future obstructions (35 on airport property and 127 acres off airport property) to FAR Part 77 primary, approach, and transitional surfaces for the runway extension
- Install a medium intensity approach lighting system on Runway 15 and runway alignment indicator lights on Runway 33
- Develop instrument approach procedures to Runway 15

How to comment: DEQ accepts comments from the public by email, fax, or U.S. mail (see below). All comments must include the name, address, and telephone number of the person commenting and be received by DEQ within the comment period. The public may review the project documents at the following locations:

• Stafford Regional Airport, 95 Aviation Way, Fredericksburg, VA 22406

• England Run Branch Public Library, 806 Lyons Boulevard, Fredericksburg, VA 22406

• Virginia Department of Aviation, 5702 Gulfstream Road, Richmond, VA 23250

• Federal Aviation Administration, Washington Airports District Office, 23723 Air Freight Lane, Suite 210, Dulles, VA 20166

• Department of Environmental Quality, 629 East Main Street, Richmond, VA 23219

• DEQ Northern Regional Office, 13901 Crown Court, Woodbridge, VA 22193

A copy of the draft environmental assessment will also be made available online at the Stafford Regional Airport's website: http://www.staffordairport.com/, and on DEQ's website at http://www.deq.virginia.gov/Programs/EnvironmentalImpactReview/NEPADocumentReviews/MajorNEPAProjects.aspx.

A public hearing to accept comments will be held on Tuesday, July 25, 2017, at 7 p.m. at the Stafford Regional Airport. Anyone desiring to be heard in support of or in opposition to this proposed action may attend and have their comments considered by the Department of Environmental Quality and the Department of Aviation.

Contact Information: John Fisher, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4339, FAX (804) 698-4319, or email john.fisher@deq.virginia.gov.

DEPARTMENT OF HEALTH

Drinking Water State Revolving Fund Program Intended Use Plan for Fiscal Year 2018

Under the Safe Drinking Water Act, Congress authorizes capitalization grants to the states through the Drinking Water State Revolving Loan Fund Program (DWSRF). As part of the annual DWSRF grant application process Virginia seeks meaningful public involvement through input, review, and comments. The Virginia Department of Health (VDH) Office of Drinking Water (ODW) has prepared a draft intended use plan (IUP) that explains the goals of the program, funding priorities, how VDH intends to use the grant funds and other important information submitted from the funding requests and set-aside suggestions.

VDH received numerous funding requests and set-aside suggestions following the January DWSRF funding solicitation announcement. The draft 2018 IUP and draft project lists are open for review and comment by the public for a period of 60 days. The document entitled "Virginia Drinking Water State Revolving Fund Program Design Manual" dated January 2017, is a part of the intended use plan and was mailed to eligible waterworks in January 2017, announced in the Virginia Register of Regulations, and placed on VDH's website. The Program Design Manual provides information on VDH's project prioritization criteria and methodologies.

VDH will hold a public meeting to solicit comments and recommendations regarding the IUP on Thursday, July 27, 2017, from 9 a.m. to 11 a.m. at VDH Office of Drinking Water, 6th Floor Library, 109 Governor Street, VA 23219. Those individuals planning to attend the public meeting should contact Theresa Hewlett at telephone (804) 864-7501 by the close of business on July 20, 2017.

Any written comments from the public are to be submitted by September 10, 2017, the close of the public comment period. VDH will consider all meaningful public input and comments and make revisions to the IUP and project priority list if necessary. Please direct requests for information and forward written comments to Steven Pellei, PE, Virginia Department of Health, Office of Drinking Water, James Madison Building, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7500, FAX (804) 864-7521.

The following information is provided under Financial and Construction Assistance Programs at http://www.vdh.virginia.gov/drinking-water/.

Alternatively, it may be found by searching for "VDH FCAP."

VDH's FY2018 Draft IUP

VDH's FY2018 Preliminary Project Priority List/Comprehensive Project List

The IUP is subject to change depending on EPA's award allocations.

VIRGINIA LOTTERY

Director's Orders

The following Director's Orders of the Virginia Lottery were filed with the Virginia Registrar of Regulations on June 21, 2017. The orders may be viewed at the Virginia Lottery, 600 East Main Street, Richmond, Virginia, or at the office of the Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia.

Director's Order Number Ninety (17)

Virginia Lottery's "Summer Corvette® Giveaway" Promotion Final Rules for Operation (effective June 9, 2017)

Director's Order Number Ninety-One (17)

Virginia Lottery's "Ultimate Corvette® Experience" Final Rules for Operation (effective June 6, 2017)

Director's Order Number Ninety-Two (17)

Certain Virginia Promotion; Promotion Drawing and Entry Amendment

Thank a Teacher Promotion (48 2017) (this Director's Order is effective nunc pro tunc to April 3, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Ninety-Three (17)

Virginia Lottery's Scratch Game 1792 "Double Doubler" Final Rules for Game Operation (effective June 4, 2017)

Director's Order Number Ninety-Four (17)

Virginia Lottery's Scratch Game 1803 "Cash Splash" Final Rules for Game Operation (effective June 8, 2017)

Director's Order Number Ninety-Five (17)

Virginia Lottery's Scratch Game 1672 "FIND THE 8'S" Final Rules for Game Operation (effective June 8, 2017)

Director's Order Number Ninety-Six (17)

Virginia Lottery's Scratch Game 1809 "$3,000,000 Cash Payout" Final Rules for Game Operation (effective June 8, 2017)

Director's Order Number Ninety-Seven (17)

Virginia Lottery's Scratch Game 1810 "$5,000,000 Cash Payout" Final Rules for Game Operation (effective June 9, 2017)

Director's Order Number Ninety-Eight (17)

Virginia Lottery's Scratch Game 1811 "$16,000,000 Cash Payout" Final Rules for Game Operation (effective June 9, 2017)

Director's Order Number Ninety-Nine (17)

Virginia Lottery's Scratch Game 1812 "$32,000,000 Cash Payout" Final Rules for Game Operation (effective June 9, 2017)

Director's Order Number One Hundred (17)

Virginia Lottery's Scratch Game 1782 "7X the Money" Final Rules for Game Operation (effective June 8, 2017)

Director's Order Number One Hundred One (17)

Certain Virginia Promotion; Participating Retailer Amendment - 2017 Mega Gift Card Giveaway Promotion (36 2017) (effective June 1, 2017)

Director's Order Number One Hundred Two (17)

Virginia Lottery's Scratch Game 1832 "Fast Bucks" Final Rules for Game Operation (effective June 8, 2017)

Director's Order Number One Hundred Three (17)

"Retailer Recruitment Incentive Promotion" Virginia Lottery Retailer Incentive Program Requirements (effective July 1, 2017)

Director's Order Number One Hundred Four (17)

Virginia Lottery's Q1/Q2 FY18 eXTRA Chances Scratcher Promotion Final Rules for Operation (effective July 1, 2017)

Director's Order Number One Hundred Twelve (17)

Certain Virginia Print 'n Play Games; End of Games

Virginia Lottery's Print 'n Play Blackjack (58 2017);

Virginia Lottery's Print 'n Play Bonus Bingo (56 2017);

Virginia Lottery's Print 'n Play Daily Crossword (59 2017);

Virginia Lottery's Print 'n Play Smokin' Hot Crossword (65 2017);

Virginia Lottery's Print 'n Play Hot 'n Spicy Bingo (63 2017)

(effective July 8, 2017)

Director's Order Number One Hundred Thirteen (17)

Certain Virginia Promotion; Retailer Incentive Amendment

June Out-of-Stock Contest - Handy Mart Retailer Incentive Promotion (16 2017) (effective June 16, 2017)

BOARD OF MEDICAL ASSISTANCE SERVICES

Notice of Scheduling for the Medicaid Appeals Workgroup

Pursuant to Chapter 836, Item WW 3 of the 2017 Acts of Assembly, the Virginia Department of Medical Assistance Services is convening a workgroup with representatives from the provider community, the legal community, and the Office of Attorney General that shall be titled the Medicaid Appeals Workgroup. The workgroup shall develop a plan to avoid or adjust retractions or for nonmaterial breaches of the provider participation agreement when the provider has substantially complied with the provider participation agreement. The plan as developed shall include an assessment of any administrative financial impact the plan will have on the department and an analysis of any implications for the department's efforts to combat fraud, waste, and abuse. The department shall conduct two meetings during the summer of 2017, an introductory meeting and a working meeting. Public comment will be held at both meetings and written comments will be accepted by the department throughout the tenure of the workgroup.

The initial meeting shall be held on July 11, 2017, from 1:30 p.m. until 3:30 p.m. at the Department of Medical Assistance Services, 600 East Broad Street, Rooms 7 A and B, Richmond, VA 23219.

Public comments concerning the issues addressed by the Medicaid Appeals Workgroup may be submitted at any time prior to the close of the 10th day following the final workgroup meeting in September.

Contact Information: Sam Metallo, Appeals Division Director, Department of Medical Assistance Services, 600 East Broad Street, Richmond, VA 23219, telephone (804) 786-1501, or email samuel.metallo@dmas.virginia.gov.

Reimbursement Changes Affecting Other Types of Care
Notice of Intent to Amend the Virginia State Plan for Medical Assistance (Pursuant to § 1902(a)(13) of the Social Security Act (USC § 1396a(a)(13)))

The Virginia Department of Medical Assistance Services (DMAS) hereby affords the public notice of its intention to amend the Virginia State Plan for Medical Assistance to provide for changes to the Methods and Standards for Establishing Payment Rates - Other Types of Care (12VAC30-80).

This notice is intended to satisfy the requirements of 42 CFR 447.205 and of § 1902(a)(13) of the Social Security Act, 42 USC § 1396a(a)(13). A copy of this notice is available for public review from William Lessard, Provider Reimbursement Division, Department of Medical Assistance Services, 600 Broad Street, Suite 1300, Richmond, VA 23219, or via email at william.lessard@dmas.virginia.gov.

This notice is available for public review on the Regulatory Town Hall at www.townhall.virginia.gov, on the General Notices page at https://townhall.virginia.gov/L/generalnotice.cfm.

Reimbursement Changes Affecting Other Types of Care (12VAC30-80)

12VAC30-80-30 is being amended to: (1) add rates for private duty nursing, assistive technology, and personal assistance services under EPSDT; and (2) add text describing the rates currently in place for the following mental health services: intensive in-home, therapeutic day treatment, therapeutic day treatment-partial hospitalization, psychosocial rehabilitation, crisis intervention, intensive community treatment, crisis stabilization, and mental health skill-building services.

There is no expected increase or decrease in aggregate annual expenditures.

Contact Information: Emily McClellan, Regulatory Manager, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, TDD (800) 343-0634, or email emily.mcclellan@dmas.virginia.gov.

STATE WATER CONTROL BOARD

Proposed Consent Order for the DuPont Teijin Films U.S. Limited Partnership

An enforcement action has been proposed for the DuPont Teijin Films, U.S. Limited Partnership, for violations at the DuPont Teijin Films, Hopewell site located at 3600 Discovery Drive, Chesterfield, Virginia. The State Water Control Board proposes to issue a consent order to address noncompliance with State Water Control Law and regulations at the Hopewell site's wastewater treatment system. The consent order requires corrective action and payment of a civil charge. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. Frank Lupini will accept comments by email at frank.lupini@deq.virginia.gov, FAX at (804) 698-4019, or postal mail at Department of Environmental Quality, P.O. Box 1105, Richmond, VA, 23218, from July 10, 2017, to August 12, 2017.

Proposed Consent Order for the Town of Lawrenceville

An enforcement action has been proposed for the Town of Lawrenceville for violations at the wastewater treatment plant located at 380 Meadow Lane in Lawrenceville, Virginia. The State Water Control Board proposes to issue a consent order to address noncompliance with State Water Control Law and regulations at the wastewater treatment plant. The consent order requires corrective action and payment of a civil charge. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. Frank Lupini will accept comments by email at frank.lupini@deq.virginia.gov, FAX at (804) 698-4019, or postal mail at Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218, from July 10, 2017, to August 12, 2017.

Proposed Enforcement Action for Verizon Virginia, LLC

An enforcement action has been proposed for Verizon Virginia, LLC for violations of State Water Control Law that occurred in Richmond, Virginia. A description of the proposed action is available online at www.deq.virginia.gov. Lee Crowell will accept comments by email at lee.crowell@deq.virginia.gov or postal mail at Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23219, from July 10, 2017, through August 9, 2017.

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the State Water Control Board conducted a small business impact review of **9VAC25-11, Public Participation Guidelines**, and determined that this regulation should be retained in its current form. The State Water Control Board is publishing its report of findings dated June 12, 2017, to support this

decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

The current regulation continues to be needed. The regulation explains how the public will be notified, explains how input will be sought, explains the use of advisory panels, and details the public participation process during regulatory actions. The regulations are explanatory in nature and do not place any additional regulatory burden on the regulated community including small businesses.

Contact Information: Melissa Porterfield, Office of Regulatory Affairs, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238, FAX (804) 698-4019, or email melissa.porterfield@deq.virginia.gov.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information: *Mailing Address:* Virginia Code Commission, Pocahontas Building, 900 East Main Street, 11th Floor, Richmond, VA 23219; *Telephone:* (804) 698-1810; *Email:* varegs@dls.virginia.gov.

Meeting Notices: Section 2.2-3707 C of the Code of Virginia requires state agencies to post meeting notices on their websites and on the Commonwealth Calendar at https://commonwealthcalendar.virginia.gov.

Cumulative Table of Virginia Administrative Code Sections Adopted, Amended, or Repealed: A table listing regulation sections that have been amended, added, or repealed in the *Virginia Register of Regulations* since the regulations were originally published or last supplemented in the print version of the Virginia Administrative Code is available at http://register.dls.virginia.gov/documents/cumultab.pdf.

Filing Material for Publication in the *Virginia Register of Regulations*: Agencies use the Regulation Information System (RIS) to file regulations and related items for publication in the *Virginia Register of Regulations.* The Registrar's office works closely with the Department of Planning and Budget (DPB) to coordinate the system with the Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.