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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.

Members of the Virginia Code Commission: **John S. Edwards**, Chair; **James M. LeMunyon**, Vice Chair; **Gregory D. Habeeb**; **Ryan T. McDougle**; **Robert L. Calhoun**; **Carlos L. Hopkins**; **Leslie L. Lilley**; **E.M. Miller, Jr.**; **Thomas M. Moncure, Jr.**; **Christopher R. Nolen**; **Timothy Oksman**; **Charles S. Sharp**; **Mark J. Vucci**.

Staff of the Virginia Register: **Jane D. Chaffin**, Registrar of Regulations; **Karen Perrine**, Assistant Registrar; **Anne Bloomsburg**, Regulations Analyst; **Rhonda Dyer**, Publications Assistant; **Terri Edwards**, Operations Staff Assistant.

PUBLICATION SCHEDULE AND DEADLINES

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

October 2017 through November 2018

<u>Volume: Issue</u>	<u>Material Submitted By Noon*</u>	<u>Will Be Published On</u>
34:3	September 13, 2017	October 2, 2017
34:4	September 27, 2017	October 16, 2017
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
34:13	January 31, 2018	February 19, 2018
34:14	February 14, 2018	March 5, 2018
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
34:25	July 18, 2018	August 6, 2018
34:26	August 1, 2018	August 20, 2018
35:1	August 15, 2018	September 3, 2018
35:2	August 29, 2018	September 17, 2018
35:3	September 12, 2018	October 1, 2018
35:4	September 26, 2018	October 15, 2018
35:5	October 10, 2018	October 29, 2018
35:6	October 24, 2018	November 12, 2018
35:7	November 7, 2018	November 26, 2018

*Filing deadlines are Wednesdays unless otherwise specified.

PETITIONS FOR RULEMAKING

TITLE 11. GAMING

CHARITABLE GAMING BOARD

Initial Agency Notice

Title of Regulation: **11VAC15-40. Charitable Gaming Regulations.**

Statutory Authority: § 18.2-340.15 of the Code of Virginia.

Name of Petitioner: Katherine Phelps, on behalf of patrons of the Redwood Community Association Bingo.

Nature of Petitioner's Request: Petitioner requests that the Charitable Gaming Board repeal subdivision E of 11VAC15-40-110 of the Charitable Gaming Regulations, which states, in part, that no landlord, his agent or employee, member of his immediate family, or person residing in the same household shall at charitable games conducted on the landlord's premises participate in the management, operation, or conduct of any charitable games. Petitioner further states: "If this rule cannot be repealed, all bingo halls should be compelled to comply with this rule and not single out just one bingo hall. If all bingo halls are not compelled to comply, that is discrimination on the part of the gaming commission. We, the undersigned, are patrons at Redwood Community Association Bingo and notice their owners are no longer working bingo. However, when visiting other bingo halls, we notice that the owners of the property are head of the bingo and family members are workers, managers, etc."

Agency Plan for Disposition of Request: The Charitable Gaming Board will consider this request at its next scheduled meeting following the public comment period. This meeting will occur on December 12, 2017.

Public Comment Deadline: October 22, 2017.

Agency Contact: Michael Menefee, Program Manager, Charitable and Regulatory Programs, Department of Agriculture and Consumer Services, 102 Governor Street, Richmond, VA 23219, telephone (804) 786-3983, or email michael.menefee@vdacs.virginia.gov.

VA.R. Doc. No. R18-06; Filed September 7, 2017, 4:25 p.m.

NOTICES OF INTENDED REGULATORY ACTION

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF 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 Medicine intends to consider amending **18VAC85-20, Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic**, and **18VAC85-50, Regulations Governing the Practice of Physician Assistants**. Consistent with provisions of Chapter 390 of the 2017 Acts of Assembly, laser hair removal must be performed by a "properly trained person" who is a licensee or a "properly trained person under the direction and supervision" of a doctor, physician assistant, or nurse practitioner. The purpose of the proposed action is to provide a regulatory framework for "direction and supervision" so that the laser hair technician, the supervising practitioner, and the public will understand the scope of responsibility for such direction and supervision.

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: November 1, 2017.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4621, FAX (804) 527-4429, or email william.harp@dhp.virginia.gov.

VA.R. Doc. No. R18-5269; Filed September 8, 2017, 2:53 p.m.

BOARD OF NURSING

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 Nursing intends to consider amending **18VAC90-30, Regulations Governing the Licensure of Nurse Practitioners**. Consistent with provisions of Chapter 390 of the 2017 Acts of Assembly, laser hair removal must be performed by a "properly trained person" who is a licensee or a "properly trained person under the direction and supervision" of a doctor, physician assistant, or nurse practitioner. The purpose of the proposed action is to provide a regulatory framework for "direction and supervision" so that the laser hair technician, the supervising practitioner, and the public will understand the scope of responsibility for such direction and supervision.

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

Statutory Authority: §§ 54.1-2400 and 54.1-2957 of the Code of Virginia.

Public Comment Deadline: November 1, 2017.

Agency Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4520, FAX (804) 527-4455, or email jay.douglas@dhp.virginia.gov.

VA.R. Doc. No. R18-5221; Filed September 8, 2017, 2:54 p.m.

TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Department for Aging and Rehabilitative Services intends to consider amending **22VAC30-100, Adult Protective Services**. The purpose of the proposed action is to review and to make needed amendments that (i) establish standards for local departments of social services for the provision of adult protective services (APS) investigations and post-investigation services; (ii) provide guidance on the imposition of civil penalties on mandated reporters who fail to report suspected adult abuse, neglect, or exploitation; (iii) outline important definitions used during the course of reporting adult abuse, neglect, and exploitation; APS investigations; and the provision of services to adults who may be victims; (iv) address the specific actions an APS worker must take in various situations; (v) ensure requirements adequately address the safety of the adult who is receiving services, while also balancing the adult's right to self-determination; and (vi) strengthen the requirements regarding workers' case documentation, including entering the case record into the state database, and eliminate language that may be redundant or confusing to workers. The proposed regulatory action seeks to assess all current regulation content; to clarify content that may be unclear, inconsistent, or obsolete; and to add new language that establishes a process to afford certain alleged perpetrators of adult abuse, neglect, or exploitation the opportunity to review the actions taken by a local department of social services.

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

This Notice of Intended Regulatory Action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Statutory Authority: §§ 51.5-131 and 51.5-148 of the Code of Virginia; 42 USC § 1397(3).

Notices of Intended Regulatory Action

Public Comment Deadline: November 1, 2017.

Agency Contact: Paige L. McCleary, Adult Services Program Consultant, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7605, or email paige.mccleary@dars.virginia.gov.

VA.R. Doc. No. R18-5270; Filed September 8, 2017, 4:09 p.m.

REGULATIONS

For information concerning the different types of regulations, see the Information Page.

Symbol Key

Roman type indicates existing text of regulations. Underscored language indicates proposed new text.
Language that has been stricken indicates proposed text for deletion. Brackets are used in final regulations to indicate changes from the proposed regulation.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Extension of Emergency Regulation

Title of Regulation: 12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-303, 12VAC30-60-310; adding 12VAC30-60-301, 12VAC30-60-302, 12VAC30-60-304, 12VAC30-60-305, 12VAC30-60-306, 12VAC30-60-308, 12VAC30-60-313, 12VAC30-60-315; repealing 12VAC30-60-300, 12VAC30-60-307, 12VAC30-60-312).

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

Expiration Date Extended Through: August 27, 2018.

The Governor has approved the Department of Medical Assistance Services request to extend the expiration date of the above-referenced emergency regulation for six months as provided for in § 2.2-4011 D of the Code of Virginia. Therefore, the emergency regulation will continue in effect through August 27, 2018. The emergency regulation relates to community-based screenings for children, community and hospital electronic screenings for community-based and nursing facility services, community and hospital preadmission teams, use of the electronic preadmission screening (ePAS) system, and public or private entities screening children and adults in communities where community preadmission screening teams are unable to complete screenings within 30 days of the initial request date for a screening. The emergency regulation was published in [32:23 VA.R. 3074-3087 July 11, 2016](#).

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. R16-4355; Filed September 8, 2017, 2:42 p.m.

Fast-Track Regulation

Titles of Regulations: 12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-130, 12VAC30-50-226).

12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-30, 12VAC30-80-32).

12VAC30-130. Amount, Duration and Scope of Selected Services (adding 12VAC30-130-5160 through 12VAC30-130-5210).

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: November 1, 2017.

Effective Date: November 16, 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.

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the board's requirements. The Medicaid authority as established by § 1902(a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

This regulatory package is also authorized by Item 306 MMM(1) of Chapter 780 of the 2016 Acts of Assembly, which states that DMAS "...shall amend the state plan for medical assistance and/or seek federal authority through an 1115 demonstration waiver, as soon as feasible, to provide coverage of ... peer support services to Medicaid individuals in the Fee-for-Service and Managed Care Delivery Systems."

Item 306 MMM(3) states that DMAS "...shall amend the State Plan for Medical Assistance and any waivers thereof to include peer support services to children and adults with mental health conditions and/or substance use disorders. The department shall work with its contractors, the Department of Behavioral Health and Developmental Services, and appropriate stakeholders to develop service definitions, utilization review criteria and provider qualifications."

DMAS shall amend the state plan for medical assistance and seek federal authority for the addition of Peer Support Services to Medicaid's delivery systems of comprehensive behavioral health and addiction and recovery and treatment services.

Purpose: The Commonwealth is currently experiencing a crisis of substance use of overwhelming proportions. More Virginians died from drug overdose in 2013 than from automobile accidents. In 2014, 80% of the people who died from drug overdoses (986 people) died from prescription opioid or heroin overdoses. Virginia's 1.1 million Medicaid/FAMIS members are affected disproportionately by this substance use epidemic as demonstrated by DMAS claims history data showing 216,555 Medicaid members with a substance use diagnosis in state fiscal year 2015. Peer supports are part of a continuum of recovery services offered by DMAS, and, as such, this regulatory action has a direct and specific impact on the health, safety, and welfare of the Commonwealth's Medicaid individuals.

This action adds the necessary component of person centered and recovery-oriented peer support services to the comprehensive program of addiction and recovery and treatment services to include community-based addiction and recovery treatment services established in response to the Governor's bipartisan Task Force on Prescription Drug and Heroin Addiction's numerous recommendations.

The provision of peer support services facilitates recovery from both serious mental illnesses and substance use disorders. Recovery is a process in which people are able to live, work, learn, and fully participate in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite their disability. For others, recovery could mean the reduction or complete remission of symptoms. Peer support services are delivered by peers who have been successful in the recovery process and can extend the reach of treatment beyond the clinical setting into an individual's community and natural environment to support and assist an individual with staying engaged in the recovery process.

Rationale for Using Fast-Track Rulemaking Process: This regulatory action is being promulgated as a fast-track rulemaking action because public comments received about the general concept and features, which have been specified to date, have been positive. The peer supports proposal offers an opportunity for substantial improvement in mental health and substance use treatment, and affected entities are actively participating with DMAS in its design efforts.

Substance: The section of the State Plan for Medical Assistance that is affected by this action is: "Amount, Duration, and Scope of Medical and Remedial Services."

Current policy:

DMAS covers approximately 1.1 million individuals; 80% of members receive care through contracted managed care organizations (MCOs) and 20% of members receive care through fee-for-service (FFS). The majority of members enrolled in Virginia's Medicaid and FAMIS programs include children, pregnant women, and individuals who meet the

disability category of being aged, blind, or disabled. The 20% of the individuals receiving care through fee-for-service do so because they meet one of 16 categories of exception to MCO participation, for example: (i) inpatients in state mental hospitals, long-stay hospitals, nursing facilities, or ICF/IIDs, (ii) individuals on spend down, (iii) individuals younger than 21 years of age who are in residential treatment facility Level C programs, (iv) newly eligible individuals in their third trimester of pregnancy, (v) individuals who permanently live outside their area of residence, (vi) individuals receiving hospice services, (vii) individuals with other comprehensive group or individual health insurance, (viii) individuals eligible for Individuals with Disabilities Education Act (IDEA) Part C services, (ix) individuals whose eligibility period is less than three months or is retroactive, and (x) individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program.

Historically, Virginia has not funded peer support services but the Commonwealth now has compelling reasons to provide Medicaid coverage for the provision of peer support services to adults and to the caregivers of youth. In a letter to state Medicaid directors, dated August 15, 2007, the Centers for Medicare & Medicaid Services (CMS) stated that they recognize "... the mental health field has seen a big shift in the paradigm of care over the last few years." CMS further states that "...now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a state's delivery of effective treatment. CMS is reaffirming its commitment to state flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services."

Beyond health care risk, the economic costs associated with mental illness and substance use disorders are significant. States and the federal government spend billions of tax dollars every year on the collateral impact associated with substance use disorders and mental illness, including criminal justice, public assistance and lost productivity costs.

Recommendations:

To address the emphasis on recovery from mental illnesses and substance use disorders and the recommendations from CMS, individuals 21 years of age or older and families or caretakers of youth 21 years of age and younger who participate in Medicaid managed care plan, GAP, FAMIS, FAMIS MOMS, or Medicaid fee-for-service shall be eligible to receive peer support services. These services shall be an added service under the Virginia's community mental health and rehabilitative services for individuals with mental health disorders and under the addiction and recovery treatment

Regulations

services (ARTS) for individuals with substance use disorders and co-occurring substance use and mental health disorders.

To be eligible to receive peer support services, adults 21 years and older shall require recovery oriented assistance and support for the acquisition of skills needed to engage in and maintain recovery, the development of self-advocacy skills to achieve a higher level of community tenure while decreasing dependency on formalized treatment systems, and to increase responsibilities, wellness potential, and shared accountability for their own recovery. Individuals 21 years or older shall have a documented substance use disorder or co-occurring mental health and substance use disorder, shall demonstrate moderate to severe functional impairment as a result of the diagnosis, and the functional impairment shall be of a degree that it interferes with or limits performance educationally, socially, vocationally, or living more independently.

Families or caretakers of individuals under age 21 shall qualify for family support ("family support partners") to assist with the individual's substance use disorder or co-occurring mental health and substance use disorder that has occurred within the past year. The family or caretaker and the individual shall require recovery assistance and two or more of the following:

1. Peer-based recovery oriented support for the maintenance of wellness and acquisition of skills needed to support the youth;
2. Assistance to develop self-advocacy skills to assist the youth in achieving self-management of the youth's health status;
3. Assistance and support to prepare the youth for a successful work or school experience; or
4. Peer modeling to increase helping the youth to assume responsibility for their recovery and resiliency.

Covered peer support services include collaborative recovery-oriented services and person centered activities and experiences, health care advocacy, the development of community roles and natural supports, support of work or other meaningful activity of the person's choosing, crisis support, and effective utilization of the service delivery system.

Peer support services shall be rendered following a documented recommendation for service by a licensed practitioner who is a credentialed addiction treatment professional or a licensed mental health professional who is enrolled as mental health or substance use Medicaid provider or who is working in an agency or facility enrolled as a mental health or substance use provider. The qualified peer will perform peer services under the supervision and clinical direction of the practitioner making the recommendation for services. The peer will be employed by or have a contractual relationship with the licensed and enrolled practitioner or

provider agency. These enrolled providers shall only hire peers who have been properly trained and certified by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and then registered with the Virginia Board of Counseling. Only the licensed and enrolled credentialed addiction treatment professional, licensed mental health professional, or provider agency shall be eligible to bill and receive reimbursement for peer support services.

A recovery, resiliency, and wellness plan based on the individual's, and as applicable the identified family's, perceived recovery needs and multidisciplinary assessment shall be required within 30 calendar days of the initiation of service. Development of the recovery, resiliency, and wellness plan shall include collaboration with the individual and, as applicable, the identified family member or caregiver involved in the individual's recovery. Ongoing and routine review of this plan will ensure effective service delivery.

Issues: There are no disadvantages identified in adding peer support services to the full continuum of addiction and recovery treatment services and community mental health rehabilitative services in Virginia. Peer support services are needed to ensure the success of Virginia's delivery system transformation that will save lives, improve patient outcomes, and decrease costs. There are no disadvantages to affected providers as this is an added service.

The advantages to Medicaid-eligible individuals are discussed above.

CMS will require an independent evaluation of the peer support services to demonstrate any improved outcomes for Medicaid members and cost savings from reducing emergency department visits and inpatient hospital utilization. This evaluation will help the Commonwealth demonstrate the impact of the service on the lives of its citizens, both Medicaid eligible and noneligible, as well as on the Commonwealth's economy.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 780 of the 2016 Acts of the Assembly, the Director of the Department of Medical Assistance Services (DMAS) proposes to implement peer support services to children and adults who have mental health conditions and/or substance use disorders.

Result of Analysis. The benefits likely exceed the costs for all proposed changes.

Estimated Economic Impact.

What are peer support services?

Peer support services are an evidence-based mental health model of care which consists of a qualified peer support

provider who assists individuals with their recovery from mental illness and substance use disorders. Peer support providers are self-identified consumers who are in successful and ongoing recovery from mental illness and/or substance use disorders.

The provision of Peer Support Services facilitates recovery from both serious mental illnesses and substance use disorders. Recovery is a process in which people are able to live, work, learn and fully participate in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite their disability. For others, recovery could mean the reduction or complete remission of symptoms. Peer Support Services are delivered by peers who have been successful in the recovery process and can extend the reach of treatment beyond the clinical setting into an individual's community and natural environment to support and assist an individual with staying engaged in the recovery process.

Need

The Commonwealth is experiencing a crisis of substance use of overwhelming proportions. More Virginians died from drug overdose in 2013 than from automobile accidents. In 2014, 80% of the people who died from drug overdoses (986 people) died from prescription opioid or heroin overdoses. Virginia's 1.1 million Medicaid/FAMIS members are affected disproportionately by this substance use epidemic as demonstrated by DMAS' claims history data showing 216,555 Medicaid members with a substance use diagnosis in fiscal year 2015.¹

Program

Peer Support Services would target individuals 21 years or older with mental health or substance use disorder or co-occurring mental health and substance use disorders. A Peer Support service called Family Support Partners would be provided to individuals under the age of 21 who have a mental health or substance use disorder or co-occurring mental health and substance use disorders which are the focus of the support with their families or caregivers.

Peer support providers would be trained and certified by the Virginia Department of Behavioral Health and Developmental Services, and then registered with the Board of Counseling at the Department of Health Professions. Supervision and care coordination are core components of peer support services.

Conclusion

Research has provided evidence that peer-delivered services generate superior outcomes in terms of decreased substance abuse, engagement of "difficult-to-reach" clients, and reduced rates of hospitalization.² Further, peer support has been found to increase participants' sense of hope, control, and ability to effect changes in their lives; increase their self-care, sense of

community belonging, and satisfaction with various life domains; and decrease participants' level of depression and psychosis.³ To the extent that the implementation of peer support services are successful in reducing the incidences of substance abuse and overdoses, and has significant positive impact on mental health, the benefits of the proposed amendments likely exceed the estimated annual cost of \$2,898,654 from the state General Fund and \$2,898,654 pass through funds from the federal government.

Businesses and Entities Affected. Based on current membership and data from the Governor's Action Plan program for those with serious mental illness, DMAS estimates approximately 4,600 current Medicaid members would benefit from peer supports. Community Service Boards have a network that could provide these services to approximately 10% of these. Currently there are approximately 5,891 provider entities with a unique National Provider Identifier that could be affected by the new regulations if they choose to participate in the service. At least half if not more of these providers are small businesses.

Localities Particularly Affected. The proposed amendments do not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendments create peer support provider positions for people who are in successful and ongoing recovery from mental illness and/or substance use disorders. These are individuals who may otherwise have difficulty finding employment.

Effects on the Use and Value of Private Property. The proposed amendments potentially benefit firms that provide mental health and drug treatment services by providing additional business and revenue. The value of these firms may thus be positively affected.

Real Estate Development Costs. The proposed amendments do not affect real estate development costs.

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. The proposed amendments do not significantly affect costs for small businesses.

Alternative Method that Minimizes Adverse Impact. The proposed amendments do not adversely affect small businesses.

Adverse Impacts:

Businesses. The proposed amendments do not adversely affect businesses.

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Localities. The proposed amendments do not adversely affect localities.

Other Entities. The proposed amendments do not adversely affect other entities.

References

Davidson, L., C. Bellamy, K. Guy, and R. Miller. 2011. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry* 11:123-128

Rowe M., C. Bellamy et al. 2007. Reducing alcohol use, drug use, and criminality among persons with severe mental illness: outcomes of a Group- and Peer-Based Intervention. *Psychiatric Services* 58:955-61.

Solomon P, J. Draine, and M. Delaney. 1995. The working alliance and consumer case management. *Journal of Mental Health Administration* 22:126-34.

¹ Source: Department of Medical Assistance Services

² See Rowe et al (2007) and Solomon et al (1995)

³ See Davison et al (2012)

Agency's Response to Economic Impact Analysis: The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget. The agency raises no issues with this analysis.

Summary:

Pursuant to Chapter 780 of the 2016 Acts of the Assembly, the amendments establish peer support services and family support services for children and adults who have mental health conditions or substance use disorders and address (i) eligibility for services; (ii) provider and setting requirements; (iii) development of a recovery, resiliency, and wellness plan; (iv) documentation of services; (v) reimbursement; (vi) service limitations; and (vii) definitions.

12VAC30-50-130. Nursing facility services, EPSDT, including school health services and family planning.

A. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older. Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

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

1. Payment of medical assistance services shall be made on behalf of individuals ~~under younger than~~ 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when

such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

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

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

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

5. Community mental health services. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual ~~12-20~~ 12 through 20 years of age; a child means an individual from birth up to 12 years of age.

"Behavioral health service" means the same as defined in 12VAC30-130-5160.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Caregiver" means the same as defined in 12VAC30-130-5160.

"Certified prescreener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"Direct supervisor" means the person who provides direct supervision to the peer recovery specialist. The direct supervisor (i) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by DBHDS, and have documented completion of the DBHDS PRS supervisor training; (ii) shall be a qualified mental health professional (QMHP-A, QMHP-C, or QMHP-E) as defined in 12VAC35-105-20 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or (iii) shall be an LMHP who has documented completion of the DBHDS PRS supervisor training who is acting within his scope of practice under state law. An LMHP providing services before April 1, 2018, shall have until April 1, 2018, to complete the DBHDS PRS supervisor training.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

"EPSDT" means early and periodic screening, diagnosis, and treatment.

"Family support partners" means the same as defined in 12VAC30-130-5170.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

~~"Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed psychiatric nurse practitioner, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist~~ the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers.

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An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Peer recovery specialist" or "PRS" means the same as defined in 12VAC30-130-5160.

"Person centered" means the same as defined in 12VAC30-130-5160.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Recovery-oriented services" means the same as defined in 12VAC30-130-5160.

"Recovery, resiliency, and wellness plan" means the same as defined in 12VAC30-130-5160.

"Resiliency" means the same as defined in 12VAC30-130-5160.

"Self-advocacy" means the same as defined in 12VAC30-130-5160.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"Services provided under arrangement" means the same as defined in 12VAC30-130-850.

"Strength-based" means the same as defined in 12VAC30-130-5160.

"Supervision" means the same as defined in 12VAC30-130-5160.

b. Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family

dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IHH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(4) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

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

(1) Service authorization shall be required for Medicaid reimbursement.

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(3) These services may be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

d. Community-based services for children and adolescents under 21 years of age (Level A) pursuant to 42 CFR 440.031(d).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

(3) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.

(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living

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skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.

(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

(9) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(10) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

e. Therapeutic behavioral services (Level B) pursuant to 42 CFR 440.130(d).

(1) Such services must be therapeutic services rendered in a residential setting ~~that~~. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

(3) Room and board costs shall not be reimbursed. Facilities that only provide independent living services are not reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(4) These residential providers must be licensed by the Department of Behavioral Health and Developmental

Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

(6) The individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

(7) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(8) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services that are based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(9) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

(10) The facility/group home shall coordinate necessary services with other providers. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

f. Mental health family support partners.

(1) Mental health family support partners are peer recovery support services and are nonclinical, peer-to-peer activities that engage, educate, and support the caregiver and an individual's self-help efforts to improve health recovery resiliency and wellness. Mental health family support partners is a peer support service and is a strength-based, individualized service provided to the caregiver of a Medicaid-eligible individual younger than 21 years of age with a mental health disorder that is the focus of support. The services provided to the caregiver and individual must be directed exclusively toward the benefit of the Medicaid-eligible individual. Services are expected to improve outcomes for individuals younger than 21 years of age with complex needs who are involved with multiple systems and increase the individual's and family's confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are

rendered by a PRS who is (i) a parent of a minor or adult child with a similar mental health disorder or (ii) an adult with personal experience with a family member with a similar mental health disorder with experience navigating behavioral health care services. The PRS shall perform the service within the scope of his knowledge, lived experience, and education.

(2) Under the clinical oversight of the LMHP making the recommendation for mental health family support partners, the peer recovery specialist in consultation with his direct supervisor shall develop a recovery, resiliency, and wellness plan based on the LMHP's recommendation for service, the individual's and the caregiver's perceived recovery needs, and any clinical assessments or service specific provider intakes as defined in this section within 30 calendar days of the initiation of service. Development of the recovery, resiliency, and wellness plan shall include collaboration with the individual and the individual's caregiver. Individualized goals and strategies shall be focused on the individual's identified needs for self-advocacy and recovery. The recovery, resiliency, and wellness plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the plan. The recovery, resiliency, and wellness plan shall be completed, signed, and dated by the LMHP, the PRS, the direct supervisor, the individual, and the individual's caregiver within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual and the caregiver to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

(3) Documentation of required activities shall be required as set forth in 12VAC30-130-5200 A and C through J.

(4) Limitations and exclusions to service delivery shall be the same as set forth in 12VAC30-130-5210.

(5) Caregivers of individuals younger than 21 years of age who qualify to receive mental health family support partners (i) care for an individual with a mental health disorder who requires recovery assistance and (ii) meet two or more of the following:

(a) Individual and his caregiver need peer-based recovery-oriented services for the maintenance of wellness and the acquisition of skills needed to support the individual.

(b) Individual and his caregiver need assistance to develop self-advocacy skills to assist the individual in achieving self-management of the individual's health status.

(c) Individual and his caregiver need assistance and support to prepare the individual for a successful work or school experience.

(d) Individual and his caregiver need assistance to help the individual and caregiver assume responsibility for recovery.

(6) Individuals 18 through 20 years of age who meet the medical necessity criteria in 12VAC30-50-226 B 7 e, who would benefit from receiving peer supports directly and who choose to receive mental health peer support services directly instead of through their caregiver, shall be permitted to receive mental health peer support services by an appropriate PRS.

(7) To qualify for continued mental health family support partners, the requirements for continued services set forth in 12VAC30-130-5180 D shall be met.

(8) Discharge criteria from mental health family support partners shall be the same as set forth in 12VAC30-130-5180 E.

(9) Mental health family support partners services shall be rendered on an individual basis or in a group.

(10) Prior to service initiation, a documented recommendation for mental health family support partners services shall be made by a licensed mental health professional (LMHP) who is acting within his scope of practice under state law. The recommendation shall verify that the individual meets the medical necessity criteria set forth in subdivision 5 a (5) of this subsection. The recommendation shall be valid for no longer than 30 calendar days.

(11) Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, experience, and certification required by DBHDS in order to be eligible to register with the Virginia Board of Counseling on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling, registration of peer recovery specialists by the Board of Counseling shall be required. The PRS shall perform mental health family support partners services under the oversight of the LMHP making the recommendation for services and providing the clinical oversight of the recovery, resiliency, and wellness plan.

(12) The PRS shall be employed by or have a contractual relationship with the enrolled provider licensed for one of the following:

(a) Acute care general and emergency department hospital services licensed by the Department of Health.

(b) Freestanding psychiatric hospital and inpatient psychiatric unit licensed by the Department of Behavioral Health and Developmental Services.

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(c) Psychiatric residential treatment facility licensed by the Department of Behavioral Health and Developmental Services.

(d) Therapeutic group home licensed by the Department of Behavioral Health and Developmental Services.

(e) Outpatient mental health clinic services licensed by the Department of Behavioral Health and Developmental Services.

(f) Outpatient psychiatric services provider.

(g) A community mental health and rehabilitative services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following community mental health and rehabilitative services as defined in this section, 12VAC30-50-226, 12VAC30-50-420, or 12VAC30-50-430 for which the individual younger than 21 years meets medical necessity criteria (i) intensive in home; (ii) therapeutic day treatment; (iii) day treatment or partial hospitalization; (iv) crisis intervention; (v) crisis stabilization; (vi) mental health skill building; or (vii) mental health case management.

(13) Only the licensed and enrolled provider as referenced in subdivision 5 f (12) of this subsection shall be eligible to bill and receive reimbursement from DMAS or its contractor for mental health family support partner services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined not to be in compliance with DMAS requirements.

(14) Supervision of the PRS shall be required as set forth in 12VAC30-130-5190 E and 12VAC30-130-5200 G.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2) for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by (i) a psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or (ii) a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements

of Part XIV (12VAC30-130-850 et seq.) of ~~12VAC30-130~~ Amount, Duration and Scope of Selected Services.

a. The inpatient psychiatric services benefit for individuals younger than 21 years of age shall include services defined at 42 CFR 440.160 that are provided under the direction of a physician pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals and shall involve active treatment designed to achieve the child's discharge from inpatient status at the earliest possible time. The inpatient psychiatric services benefit shall include services provided under arrangement furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility (i) arranges for and oversees the provision of all services, (ii) maintains all medical records of care furnished to the individual, and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

b. Eligible services provided under arrangement with the inpatient psychiatric facility shall vary by provider type as described in this subsection. For purposes of this section, emergency services means the same as is set out in 12VAC30-50-310 B.

(1) State freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) pharmacy services and (ii) emergency services.

(2) Private freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) outpatient hospital services; (iii) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (iv) laboratory and radiology services; (v) vision services; (vi) dental, oral surgery, and orthodontic services; (vii) transportation services; and (viii) emergency services.

(3) Residential treatment facilities, as defined at 42 CFR 483.352, shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e.,

nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) pharmacy services; (iii) outpatient hospital services; (iv) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (v) laboratory and radiology services; (vi) durable medical equipment; (vii) vision services; (viii) dental, oral surgery, and orthodontic services; (ix) transportation services; and (x) emergency services.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with (i) 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151(a) and (b) and 441.152 through 441.156, and (ii) the conditions of participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

d. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

8. Addiction and recovery treatment services shall be covered under EPSDT consistent with 12VAC30-130-5000 et seq.

C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet

applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services.

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing

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changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialists, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D (12VAC30-50-530). Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

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

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

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions.

3. Family planning services as established by § 1905(a)(4)(C) of the Social Security Act include annual family planning exams; cervical cancer screening for women; sexually transmitted infection (STI) testing; lab services for family planning and STI testing; family planning education, counseling, and preconception health; sterilization procedures; nonemergency transportation to a family planning service; and U.S. Food and Drug Administration approved prescription and over-the-counter contraceptives, subject to limits in 12VAC30-50-210.

12VAC30-50-226. Community mental health services.

A. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" or "ADLs" means personal care tasks such as bathing, dressing, toileting, transferring, and eating or feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Affiliated" means any entity or property in which a provider or facility has a direct or indirect ownership interest of 5.0% or more, or any management, partnership, or control of an entity.

"Behavioral health service" means the same as defined in 12VAC30-130-5160.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS. DMAS' designated BHSA shall be authorized to constitute, oversee, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Such authority shall include entering into or terminating contracts with providers in accordance with DMAS authority pursuant to 42 CFR Part 1002 and § 32.1-325 D and E of the Code of Virginia. DMAS shall retain authority for and oversight of the BHSA entity or entities.

"Certified prescriber" means an employee of either the local community services board/behavioral health authority or its designee who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by DBHDS.

"Clinical experience" means, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health skill building, (v) crisis stabilization, or (vi) crisis intervention services, practical experience in providing direct services to individuals with diagnoses of mental illness or intellectual disability or the provision of direct geriatric services or special education services. Experience shall include supervised internships, supervised practicums, or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be established by DBHDS in the document titled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Code" means the Code of Virginia.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"Direct supervisor" means the person who provides direct supervision to the peer recovery specialist. The direct supervisor (i) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by DBHDS, and have documented completion of the DBHDS PRS supervisor training; (ii) shall be a qualified mental health professional (QMHP-A, QMHP-C, or QMHP-E) as defined in 12VAC35-105-20 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or (iii) shall be an LMHP who has documented completion of the DBHDS PRS supervisor training who is acting within his scope of practice under state law. An LMHP providing services before April 1, 2018, shall have until April 1, 2018, to complete the DBHDS PRS supervisor training.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

"Human services field" means the same as the term is defined by DBHDS in the guidance document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual" means the patient, client, or recipient of services described in this section.

"Individual service plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the service-specific provider intake. The ISP contains, but is not limited to, the individual's treatment or training needs, the individual's goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual. If the individual is a minor child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a minor child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.

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"Individualized training" means instruction and practice in functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living skills, and use of community resources; assistance with medical management; and monitoring health, nutrition, and physical condition. The training shall be rehabilitative and based on a variety of incremental (or cumulative) approaches or tools to organize and guide the individual's life planning and shall reflect what is important to the individual in addition to all other factors that affect his functioning, including effects of the disability and issues of health and safety.

"Licensed mental health professional" or "LMHP" means the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" is defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these

persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Peer recovery specialist" or "PRS" means the same as defined in 12VAC30-130-5160.

"Person centered" means the same as defined in 12VAC30-130-5160.

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in 12VAC35-105-20.

"Qualified mental health professional-child" or "QMHP-C" means the same as defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as defined in 12VAC35-105-20.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as defined in 12VAC35-105-20.

"Recovery-oriented services" means the same as defined in 12VAC30-130-5160.

"Recovery, resiliency, and wellness plan" means the same as defined in 12VAC30-130-5160.

"Register" or "registration" means notifying DMAS or its contractor that an individual will be receiving services that do not require service authorization.

"Resiliency" means the same as defined in 12VAC30-130-5160.

"Review of ISP" means that the provider evaluates and updates the individual's progress toward meeting the individualized service plan objectives and documents the outcome of this review. For DMAS to determine that these reviews are satisfactory and complete, the reviews shall (i) update the goals, objectives, and strategies of the ISP to reflect any change in the individual's progress and treatment needs as well as any newly identified problems; (ii) be conducted in a manner that enables the individual to participate in the process; and (iii) be documented in the individual's medical record no later than 15 calendar days from the date of the review.

"Self-advocacy" means the same as defined in 12VAC30-130-5160.

"Service authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by a DMAS service authorization contractor prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

"Service-specific provider intake" means the same as defined in 12VAC30-50-130 and also includes individuals who are older than 21 years of age.

"Strength-based" means the same as defined in 12VAC30-130-5160.

"Supervision" means the same as defined in 12VAC30-130-5160.

B. Mental health services. The following services, with their definitions, shall be covered: day treatment/partial hospitalization, psychosocial rehabilitation, crisis services, intensive community treatment (ICT), and mental health skill building. Staff travel time shall not be included in billable time for reimbursement. These services, in order to be covered, shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services. These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities. All services which do not require service authorization require registration. This registration shall transmit service-specific information to DMAS or its contractor in accordance with service authorization requirements.

1. Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial, and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement.

a. Day treatment/partial hospitalization services shall be time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.

b. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising

from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that the individual requires repeated interventions or monitoring by the mental health, social services, or judicial system that have been documented; or

(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

c. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state and other less intensive services may achieve psychiatric stabilization.

d. Admission and services for time periods longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist.

e. These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH.

2. Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service.

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a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals: (i) who without these services would be unable to remain in the community or (ii) who meet at least two of the following criteria on a continuing or intermittent basis:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary; or

(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

b. These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH.

3. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. The provision of this service to an individual shall be registered with either DMAS, DMAS contractors, or the BHSA within one business day or the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising

from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary; or

(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

b. The annual limit for crisis intervention is 720 units per year. A unit shall equal 15 minutes.

c. These services may only be rendered by an LMHP, an LMHP-supervisee, LMHP-resident, LMHP-RP, or a certified prescreener.

4. Intensive community treatment (ICT), initially covered for a maximum of 26 weeks based on an initial service-specific provider intake and may be reauthorized for up to an additional 26 weeks annually based on written intake and certification of need by a licensed mental health provider (LMHP), shall be defined by 12VAC35-105-20 or LMHP-S, LMHP-R, and LMHP-RP and shall include medical psychotherapy, psychiatric assessment, medication management, and care coordination activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community. Authorization is required for Medicaid reimbursement.

a. To qualify for ICT, the individual must meet at least one of the following criteria:

(1) The individual must be at high risk for psychiatric hospitalization or becoming or remaining homeless due to mental illness or require intervention by the mental health or criminal justice system due to inappropriate social behavior.

(2) The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for co-occurring serious mental illness and substance use disorder and demonstrates a resistance to seek out and utilize appropriate treatment options.

b. A written, service-specific provider intake, as defined at 12VAC30-50-130, that documents the individual's

eligibility and the need for this service must be completed prior to the initiation of services. This intake must be maintained in the individual's records.

c. An individual service plan shall be initiated at the time of admission and must be fully developed, as defined in this section, within 30 days of the initiation of services.

d. The annual unit limit shall be 130 units with a unit equaling one hour.

e. These services may only be rendered by a team that meets the requirements of 12VAC35-105-1370.

5. Crisis stabilization services for nonhospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation. Services may be provided for up to a 15-day period per crisis episode following a face-to-face service-specific provider intake by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. Only one unit of service shall be reimbursed for this intake. The provision of this service to an individual shall be registered with either DMAS, DMAS contractors, or the BHSA within one business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

a. The goals of crisis stabilization programs shall be to avert hospitalization or rehospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation. The services must be documented in the individual's records as having been provided consistent with the ISP in order to receive Medicaid reimbursement.

b. The crisis stabilization program shall provide to individuals, as appropriate, psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling.

c. This service may be provided in any of the following settings, but shall not be limited to: (i) the home of an individual who lives with family or other primary caregiver; (ii) the home of an individual who lives independently; or (iii) community-based programs licensed by DBHDS to provide residential services but which are not institutions for mental disease (IMDs).

d. This service shall not be reimbursed for (i) individuals with medical conditions that require hospital care; (ii) individuals with primary diagnosis of substance abuse; or (iii) individuals with psychiatric conditions that cannot

be managed in the community (i.e., individuals who are of imminent danger to themselves or others).

e. The maximum limit on this service is 60 days annually.

f. Services must be documented through daily progress notes and a daily log of times spent in the delivery of services. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing and maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions documented by the mental health, social services, or judicial system are or have been necessary; or

(4) Exhibit difficulty in cognitive ability such that the individual is unable to recognize personal danger or significantly inappropriate social behavior.

g. These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E or a certified prescreener.

6. Mental health skill-building services (MHSS) shall be defined as goal-directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed. These services may be authorized up to six consecutive months as long as the individual meets the coverage criteria for this service. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. These services shall provide goal-directed training in the following areas in order to be reimbursed by Medicaid or the BHSA: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication

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management; and (iii) monitoring of health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities. Providers shall be reimbursed only for training activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and this section. A review of MHSS services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individuals who have received at least six months of MHSS to determine the continued need for this service.

a. Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who require individualized goal-directed training in order to achieve or maintain stability and independence in the community.

b. Individuals ages 21 and older shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

(1) The individual shall have one of the following as a primary mental health diagnosis:

(a) Schizophrenia or other psychotic disorder as set out in the DSM-5;

(b) Major depressive disorder;

(c) Recurrent Bipolar I or Bipolar II; or

(d) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year and that includes all of the following: (i) is a serious mental illness; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record; and (iv) requires individualized training for the individual in order to achieve or maintain independent living in the community.

(2) The individual shall require individualized goal-directed training in order to acquire or maintain self-regulation of basic living skills, such as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support systems; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

(3) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv)

placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation, pursuant to § 37.2-809 B of the Code of Virginia. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

(4) The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the service-specific provider intake date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that antipsychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services and shall not be required for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

c. Individuals aged 18 to 21 years shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

(1) The individual shall not be living in a supervised setting as described in § 63.2-905.1 of the Code of Virginia. If the individual is transitioning into an independent living situation, MHSS shall only be authorized for up to six months prior to the date of transition.

(2) The individual shall have at least one of the following as a primary mental health diagnosis.

(a) Schizophrenia or other psychotic disorder as set out in the DSM-5;

(b) Major depressive disorder;

(c) Recurrent Bipolar-I or Bipolar II; or

(d) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year and that includes all of the following: (i) is a serious mental illness or serious emotional disturbance; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record; and (iv) requires individualized training for the individual in order to achieve or maintain independent living in the community.

(3) The individual shall require individualized goal-directed training in order to acquire or maintain self-regulation of basic living skills such as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support systems; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

(4) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) temporary detention order (TDO) evaluation pursuant to § 37.2-809 B of the Code of Virginia. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

(5) The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications, within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that antipsychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation of medication management shall be maintained in the individual's mental health skill-building services record. For individuals not prescribed antipsychotic, mood stabilizing, or antidepressant medications, the provider shall have documentation from the medication management physician describing how

the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

(6) An independent clinical assessment, established in 12VAC30-130-3020, shall be completed for the individual.

d. Service-specific provider intakes shall be required at the onset of services and individual service plans (ISPs) shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in 12VAC30-50-130.

e. The yearly limit for mental health skill-building services is 520 units. Only direct face-to-face contacts and services to the individual shall be reimbursable. One unit is 1 to 2.99 hours per day, two units is 3 to 4.99 hours per day.

f. These services may only be rendered by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or QPPMH.

g. The provider shall clearly document details of the services provided during the entire amount of time billed.

h. The ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

i. Limits and exclusions.

(1) Group home (Level A or B) and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the provider's respective facility. Individuals residing in facilities may, however, receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside.

(2) Mental health skill-building services shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services

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through the Intellectual Disability Waiver or Individual and Family Developmental Disabilities Support Waiver.

(3) Mental health skill-building services shall not be reimbursed for individuals who are also receiving services under the Department of Social Services independent living program (22VAC40-151), independent living services (22VAC40-131 and 22VAC40-151), or independent living arrangement (22VAC40-131) or any Comprehensive Services Act-funded independent living skills programs.

(4) Mental health skill-building services shall not be available to individuals who are receiving treatment foster care (12VAC30-130-900 et seq.).

(5) Mental health skill-building services shall not be available to individuals who reside in intermediate care facilities for individuals with intellectual disabilities or hospitals.

(6) Mental health skill-building services shall not be available to individuals who reside in nursing facilities, except for up to 60 days prior to discharge. If the individual has not been discharged from the nursing facility during the 60-day period of services, mental health skill-building services shall be terminated and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that mental health skill-building services are necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 days of mental health skill-building services.

(7) Mental health skill-building services shall not be available for residents of residential treatment centers (Level C facilities) except for the intake code H0032 (modifier U8) in the seven days immediately prior to discharge.

(8) Mental health skill-building services shall not be reimbursed if personal care services or attendant care services are being received simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the Intellectual Disability Waiver (12VAC30-120-1000 et seq.), Individual and Family Developmental Disabilities Support Waiver (12VAC30-120-700 et seq.), the Elderly or Disabled with Consumer Direction Waiver (12VAC30-120-900 et seq.), and EPSDT services (12VAC30-50-130).

(9) Mental health skill-building services shall not be duplicative of other services. Providers shall be required

to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or QPPMH to avoid duplication of services.

(10) Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving mental health skill-building services unless their physicians issue signed and dated statements indicating that the individuals can benefit from this service.

(11) Individuals who are not diagnosed with a serious mental health disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability shall not be excluded from the mental health skill-building services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in subdivision B 6 b (1) or B 6 c (2) of this section and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health skill-building services.

7. Mental health peer support services.

a. Mental health peer support services are peer recovery support services and are nonclinical, peer-to-peer activities that engage, educate, and support an individual's self-help efforts to improve health recovery, resiliency, and wellness. Mental health peer support services for adults is a person centered, strength-based, and recovery-oriented rehabilitative service for individuals 21 years or older provided by a peer recovery specialist successful in the recovery process with lived experience with a mental health disorder, who is trained to offer support and assistance in helping others in the recovery to reduce the disabling effects of a mental health disorder that is the focus of support. Services assist the individual with developing and maintaining a path to recovery, resiliency, and wellness. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illnesses or disorders.

b. Under the clinical oversight of the LMHP making the recommendation for mental health support services, the peer recovery specialist in consultation with his direct supervisor shall develop a recovery, resiliency, and wellness plan based on the LMHP's recommendation for service, the individual's perceived recovery needs, and

any clinical assessments or service specific provider intakes as defined in this section within 30 calendar days of the initiation of service. Development of the recovery, resiliency, and wellness plan shall include collaboration with the individual. Individualized goals and strategies shall be focused on the individual's identified needs for self-advocacy and recovery. The recovery, resiliency, and wellness plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the plan. The recovery, resiliency, and wellness plan shall be completed, signed, and dated by the LMHP, the PRS, the direct supervisor, and the individual within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

c. Documentation of required activities shall be required as set forth in 12VAC30-130-5200 A and C through J.

d. Limitations and exclusions to service delivery shall be the same as set forth in 12VAC30-130-5210.

e. Individuals 21 years or older qualifying for mental health peer support services shall meet the following requirements:

(1) Require recovery-oriented assistance and support services for the acquisition of skills needed to engage in and maintain recovery; for the development of self-advocacy skills to achieve a decreasing dependency on formalized treatment systems; and to increase responsibilities, wellness potential, and shared accountability for the individual's own recovery.

(2) Have a documented mental health disorder diagnosis.

(3) Demonstrate moderate to severe functional impairment because of a diagnosis that interferes with or limits performance in at least one of the following domains: educational (e.g., obtaining a high school or college degree); social (e.g., developing a social support system); vocational (e.g., obtaining part-time or full-time employment); self-maintenance (e.g., managing symptoms, understanding his illness, living more independently).

f. To qualify for continued mental health peer support services, the requirements for continued services set forth in 12VAC30-130-5180 D shall be met.

g. Discharge criteria from mental health peer support services is the same as set forth in 12VAC30-130-5180 E.

h. Mental health peer support services shall be rendered on an individual basis or in a group.

i. Prior to service initiation, a documented recommendation for mental health peer support services shall be made by a licensed mental health professional acting within the scope of practice under state law. The recommendation shall verify that the individual meets the medical necessity criteria set forth in subdivision 7 e of this subsection. The recommendation shall be valid for no longer than 30 calendar days.

j. Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, experience, and certification established by DBHDS in order to be eligible to register with the Board of Counseling on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling, registration of peer recovery specialists by the Board of Counseling shall be required. The PRS shall perform mental health peer support services under the oversight of the LMHP making the recommendation for services and providing the clinical oversight of the recovery, resiliency, and wellness plan. The PRS shall be employed by or have a contractual relationship with an enrolled provider licensed for one of the following:

(1) Acute care general hospital licensed by the Department of Health.

(2) Freestanding psychiatric hospital and inpatient psychiatric unit licensed by the Department of Behavioral Health and Developmental Services.

(3) Outpatient mental health clinic services licensed by the Department of Behavioral Health and Developmental Services.

(4) Outpatient psychiatric services provider.

(5) Rural health clinics and federally qualified health centers.

(6) Hospital emergency department services licensed by the Department of Health.

(7) Community mental health and rehabilitative services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following community mental health and rehabilitative services defined in this section or 12VAC30-50-420 for which the individual meets medical necessity criteria:

(a) Day treatment or partial hospitalization;

(b) Psychosocial rehabilitation;

(c) Crisis intervention;

(d) Intensive community treatment;

(e) Crisis stabilization;

(f) Mental health skill building; or

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(g) Mental health case management.

k. Only the licensed and enrolled provider referenced in subdivision 7 j of this subsection shall be eligible to bill mental health peer support services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

l. Supervision of the PRS shall be required as set forth in 12VAC30-130-5190 E and 12VAC30-130-5200 G.

12VAC30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services. Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public). The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms, when used in this subdivision 1 shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services rendered in emergency departments that DMAS determines are nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12VAC30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12VAC30-95-5.

2. Dentists' services.

3. Mental health services including: (i) community mental health services, (ii) services of a licensed clinical psychologist, ~~or~~ (iii) mental health services provided by a physician, or (iv) peer support services.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME) and supplies.

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

"DMERC" means the Durable Medical Equipment Regional Carrier rate as published by the Centers for Medicare and Medicaid Services at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>.

"HCPCS" means the Healthcare Common Procedure Coding System, Medicare's National Level II Codes, HCPCS 2006 (Eighteenth edition), as published by Ingenix, as may be periodically updated.

a. Obtaining prior authorization shall not guarantee Medicaid reimbursement for DME.

b. The following shall be the reimbursement method used for DME services:

(1) If the DME item has a DMERC rate, the reimbursement rate shall be the DMERC rate minus 10%. For dates of service on or after July 1, 2014, DME items subject to the Medicare competitive bidding program shall be reimbursed the lower of:

(a) The current DMERC rate minus 10% or

(b) The average of the Medicare competitive bid rates in Virginia markets.

(2) For DME items with no DMERC rate, the agency shall use the agency fee schedule amount. The reimbursement rates for DME and supplies shall be listed in the DMAS Medicaid Durable Medical Equipment (DME) and Supplies Listing and updated periodically. The agency fee schedule shall be available on the agency website at www.dmas.virginia.gov.

(3) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the manufacturer's net charge to the provider, less shipping and handling, plus 30%. The manufacturer's net charge to the provider shall be the cost to the provider minus all available discounts to the provider. Additional information specific to how DME providers, including manufacturers who are enrolled as providers, establish and document their cost or costs for DME codes that do

not have established rates can be found in the relevant agency guidance document.

c. DMAS shall have the authority to amend the agency fee schedule as it deems appropriate and with notice to providers. DMAS shall have the authority to determine alternate pricing, based on agency research, for any code that does not have a rate.

d. The reimbursement for incontinence supplies shall be by selective contract. Pursuant to § 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d), the Commonwealth assures that adequate services/devices shall be available under such arrangements.

e. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical equipment such as service maintenance agreements shall be bundled under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12VAC30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

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(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services.

8. Laboratory services (other than inpatient hospital). The agency's rates for clinical laboratory services were set as of July 1, 2014, and are effective for services on or after that date.

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

10. X-ray services.

11. Optometry services.

12. Medical supplies and equipment.

13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90.

16. Supplemental payments for services provided by Type I physicians.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Type I physicians for furnished services provided on or after July 2, 2002. A Type I physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 2, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for Type I physician services and Medicare rates. Effective August 13, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 143% of Medicare rates.

Effective January 3, 2012, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 181% of Medicare rates. Effective January 1, 2013, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 197% of Medicare rates. Effective April 8, 2014, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 201% of Medicare rates.

c. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

d. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter.

e. Payment will not be made to the extent that the payment would duplicate payments based on physician costs covered by the supplemental payments.

17. Supplemental payments for services provided by physicians at Virginia freestanding children's hospitals.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for provision of physician services at the qualifying Virginia freestanding children's hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 1, 2011, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 143% of Medicare rates subject to the following reduction. Final payments shall be reduced on a prorated basis so that total payments for freestanding children's hospital physician services are \$400,000 less annually than would be calculated based on the formula in the previous sentence. Payments shall

be made quarterly no later than 90 days after the end of the quarter. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

18. Supplemental payments for services provided by physicians affiliated with publicly funded medical schools in Tidewater.

a. In addition to payments for physician services specified elsewhere in the State Plan, the Department of Medical Assistance Services provides supplemental payments to physicians affiliated with publicly funded medical schools in Tidewater for furnished services provided on or after October 1, 2012. A physician affiliated with a publicly funded medical school is a physician who is employed by a publicly funded medical school that is a political subdivision of the Commonwealth of Virginia, who provides clinical services through the faculty practice plan affiliated with the publicly funded medical school, and who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective October 1, 2012, the supplemental payment amount for services furnished by physicians affiliated with publicly funded medical schools in Tidewater shall be the difference between the Medicaid payments otherwise made for physician services and 135% of Medicare rates. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

19. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or government-operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a qualifying clinic is a clinic operated by a community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or government-operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 19 d of this subsection and the

amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 19 b (1) of this subsection for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision 19 b (2) of this subsection by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

d. To determine the aggregate upper payment limit referred to in subdivision 19 b (3) of this subsection, Medicaid payments to nonstate government-owned or government-operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B 2) in regard to the state agency fee schedule for Resource Based Relative Value Scale. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

20. Personal assistance services (PAS) for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200. These services are reimbursed in accordance with the state agency fee schedule described in 12VAC30-80-190. The state agency fee schedule is published on the DMAS website at <http://www.dmas.virginia.gov>.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

12VAC30-80-32. Reimbursement for substance abuse use disorder services.

A. Physician services described in 12VAC30-50-140, other licensed practitioner services described in 12VAC30-50-150, and clinic services described in 12VAC30-50-180 for assessment and evaluation or treatment of substance use disorders shall be reimbursed using the methodology in 12VAC30-80-30 and 12VAC30-80-190 subject to the following reductions for psychotherapy services for other licensed practitioners.

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1. Psychotherapy services of licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

2. Psychotherapy services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed psychiatric nurse practitioners, licensed substance abuse treatment practitioners, or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

3. The same rates shall be paid to governmental and private providers. These services are reimbursed based on the Common Procedural Terminology codes and Healthcare Common Procedure Coding System codes. The agency's rates were set as of July 1, 2007, and are updated as described in 12VAC30-80-190. All rates are published on the Department of Medical Assistance Services (DMAS) website at www.dmas.virginia.gov.

B. Rates for the following addiction and recovery treatment services (ARTS) physician and clinic services shall be based on the agency fee schedule: medication assisted treatment induction with a visit unit of service; individual and group opioid treatment service with a 15-minute unit of service; and substance use care coordination with a monthly unit of service. The agency's rates shall be set as of April 1, 2017. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to public and private providers. All rates are published on the DMAS website at www.dmas.virginia.gov.

C. Community ARTS rehabilitation services. Per diem rates for clinically managed low intensity residential services (ASAM Level 3.1), partial hospitalization (ASAM Level 2.5), and intensive outpatient (ASAM Level 2.1) for ARTS shall be based on the agency fee schedule. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at: www.dmas.virginia.gov.

D. ARTS federally qualified health center or rural health clinic services (ASAM Level 1.0) for assessment and evaluation or treatment of substance use disorder, as described in 12VAC30-130-5000 et seq., shall be reimbursed using the methodology described in 12VAC30-80-25.

E. Substance use case management services. Substance use case management services, as described in 12VAC30-50-491,

shall be reimbursed a monthly rate based on the agency fee schedule. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payment shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at www.dmas.virginia.gov.

F. Peer support services. Peer support services as described in 12VAC30-130-5160 through 12VAC30-130-5210 furnished by enrolled providers or provider agencies as described in 12VAC30-130-5190 shall be reimbursed based on the agency fee schedule for 15-minute units of service. The agency's rates set as of July 1, 2017, are effective for services on or after that date. All rates are published on the DMAS website at: www.dmas.virginia.gov.

12VAC30-130-5160. Peer support services and family support partners: definitions.

The following words and terms when used in this part shall have the following meanings:

"Behavioral health service" means treatments and services for mental or substance use disorders.

"Caregiver" means the family members, friends, or neighbors who provide unpaid assistance to a Medicaid member with a mental health or substance use disorder or co-occurring mental health and substance use disorder. "Caregiver" does not include individuals who are employed to care for the member.

"Direct supervisor" means the person who provides direct supervision to the peer recovery specialist. The direct supervisor (i) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by DBHDS, and have documented completion of the DBHDS PRS supervisor training; (ii) shall be a practitioner who has documented completion of the DBHDS PRS supervisor training, meets clauses (i) through (xii) of the definition of "credentialed addiction treatment professional" found in 12VAC30-130-5020, and is acting within his scope of practice under state law; or (iii) shall be a certified substance abuse counselor (CSAC) as defined in § 54.1-3507.1 of the Code of Virginia who has documented completion of the DBHDS PRS supervisor training if he is acting under the supervision or direction of a licensed substance use treatment practitioner or licensed mental health professional. If a practitioner referenced in clause (ii) of this definition or a CSAC referenced in clause (iii) of this definition provides services before April 1, 2018, he shall have until April 1, 2018, to complete the DBHDS PRS supervisor training.

"Peer recovery specialist" or "PRS" means a person who has the qualifications, education, and experience established by the Department of Behavioral Health and Developmental Services and who has received certification in good standing by a certifying body recognized by DBHDS. A PRS is professionally qualified and trained (i) to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental health disorders, substance use disorders, or both; (ii) to provide peer support as a self-identified individual successful in the recovery process with lived experience with mental health disorders or substance use disorders, or co-occurring mental health and substance use disorders; and (iii) to offer support and assistance in helping others in the recovery and community-integration process. A PRS may be a parent of a minor or adult child with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder, or an adult with personal experience with a family member with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services.

"Person centered" means a collaborative process where the individual participates in the development of his treatment goals and makes decisions about the services provided.

"Recovery-oriented services" means providing support and assistance to an individual with mental health or substance use disorders or both so that the individual (i) improves his health, recovery, resiliency, and wellness; (ii) lives a self-directed life; and (iii) strives to reach his full potential.

"Recovery, resiliency, and wellness plan" means a written set of goals, strategies, and actions to guide the individual and the health care team to move the individual toward the maximum achievable independence and autonomy in the community. The documented comprehensive wellness plan shall be developed by the individual or caregiver, as applicable, the PRS, and the direct supervisor within 30 days of the initiation of services and shall describe how the plan for peer support services and activities will meet the individual's needs. This document shall be updated as the needs and progress of the individual change and shall document the individual's or caregiver's, as applicable, request for any changes in peer support services. The recovery, resiliency, and wellness plan is a component of the individual's overall plan of care and shall be maintained by the enrolled provider in the individual's medical record.

"Resiliency" means the ability to respond to stress, anxiety, trauma, crisis, or disaster.

"Self-advocacy" means an empowerment skill that allows the individual to effectively communicate preferences and choice.

"Strength-based" means to emphasize individual strengths, assets, and resiliencies.

"Supervision" means the ongoing process performed by a direct supervisor who monitors the performance of the PRS and provides regular documented consultation and instruction with respect to the skills and competencies of the PRS.

12VAC30-130-5170. Peer support services and family support partners: service definitions.

A. ARTS peer support services and ARTS family support partners are peer recovery support services and are nonclinical, peer-to-peer activities that engage, educate, and support an individual's, and as applicable the caregiver's, self-help efforts to improve health recovery, resiliency, and wellness. These services shall be available to either:

1. Individuals 21 years of age or older with mental health or substance use disorders or co-occurring mental health and substance use disorders that are the focus of the support; or

2. The caregiver of individuals younger than 21 years of age with mental health or substance use disorders or co-occurring mental health and substance use disorders that are the focus of the support.

3. Individuals 18 through 20 years of age who meet the medical necessity criteria set forth in 12VAC30-130-5180 A who would benefit from receiving peer supports directly, and who choose to receive ARTS peer support services directly instead of through their family shall be permitted to receive peer support services by an appropriate PRS.

B. ARTS peer support services for adults is a person centered, strength-based, and recovery-oriented rehabilitative service for individuals 21 years of age or older provided by a peer recovery specialist successful in the recovery process with lived experience with substance use disorders or co-occurring mental health and substance use disorders who is trained to offer support and assistance in helping others in recovery to reduce the disabling effects of a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. Services assist the individual with developing and maintaining a path to recovery, resiliency, and wellness. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

C. ARTS family support partners is a peer support service and a strength-based, individualized service provided to the caregiver of a Medicaid-eligible individual younger than 21

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years of age with a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. The services provided to the caregiver and the individual must be directed exclusively toward the benefit of the Medicaid-eligible individual. Services are expected to improve outcomes for an individual younger than 21 years of age with complex needs who is involved with multiple systems and increase the individual's and family's confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are rendered by a PRS who is (i) a parent of a minor or adult child with a similar substance use disorder or co-occurring mental health and substance use disorder or (ii) an adult with personal experience with a family member with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services. The PRS shall perform the service within the scope of his knowledge, lived experience, and education.

D. ARTS peer support services shall be rendered on an individual basis or in a group.

12VAC30-130-5180. Peer support services and family support partners: medical necessity criteria.

A. In order to receive ARTS peer support services, individuals 21 years of age or older shall meet the following requirements:

1. The individual shall have a substance use disorder or co-occurring mental health and substance use disorders diagnosis.

2. The individual shall require recovery-oriented assistance and support services for:

a. The acquisition of skills needed to engage in and maintain recovery;

b. The development of self-advocacy skills to achieve a decreasing dependency on formalized treatment systems; and

c. Increasing responsibilities, wellness potential, and shared accountability for the individual's own recovery.

3. The individual shall demonstrate moderate to severe functional impairment as a result of the diagnosis, and the functional impairment shall be of a degree that it interferes with or limits performance in at least one of the following domains: educational (e.g., obtaining a high school or college degree); social (e.g., developing a social support system); vocational (e.g., obtaining part-time or full-time employment); or self-maintenance (e.g., managing symptoms, understanding his illness, living more independently).

B. Caregivers of individuals younger than 21 years of age who qualify for ARTS family support partners (i) have an

individual with a substance use disorder or co-occurring mental health and substance use disorders who requires recovery assistance and (ii) meet two or more of the following:

1. Individual and his caregiver need peer-based recovery oriented services for the maintenance of wellness and acquisition of skills needed to support the individual.

2. Individual and his caregiver need assistance to develop self-advocacy skills to assist the individual in achieving self-management of the individual's health status.

3. Individual and his caregiver need assistance and support to prepare the individual for a successful work or school experience.

4. Individual and his caregiver need assistance to help the individual and caregiver assume responsibility for recovery.

C. Individuals 18 through 20 years of age who meet the medical necessity criteria in subsection A of this section, who would benefit from receiving peer supports directly, and who choose to receive peer support services directly instead of through their family shall be permitted to receive peer support services by an appropriate PRS.

D. To qualify for continued ARTS peer support services and ARTS family support partners, medical necessity criteria shall continue to be met and progress notes shall document the status of progress relative to the goals identified in the recovery resiliency and wellness plan.

E. Discharge shall occur when one or more of the following is met:

1. Goals of the recovery resiliency and wellness plan have been met;

2. The individual, or as applicable for individuals younger than 21 years of age, the caregiver, requests discharge; or

3. The individual, or as applicable for individuals younger than 21 years of age, the caregiver, fail to make minimum contact requirements set forth in 12VAC30-130-5210 L and M or the individual or caregiver, as applicable, discontinues participation in services.

12VAC30-130-5190. Peer support services and family support partners: provider and setting requirements.

A. Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, and experience established by DBHDS and show certification in good standing by the U.S. Department of Veterans Affairs, NAADAC - the Association of Addiction Professionals, a member board of the International Certification and Reciprocity Consortium, or any other certifying body or state certification with standards comparable to or higher than those specified by DBHDS to be eligible to register with the Board of Counseling on or after

July 1, 2018. Upon the promulgation of regulations by the Board of Counseling, registration of peer recovery specialists by the Board of Counseling shall be required.

B. Prior to service initiation, a documented recommendation for service by a practitioner who meets clauses (i) through (xii) of the definition of "credentialed addiction treatment professional" found in 12VAC30-130-5020 and who is acting within his scope of practice under state law shall be required. A certified substance abuse counselor, as defined in § 54.1-3507.1 of the Code of Virginia, may also provide a documented recommendation for service if he is acting under the supervision or direction of a licensed substance use treatment practitioner or licensed mental health professional. The PRS shall perform ARTS peer services under the oversight of the practitioner described in this subsection making the recommendation for services and providing the clinical oversight of the recovery, resiliency, and wellness plan. The recommendation shall verify that the individual meets the medical necessity criteria set forth in 12VAC30-130-5180 A or B, as applicable.

C. The PRS shall be employed by or have a contractual relationship with the enrolled provider licensed for one of the following:

1. Acute care general hospital (ASAM Level 4.0) licensed by the Department of Health as defined in 12VAC30-130-5150.
2. Freestanding psychiatric hospital or inpatient psychiatric unit (ASAM Levels 3.5 and 3.7) licensed by the Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5130 and 12VAC30-130-5140.
3. Residential placements (ASAM Levels 3.1, 3.3, 3.5, and 3.7) licensed by the Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5110 through 12VAC30-130-5140.
4. ASAM Levels 2.1 and 2.5, licensed by the Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5090 and 12VAC30-130-5100.
5. ASAM Level 1.0 as defined in 12VAC30-30-5080.
6. Opioid treatment services as defined in 12VAC30-130-5050.
7. Office-based opioid treatment as defined in 12VAC30-130-5060.
8. Hospital emergency department services licensed by the Department of Health.
9. Pharmacy services licensed by the Department of Health.

D. Only a licensed and enrolled provider referenced in subsection C of this section shall be eligible to bill and

receive reimbursement from DMAS or its contractor for ARTS peer support services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

E. The direct supervisor, as defined in 12VAC30-130-5160, shall perform direct supervision of the PRS as needed based on the level of urgency and intensity of service being provided. The direct supervisor shall have an employment or contract relationship with the same provider entity that employs or contracts with the PRS. Direct supervisors shall maintain documentation of all supervisory sessions. In no instance shall supervisory sessions be performed less than as provided below:

1. If the PRS has less than 12 months experience delivering ARTS peer support services or ARTS family support partners, he shall receive face-to-face, one-to-one supervisory meetings of sufficient length to address identified challenges for a minimum of 30 minutes, two times a month. The direct supervisor must be available at least by telephone while the PRS is on duty.

2. If the PRS has been delivering ARTS peer recovery services over 12 months and fewer than 24 months, he must receive monthly face-to-face, one-to-one supervision of sufficient length to address identified challenges for a minimum of 30 minutes. The direct supervisor must be available by telephone for consult within 24 hours of service delivery if needed for challenging situations.

F. The caseload assignment of a full-time PRS shall not exceed 12 to 15 individuals at any one time and 30 to 40 individuals annually allowing for new case assignments as those on the existing caseload begin to self-manage with less support. The caseload assignment of a part-time PRS shall not exceed six to nine individuals at any one time and 15 annually.

12VAC30-130-5200. Peer support services and family support partners: documentation of required activities.

A. The recommendation for services shall include the dated signature and credentials of the practitioner described in 12VAC30-130-5190 B who made the recommendation. The recommendation shall be included as part of the recovery, resiliency, and wellness plan and medical record. The recommendation shall verify that the individual meets the medical necessity criteria and shall be valid for no longer than 30 calendar days.

B. Under the clinical oversight of the practitioner making the recommendation described in 12VAC50-130-5190 B for ARTS peer support services or ARTS family support partners, the peer recovery specialist in consultation with his direct supervisor shall develop a recovery, resiliency, and wellness plan based on the recommendation for service, the

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individual's, and, as applicable the caregiver's, perceived recovery needs and multidisciplinary assessment as defined in this section within 30 calendar days of the initiation of service. Development of the recovery, resiliency, and wellness plan shall include collaboration with the individual and, as applicable, the identified family member or caregiver involved in the individual's recovery. Individualized goals and strategies shall be focused on the individual's identified needs for self-advocacy and recovery. The recovery, resiliency, and wellness plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the plan. The recovery, resiliency, and wellness plan shall be completed, signed, and dated by the practitioner making the recommendation, the PRS, the direct supervisor, the individual, and, as applicable, the identified family member or caregiver involved in the individual's recovery within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual, and as applicable the caregiver, to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

C. Services shall be delivered in accordance with the individual's goals and objectives as identified in the recovery, resiliency, and wellness plan and consistent with the recommendation of the referring practitioner who recommended services. As determined by the goals identified in the recovery, resiliency, and wellness plan, services may be rendered in the provider's office or in the community, or both. The level of services provided and total time billed by the enrolled provider for the week shall not exceed the frequency established in the recovery, resiliency, and wellness plan.

D. Under the clinical oversight of the practitioner described in 12VAC30-130-5190 B making the recommendation, the peer recovery specialist in consultation with his direct supervisor shall conduct and document a review of the recovery, resiliency, and wellness plan every 90 calendar days with the individual and the caregiver, as applicable. The review shall be signed by the PRS and the individual and, as applicable, the identified family member or caregiver. Review of the recovery, resiliency, and wellness plan means the PRS evaluates and updates the individual's progress every 90 days toward meeting the plan's goals and documents the outcome of this review in the individual's medical record. For DMAS to determine that these reviews are complete, the reviews shall (i) update the goals and objectives as needed to reflect any change in the individual's recovery as well as any newly identified needs, (ii) be conducted in a manner that enables the individual to actively participate in the process, and (iii) be documented by the PRS in the individual's medical record no later than 15 calendar days from the date of the review.

E. Progress notes as defined in 12VAC30-50-130 shall be required and shall record the date, time, place of service, participants, face-to-face or telephone contact, and

circumstance of contact, regardless of whether or not a billable service was provided, and shall summarize the purpose and content of the session along with the specific strategies and activities utilized as related to the goals in the recovery, resiliency, and wellness plan. Documentation of specific strategies and activities shall fully disclose the details of services rendered and align with the recovery, resiliency, and wellness plan. Strategies and activities shall include at a minimum:

1. Person centered, strength-based planning to promote the development of self-advocacy skills;

2. Empowering the individual to take a proactive role in the development and updating of his recovery, resiliency, and wellness plan;

3. Crisis support; and

4. Assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the recovery, resiliency, and wellness plan so that the individual:

a. Remains in the least restrictive setting;

b. Achieves his goals and objectives identified in the recovery resiliency and wellness plan;

c. Self-advocates for quality physical and behavioral health services; and

d. Has access to strength-based behavioral health services, social services, educational services, and other supports and resources.

F. Progress notes shall reflect collaboration between the PRS and the individual in the development of the progress notes. If contact with the individual cannot be made, the service is not billable. However, the progress notes shall reflect attempts to contact the individual. Progress notes shall contain the dated signature of the PRS who provided the service.

G. The enrolled provider shall ensure that documentation of all supervision sessions is maintained in a supervisor's log or the personnel file of the PRS.

H. The enrolled provider shall have oversight of the individual's record and maintain individual records in accordance with state and federal requirements. The enrolled provider shall ensure documentation of all activities and documentation of all relevant information about the Medicaid individuals receiving services. Such documentation shall fully disclose the extent of services provided in order to support providers claims for reimbursement for services rendered. This documentation shall be written, signed, and dated at the time the services are rendered.

I. The enrolled provider may integrate an individual's peer support record with the individual's other records maintained within same provider agency or facility, provided all peer support documentation is clearly identified. Logs and progress notes documenting the provision of services shall corroborate billed services.

J. Collaboration shall be required with behavioral health service providers and shall include the PRS and the individual, or caregiver as applicable, and shall involve discussion regarding initiation of services and updates on the individual's status and changes in the individual's progress. Documentation of all collaboration shall be maintained in the individual's record.

12VAC30-130-5210. Peer support services and family support partners: limitations and exclusions to service delivery.

A. An approved service authorization submitted by the enrolled provider shall be required prior to service delivery in order for reimbursement to occur. To obtain service authorization, all provider information supplied to the Department of Medical Assistance Services or its contractor shall be fully substantiated throughout the individual's record.

B. Service shall be initiated within 30 calendar days of the documented recommendation. The recommendation shall be valid for no longer than 30 calendar days.

C. Services rendered in a group setting shall have a ratio of no more than 10 individuals to one PRS, and progress notes shall be included in each individual's record.

D. General support groups that are made available to the public to promote education and global advocacy do not qualify as peer support services or family support partners.

E. Noncovered activities include transportation, recordkeeping or documentation activities (including progress notes, tracking hours and billing, and other administrative paperwork), services performed by volunteers, household tasks, chores, grocery shopping, on-the-job training, case management, outreach to potential clients, and room and board.

F. A unit of service shall be defined as 15 minutes. Peer support services and family support partners shall be limited to four hours per day (up to 16 units per calendar day) and 900 hours per calendar year. Service delivery limits may be exceeded based upon documented medical necessity and service authorization approval.

G. If a service recommendation for mental health peer support services or mental health family support partners as set forth in 12VAC30-50-130 or 12VAC30-50-226 is made in addition to a service recommendation for ARTS peer support services or ARTS family support partners as set forth in 12VAC30-130-5160 through 12VAC30-130-5210, the enrolled provider shall coordinate services to ensure the four-

hour daily service limit is not exceeded. No more than a total of four hours of one type of service, or a total of four hours of a combination of service types, up to 16 units of total service, shall be provided per calendar day. The enrolled provider cannot bill DMAS separately for (i) mental health peer services (mental health peer support services or mental health family support partners) and (ii) ARTS peer services (peer support services or ARTS family support partners) rendered on the same calendar day unless the mental health peer services and ARTS peer services are rendered at different times. A separate annual service limit of up to 900 hours shall apply to mental health peer support services or mental health family support partners service and ARTS peer support services or ARTS family support partners.

H. The PRS shall document each 15-minute unit in which the individual was actively engaged in peer support services or family support partners. Meals and breaks and other noncovered services listed in this section shall not be included in the reporting of units of service delivered. Should an individual receive other services during the range of documented time in/time out for peer support hours, the absence of or interrupted services must be documented.

I. Service delivery shall be based on the individual's identified needs, established medical necessity criteria, and goals identified in the individual recovery resiliency and wellness plan.

J. Billing shall occur only for services provided with the individual present. Telephone time is supplemental rather than replacement of face-to-face contact and is limited to 25% or less of total time per recipient per calendar year. Justification for services rendered with the individual via telephone shall be documented. Any telephone time rendered over the 25% limit will be subject to retraction.

K. Peer support services or family support partners may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space. Peer support services shall be an ancillary service and shall not impede, interrupt, or interfere with the provision of the primary service setting.

L. Contact shall be made with the individual receiving peer support services or family support partners a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact depending on the individual's support needs and documented preferences.

M. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month, not to exceed two units. After two

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consecutive months of unsuccessful attempts to make face-to-face contact, discharge shall occur.

N. Family support partners is not billable for siblings of the targeted individual for whom a need is specified unless there is applicability to the targeted individual or family. The applicability to the targeted individual must be documented.

O. Family support partners services shall not be billed for an individual who resides in a congregate setting in which the caregivers are paid, such as child caring institutions or any other living environment that is not comprised of more permanent caregivers. An exception would be for an individual actively preparing for transition back to a single-family unit, the caregiver is present during the intervention, and the service is directed to supporting the unification or reunification of the individual and his caregiver and takes place in that home and community. The circumstances surrounding the exception shall be documented.

P. Individuals with the following conditions are excluded from family support partners unless there is clearly documented evidence and diagnosis of a substance use disorder or mental health disorder overlaying the diagnosis: developmental disability including intellectual disabilities, organic mental disorder including dementia or Alzheimer's, or traumatic brain injury. There must be documented evidence that the individual is able to participate in the service and benefit from family support partners.

Q. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures. Progress notes, as defined in 12VAC30-50-130, shall disclose the extent of services provided and corroborate the units billed. Claims not supported by corroborating progress notes shall be subject to recovery of expenditures.

R. The enrolled provider shall be subject to utilization reviews conducted by DMAS or its designated contractor.

VA.R. Doc. No. R18-4955; Filed September 11, 2017, 10:37 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: **14VAC5-318. Rules Governing Term and Universal Life Insurance Reserve Financing (adding 14VAC5-318-10 through 14VAC5-318-80).**

Statutory Authority: §§ 12.1-13, 38.2-223, and 38.2-1316.7 of the Code of Virginia.

Public Hearing Information: A public hearing will be held upon request.

Public Comment Deadline: November 3, 2017.

Agency Contact: Raquel C. Pino, Policy Advisor, Bureau of Insurance, State Corporation Commission, P.O. Box 1157, Richmond, VA 23218, telephone (804) 371-9499, FAX (804) 371-9873, or email raquel.pino@scc.virginia.gov.

Summary:

Pursuant to Chapter 477 of the 2017 Acts of Assembly, the State Corporation Commission proposes to adopt new regulations setting forth standards governing reserve financing arrangements pertaining to (i) life insurance policies containing guaranteed nonlevel gross premiums or guaranteed nonlevel benefits and (ii) universal life insurance policies with secondary guarantees. The proposed regulations provide additional requirements related to the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements, and the circumstances in which credit will be reduced or eliminated. The implementation of the proposed regulations will address reinsurance arrangements entered into with life and health insurer-affiliated captives, special purpose vehicles, or similar entities that may not have the same statutory accounting or solvency requirements as multistate life and health insurers based in the United States.

AT RICHMOND, SEPTEMBER 5, 2017

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. INS-2017-00186

Ex Parte: In the matter of
Adopting New Rules Governing
Term and Universal Life Insurance
Reserve Financing

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 also may be found at the Commission's website: <http://www.scc.virginia.gov/case>.

The Bureau of Insurance ("Bureau") has submitted to the Commission a proposal to promulgate new rules at Chapter 318 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Term and Universal Life Insurance Reserve Financing," which are recommended to be set out at 14 VAC 5-318-10 through 14 VAC 5-318-80.

The proposed new rules are necessary to implement the amendments to §§ 38.2-1316.1, 38.2-1316.2, 38.2-1316.4 and 38.2-1316.7 of the Code, which were enacted in Chapter 477 of the 2017 Acts of Assembly (HB 1471). The amendments to the Code authorize the Commission to adopt regulations specifying additional requirements relating to the valuation of asset or reserve credits, the amount and forms of security supporting certain reinsurance arrangements, and the circumstances pursuant to which credit will be reduced or eliminated. The amendments to the Code became effective on July 1, 2017.

NOW THE COMMISSION is of the opinion that the proposal to adopt new rules recommended to be set out at Chapter 318 in the Virginia Administrative Code as submitted by the Bureau should be considered for adoption with a proposed effective date of January 1, 2018.

Accordingly, IT IS ORDERED THAT:

(1) The proposed new rules entitled "Rules Governing Term and Universal Life Insurance Reserve Financing," recommended to be set out at 14 VAC 5-318-10 through 14 VAC 5-318-80 are 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 adoption of proposed Chapter 318, shall file such comments or hearing request on or before November 3, 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-2017-00186.

(3) If no written request for a hearing on the adoption of the proposed new rules as outlined in this Order is received on or before November 3, 2017, the Commission, upon consideration of any comments submitted in support of or in opposition to the proposal, may adopt the rules as submitted by the Bureau.

(4) The Bureau forthwith shall give notice of the proposal by mailing a copy of this Order, together with the proposal, to all

life insurers domiciled in Virginia, and to all interested persons.

(5) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with the proposed 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 proposal 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 Donald C. Beatty.

CHAPTER 318
RULES GOVERNING TERM AND UNIVERSAL LIFE
INSURANCE RESERVE FINANCING

14VAC5-318-10. Purpose and scope.

The purpose of this chapter is to set forth rules and procedural requirements to establish uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums or guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees and to ensure that, with respect to each such financing arrangement, funds consisting of primary security and other security, as defined in 14VAC5-318-30, are held by or on behalf of ceding insurers in the forms and amounts required in this chapter. In general, reinsurance ceded for reserve financing purposes has one or more of the following characteristics: some or all of the assets used to secure the reinsurance treaty or to capitalize the reinsurer (i) are issued by the ceding insurer or its affiliates; (ii) are not unconditionally available to satisfy the general account obligations of the ceding insurer; or (iii) create a reimbursement, indemnification, or other similar obligation on the part of the ceding insurer or any of its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty).

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14VAC5-318-20. Applicability.

This chapter shall apply to reinsurance treaties that cede liabilities pertaining to covered policies, as that term is defined in 14VAC5-318-30, issued by any life insurance company domiciled in this Commonwealth. The requirements of this chapter shall pertain to all covered policies in force as of and after January 1, 2018. This chapter and 14VAC5-300 shall both apply to such reinsurance treaties, provided that in the event of a direct conflict between the provisions of this chapter and 14VAC5-300, the provisions of this chapter shall apply, but only to the extent of the conflict.

14VAC5-318-30. Definitions.

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

"Actuarial method" means the methodology used to determine the required level of primary security, as described in 14VAC5-318-50.

"Commission" means the State Corporation Commission when acting pursuant to or in accordance with Title 38.2 of the Code of Virginia.

"Covered policy" means, subject to the exemptions described in 14VAC5-318-40, those policies, other than grandfathered policies, of the following policy types:

1. Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or
2. Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

"Grandfathered policies" means policies of the types described in the "covered policy" definition that were:

1. Issued prior to January 1, 2015; and
2. Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in 14VAC5-318-40 had that section then been in effect.

"NAIC" means the National Association of Insurance Commissioners.

"Noncovered policy" means any policy that does not meet the definition of covered policy, including grandfathered policies.

"Required level of primary security" means the dollar amount determined by applying the actuarial method to the risks ceded with respect to covered policies, but not more than the total reserve ceded.

"Primary security" means the following forms of security:

1. Cash meeting the requirements of subdivision 2 a of § 38.2-1316.4 of the Code of Virginia;

2. Securities listed by the Securities Valuation Office meeting the requirements of subdivision 2 b of § 38.2-1316.4 of the Code of Virginia, but excluding any synthetic letter of credit, contingent note, credit-linked note, or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and

3. For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:

- a. Commercial loans in good standing of CM3 quality and higher as calculated for the life risk-based capital report;
- b. Policy loans; and
- c. Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

"Other security" means any security acceptable to the commission other than security meeting the definition of primary security.

"Valuation manual" means the valuation manual adopted by the NAIC as described in subdivision B 1 of § 38.2-1379 of the Code of Virginia, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.

"VM-20" means "requirements for principle-based reserves for life products," including all relevant definitions, from the valuation manual.

14VAC5-318-40. Exemptions from this chapter.

This chapter does not apply to the situations described in subdivisions 1 through 6 of this section.

1. Reinsurance of:

a. Policies that satisfy the criteria for exemption set forth in 14VAC5-319-50 F or G and that are issued before the later of:

- (1) January 1, 2018; and
- (2) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than January 1, 2020;

b. Portions of policies that satisfy the criteria for exemption set forth in 14VAC5-319-50 E and that are issued before the later of:

- (1) January 1, 2018; and
- (2) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies'

statutory reserves, but in no event later than January 1, 2020;

c. Any universal life policy that meets all of the following requirements:

(1) Secondary guarantee period, if any, is five years or less;

(2) Specified premium for the secondary guarantee period is equal to or greater than the net level reserve premium for the secondary guarantee period based on the Commissioners Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and

(3) The initial surrender charge is equal to or greater than 100% of the first year annualized specified premium for the secondary guarantee period;

d. Credit life insurance;

e. Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or

f. Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year;

2. Reinsurance ceded to an assuming insurer that meets the applicable requirements of subdivision C 4 of § 38.2-1316.2 of the Code of Virginia and 14VAC5-300-90 C 1;

3. Reinsurance ceded to an assuming insurer that meets the applicable requirements of subdivision C 1, C 2, or C 3 of § 38.2-1316.2 of the Code of Virginia and that in addition:

a. Prepares statutory financial statements in compliance with § 38.2-1300 of the Code of Virginia, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer's reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1 ("SSAP 1"); and

b. Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in Chapter 55 (§ 38.2-5500 et seq.) of Title 38.2 of the Code of Virginia when its risk-based capital (RBC) is calculated in accordance with § 38.2-5502 of the Code of Virginia;

4. Reinsurance ceded to an assuming insurer that meets the applicable requirements of subdivision C 1, C 2, or C 3 of § 38.2-1316.2 of the Code of Virginia and that in addition:

a. Is not an affiliate, as that term is defined in § 38.2-1322 of the Code of Virginia, of:

(1) The insurer ceding the business to the assuming insurer; or

(2) Any insurer that directly or indirectly ceded the business to that ceding insurer;

b. Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

c. Is both:

(1) Licensed or accredited in at least 10 states (including its state of domicile); and

(2) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

d. Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in § 38.2-5501 of the Code of Virginia when its RBC is calculated in accordance with § 38.2-5502 of the Code of Virginia;

5. Reinsurance ceded to an assuming insurer that meets the requirements of either subdivision B 4 a or B 4 b of § 38.2-1316.7 of the Code of Virginia; or

6. Reinsurance not otherwise exempt under subdivisions 1 through 5 of this section if the commission, after consulting with the NAIC Financial Analysis Working Group or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

a. The risks are clearly outside of the intent and purpose of this chapter, as described in 14VAC5-318-10;

b. The risks are included within the scope of this chapter only as a technicality; and

c. The application of this chapter to those risks is not necessary to provide appropriate protection to policyholders. The commission shall publicly disclose any decision made pursuant to this subdivision to exempt a reinsurance treaty from this chapter, as well as the general basis therefor (including a summary description of the treaty).

14VAC5-318-50. The actuarial method.

A. The actuarial method to establish the required level of primary security for each reinsurance treaty subject to this chapter shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

1. For covered policies as provided in subdivision 1 of the definition of "covered policy" in 14VAC5-318-30, the

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actuarial method is the greater of the deterministic reserve or the net premium reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the covered policies do not meet the requirements of the stochastic reserve exclusion test in the valuation manual, then the actuarial method is the greatest of the deterministic reserve, the stochastic reserve, or the NPR. In addition, if such covered policies are reinsured in a reinsurance treaty that also contains covered policies as provided in subdivision 2 of the definition of "covered policy" in 14VAC5-318-30, the ceding insurer may elect to instead use subdivision 2 of this subsection as the actuarial method for the entire reinsurance agreement. Whether subdivision 1 or 2 of this subsection is used, the actuarial method must comply with any requirements or restrictions that the valuation manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

2. For covered policies, as that term is defined in subdivision 2 of the definition of "covered policy" of 14VAC5-318-30, the actuarial method is the greatest of the deterministic reserve, the stochastic reserve, or the NPR regardless of whether the criteria for exemption testing can be met.

3. Except as provided in subdivision 4 of this subsection, the actuarial method is to be applied on a gross basis to all risks with respect to the covered policies as originally issued or assumed by the ceding insurer.

4. If the reinsurance treaty cedes less than 100% of the risk with respect to the covered policies then the required level of primary security may be reduced as follows:

a. If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the covered policies, the required level of primary security, as well as any adjustment under subdivision A 4 c of this section, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

b. If the reinsurance treaty in a nonexempt arrangement cedes only the risks pertaining to a secondary guarantee, the required level of primary security may be reduced by an amount determined by applying the actuarial method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the covered policies, except that for covered policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the required level of primary security may be reduced by the statutory reserve retained by the ceding insurer on those covered policies, where the retained reserve of those covered policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

c. If a portion of the covered policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the required level of primary security may be reduced by the amount resulting by applying the actuarial method including the reinsurance section of VM-20 to the portion of the covered policy risks ceded in the exempt arrangement, except that for covered policies issued prior to January 1, 2017, this adjustment is not to exceed:

$$c_x$$

2(number of reinsurance premiums per year)

where c_x is calculated using the same assumptions used in calculating the NPR; and

d. For any other treaty ceding a portion of risk to a different reinsurer, including stop loss, excess of loss, and other nonproportional reinsurance treaties, there will be no reduction in the required level of primary security.

It is possible for any combination of subdivisions A 4 a, b, c, and d of this section to apply. Such adjustments to the required level of primary security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the required level of primary security due to the cession of less than 100% of the risk.

The adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

5. In no event will the required level of primary security resulting from application of the actuarial method exceed the amount of statutory reserves ceded.

6. If the ceding insurer cedes risks with respect to covered policies, including any riders, in more than one reinsurance treaty subject to this chapter, in no event will the aggregate required level of primary security for those reinsurance treaties be less than the required level of primary security calculated using the actuarial method as if all risks ceded in those treaties were ceded in a single treaty subject to this chapter.

7. If a reinsurance treaty subject to this chapter cedes risk on both covered and noncovered policies, credit for the ceded reserves shall be determined as follows:

a. The actuarial method shall be used to determine the required level of primary security for the covered policies, and 14VAC5-318-60 shall be used to determine the reinsurance credit for the covered policy reserves; and

b. Credit for the noncovered policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of subdivision A 7 a of this section, is held by or on behalf of the ceding insurer in accordance with §§ 38.2-1316.2 and 38.2-1316.4 of the Code of Virginia, 14VAC5-300-90 C, 14VAC5-300-100, and 14VAC5-300-150 B and C. Any primary security used to meet the requirements of this subdivision may not be used to satisfy the required level of primary security for the covered policies.

B. For the purposes of both calculating the required level of primary security pursuant to the actuarial method and determining the amount of primary security and other security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

1. For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer's general account and without taking into consideration the effect of any prescribed or permitted practices; and

2. For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the actuarial method if adopted by the NAIC Life Actuarial (A) Task Force no later than the December 31st on or immediately preceding the valuation date for which the required level of primary security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the actuarial method in the manner specified in VM-20.

14VAC5-318-60. Requirements applicable to covered policies to obtain credit for reinsurance; opportunity for remediation.

A. Subject to the exemptions described in 14VAC5-318-40 and the provisions of subsection B of this section, credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to covered policies pursuant to § 38.2-1316.2 of the Code of Virginia, 14VAC5-300-90 C, 14VAC5-300-100, and 14VAC5-300-150 B and C, or § 38.2-1316.4 of the Code of Virginia if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

1. The ceding insurer's statutory policy reserves with respect to the covered policies are established in full and in accordance with the applicable requirements of Article 10 (§ 38.2-1365 et seq.) of Chapter 13 of Title 38.2 of the Code of Virginia and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty

subject to this chapter does not exceed the proportionate share of those reserves ceded under the contract;

2. The ceding insurer determines the required level of primary security with respect to each reinsurance treaty subject to this chapter and provides support for its calculation as determined to be acceptable to the commission;

3. Funds consisting of primary security, in an amount at least equal to the required level of primary security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of § 38.2-1316.4 of the Code of Virginia, on a funds withheld, trust, or modified coinsurance basis;

4. Funds consisting of other security, in an amount at least equal to any portion of the statutory reserves as to which primary security is not held pursuant to subdivision 3 of this subsection, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of § 38.2-1316.4 of the Code of Virginia;

5. Any trust used to satisfy the requirements of this section shall comply with all of the conditions and qualifications of 14VAC5-300-120, except that:

a. Funds consisting of primary security or other security held in trust shall for the purposes identified in 14VAC5-318-50 B be valued according to the valuation rules set forth in 14VAC5-318-50 B, as applicable;

b. There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of subdivision 3 of this subsection;

c. The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the primary security within the trust when aggregated with primary security outside the trust that is held by or on behalf of the ceding insurer in the manner required by subdivision 3 of this subsection below 102% of the level required by subdivision 3 of this subsection at the time of the withdrawal or substitution; and

d. The determination of reserve credit under 14VAC5-300-120 D shall be determined according to the valuation rules set forth in 14VAC5-318-50 B, as applicable; and

6. The reinsurance treaty has been approved by the commission.

B. Requirements at inception date and on an on-going basis; remediation.

1. The requirements of subsection A of this section must be satisfied as of the date that risks under covered policies are ceded if such date is on or after January 1, 2018, and on an ongoing basis thereafter. Under no circumstances shall a

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ceding insurer take or consent to any action or series of actions that would result in a deficiency under subdivision A 3 or A 4 of this section with respect to any reinsurance treaty under which covered policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.

2. Prior to the due date of each quarterly or annual statement, each life insurance company that has ceded reinsurance within the scope of 14VAC5-318-20 shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which covered policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of subdivision A 3 or A 4 of this section were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of primary security actually held pursuant to subdivision A 3 of this section, unless either:

a. The requirements of subdivision A 3 or A 4 of this section were fully satisfied as of the valuation date as to such reinsurance treaty; or

b. Any deficiency has been eliminated before the due date of the quarterly or annual statement to which the valuation date relates through the addition of primary security or other security, as the case may be, in such amount and in such form as would have caused the requirements of subdivision A 3 or A 4 of this section to be fully satisfied as of the valuation date.

3. Nothing in subdivision 2 of this subsection shall be construed to allow a ceding company to maintain any deficiency under subdivision A 3 or A 4 of this section for any period of time longer than is reasonably necessary to eliminate it.

14VAC5-318-70. Prohibition against avoidance.

No insurer that has covered policies to which this chapter applies, as set forth in 14VAC5-318-20, shall take any action or series of actions or enter into any transaction, arrangement, or series of transactions or arrangements if the purpose of such action, transaction, arrangement, or series thereof is to avoid the requirements of this chapter or to circumvent its purpose and intent, as set forth in 14VAC5-318-10.

14VAC5-318-80. Severability.

If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of the provision to other persons or circumstances shall not be affected thereby.

VA.R. Doc. No. R18-5199; Filed September 5, 2017, 11:56 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

VIRGINIA BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

Forms

REGISTRAR'S NOTICE: Forms used in administering the following regulation have been filed by the Virginia Board for Asbestos, Lead, and Home Inspectors. 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, 11th Floor, Richmond, Virginia 23219.

Title of Regulation: **18VAC15-40. Home Inspector Licensing Regulations.**

Contact Information: Joseph Haughwout, Board Administrator, Department of Professional and Occupational Regulation, 9960 Mayland Drive, Richmond, VA 23233, telephone (804) 367-2684, or email joseph.haughwout@dpor.virginia.gov.

FORMS (18VAC15-40)

~~Home Inspector License/NRS Specialty Designation Application, A506-3380LIC-v1 (eff. 7/2017)~~

~~Home Inspector Experience Verification Form, A506-3380EXP-v5 (eff. 7/2017)~~

[Home Inspector License Application, A506-3380LIC-v3 \(eff. 9/2017\)](#)

[Home Inspector NRS Specialty Designation Application, A506-3380NRS-v1 \(eff. 7/2017\)](#)

[Home Inspector Experience Verification Form, A506-3380EXP-v7 \(eff. 9/2017\)](#)

[Home Inspectors – Inspection Log, A506-3380ILOG-v1 \(eff. 9/2017\)](#)

[Home Inspector Reinstatement Application, A506-3380REI-v1 \(eff. 7/2017\)](#)

[Home Inspector - Course Approval Application, Prelicense Education Course/NRS Training Module/NRS CPE, A506-3331HICRS-v1 \(eff. 4/2017\)](#)

VA.R. Doc. No. R18-5264; Filed September 8, 2017, 3:59 p.m.

COMMON INTEREST COMMUNITY BOARD

Forms

REGISTRAR'S NOTICE: Forms used in administering the following regulation have been filed by the Common Interest Community Board. 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, 11th Floor, Richmond, Virginia 23219.

Title of Regulation: **18VAC48-60. Common Interest Community Board Management Information Fund Regulations.**

Contact Information: Joseph Haughwout, Board Administrator, Department of Professional and Occupational Regulation, 9960 Mayland Drive, Richmond, VA 23233, telephone (804) 367-2684, or email joseph.haughwout@dpor.virginia.gov.

FORMS (18VAC48-60)

~~Community Association Registration Application, A492-0550REG-v3 (eff. 5/2017)~~

~~Community Association Annual Report, A492-0550ANRPT-v5 (eff. 5/2017)~~

[Community Association Registration Application, A492-0550REG-v4 \(eff. 9/2017\)](#)

[Community Association Annual Report, A492-0550ANRPT-v6 \(eff. 9/2017\)](#)

[Community Association Governing Board Change Form, A492-0550GBCHG-v1 \(eff. 9/2013\)](#)

~~Community Association Point of Contact/Management Change Form, A492-0550POCCHG-v1 (eff. 9/2013)~~

[Community Association Point of Contact/Management Change Form, A492-0550POCCHG-v2 \(eff. 9/2017\)](#)

VA.R. Doc. No. R18-5248; Filed September 6, 2017, 5:43 p.m.

TITLE 19. PUBLIC SAFETY

DEPARTMENT OF STATE POLICE

Forms

REGISTRAR'S NOTICE: Forms used in administering the following regulation have been filed by the Department of State Police. 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, 11th Floor, Richmond, Virginia 23219.

Title of Regulation: **19VAC30-20. Motor Carrier Safety Regulations.**

Agency Contact: Kirk Marlowe, Regulatory Coordinator, Bureau of Administrative and Support Services, Department of State Police, P.O. Box 27472, Richmond, VA 23261-7472, telephone (804) 674-4606, FAX (804) 674-2936, or email kirk.marlowe@vsp.virginia.gov.

FORMS (19VAC30-20)

~~Virginia State Police Motor Carrier Safety Inspection, SP-233, rev. 1/94.~~

~~Virginia State Police Motor Carrier Safety Inspection (Continuation Sheet), SP 233 A, rev. 1/90.~~

[Virginia State Police Driver/Vehicle Inspection Report, SP-233 \(rev. 7/2004\)](#)

[Virginia State Police Driver/Vehicle Inspection Report Continuation Sheet SP233-A \(rev. 7/2004\)](#)

VA.R. Doc. No. R18-4234; Filed August 30, 2017, 2:36 p.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Proposed Regulation

Title of Regulation: **22VAC40-201. Permanency Services - Prevention, Foster Care, Adoption and Independent Living (amending 22VAC40-201-10, 22VAC40-201-35, 22VAC40-201-40, 22VAC40-201-70 through 22VAC40-201-110, 22VAC40-201-130, 22VAC40-201-140, 22VAC40-201-161; adding 22VAC40-201-105).**

Statutory Authority: §§ 63.2-217 and 63.2-900 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: December 1, 2017.

Agency Contact: Em Parente, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7895, FAX (804) 726-7538, or email em.parente@dss.virginia.gov.

Basis: The legal basis for this action is § 63.2-217 of the Code of Virginia. This statute provides the authority for the State Board of Social Services to adopt regulations as may be necessary to carry out the mandated purposes of the Department of Social Services. Throughout Title 63.2 of the Code of Virginia are requirements for regulations to be developed to implement permanency services. This regulatory

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action will provide a comprehensive and accurate structure for the provision of these services.

Purpose: The regulation is necessary for protecting the welfare of children in foster care because it addresses issues such as service planning, notification of relatives, factors to consider in placement, adoption assistance, and many other provisions intended to ensure the well-being of the child. The purpose of this proposal is to make the regulation consistent with current state and federal laws and to make any other changes deemed necessary to ensure the accuracy and clarity of the regulation.

Substance: This regulatory action incorporates technical corrections, language, and processes necessary to ensure consistency between the Code of Virginia and federal law and addresses requirements that have become law since the introduction of the current permanency services regulation. Amendments include adding the definition of "sibling" and a requirement to notify parents of siblings when a child enters foster care; adding definitions of "reasonable and prudent parent standard" and "prior family"; limiting permanency goals of another planned permanent living arrangement and permanent foster care to youth age 16 years and over; establishing standards for normalcy for children in foster care; ensuring that children age 14 years and older in foster care are actively involved in the development of their foster care plans, are provided with an opportunity to choose two members of their planning team, are presented with a youth's rights document, and receive their credit reports every year, ensuring that youth in foster care are provided with personal documents when they turn age 18 years; and extending foster care services to youth who turn age 18 years in foster care to age 21 years. The conditions under which adoption assistance can be continued for a youth who is adopted after age 16 years is also addressed.

Issues: This action poses no disadvantages to the public or the Commonwealth. This regulatory action proposes amendments that provide for the safety of children who come into the child welfare system and for children in the Commonwealth who are adopted. In particular this action addresses recent Code of Virginia changes to improve service delivery for older youth and ensures compliance with the federal Preventing Sex Trafficking and Strengthening Families Act of 2014. Compliance with federal mandates is a requirement for continuing to receive federal funding for the operation of child welfare service programs in Virginia.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Social Services (Board) proposes to amend the regulation for permanency services to account for changes in state and federal law. Specifically, the Board proposes to add a definition for "sibling" and "prior family" and a requirement that, in most cases, parents of siblings be notified when a

child enters foster care; add definitions for "reasonable and prudent parenting standard" and "normalcy" for children in foster care; and establish rules for permanency goals for foster children 16 years old and older. The Board also proposes to specify how individuals older than 14 may be involved in meetings affecting future plans for them and to add rules for adoption and foster care subsidies dispersed for individuals over the age of 18 under Virginia's "Fostering Futures" program.

Result of Analysis. Benefits likely outweigh costs for these proposed regulatory changes.

Estimated Economic Impact. In 2014, the United States Congress passed the Preventing Sex Trafficking and Strengthening Families Act¹ which mandated certain changes to foster care policy for foster care placements that are supported by federal dollars. In 2016, the General Assembly passed legislation² 1) adding victims of sex trafficking to the list of individuals defined as an "abused or neglected child," 2) allowing teens 16 years or older to have additional allowable permanency goals and 3) allowing teens 14 years old or older to choose two members of their case planning team and to be involved in the planning of their placement. In 2017, the Virginia General Assembly passed a budget³ that funded and set rules for Virginia's "Fostering Futures" program. The "Fostering Futures" program extends foster care payments and in some instances, adoption subsidy payments to adults between the ages of 18 and 21. The Board now proposes to amend this regulation to harmonize it with these legislative changes. All of the substantive changes in this proposed regulation have been law and were implemented on the effective date of their controlling legislation. Interested parties will benefit from this proposed regulatory act as it will remove any confusion that might have been caused by having inconsistencies between this regulation and its controlling legislation.

Businesses and Entities Affected. These changes will affect local Departments of Social Services (LDSS) as well as all children and adolescents in foster care and adults between the ages of 18 and 21 who are now eligible for continued services or subsidies.

Localities Particularly Affected. No localities will be particularly affected by this proposed change.

Projected Impact on Employment. To the extent that implementing Fostering Futures increases cases loads at LDSS, LDSS may increase the number of workers they hire and retain.

Effects on the Use and Value of Private Property. This proposed regulatory change is 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 businesses are unlikely to incur any costs on account of this regulatory action.

Alternative Method that Minimizes Adverse Impact. Small businesses are unlikely to incur any costs on account of this regulatory action.

Adverse Impacts:

Businesses. Businesses are unlikely to be adversely affected by this regulatory change.

Localities. No locality is likely to suffer adverse impacts on account of this proposed regulatory change.

Other Entities. No other entities are likely to suffer adverse impacts on account of this proposed regulatory change.

¹ The text and legislative history of this Act can be found here: <https://www.congress.gov/bill/113th-congress/house-bill/4980>.

² <http://leg1.state.va.us/cgi-bin/legp504.exe?161+ful+CHAP0631>

³ <https://budget.lis.virginia.gov/item/2017/1/HB1500/Chapter/1/346/>. To pay for "Fostering Futures" this budget appropriated \$1,015,451 from the general fund in FY2017 and \$2,925,954 from the general fund in FY2018. Additionally, this budget appropriated \$999,050 from the nongeneral fund in FY2017 and \$2,886,611 from the nongeneral fund in FY2018 to support "Fostering Futures."

Agency's Response to Economic Impact Analysis: The Department of Social Services concurs with the economic impact analysis prepared by the Department of Planning and Budget.

Summary:

The proposed amendments incorporate changes to ensure consistency with the Code of Virginia and federal law. Specifically, the proposed amendments add a definition for "sibling" and "prior family" and a requirement that, in most cases, parents of siblings be notified when a child enters foster care; add definitions for "reasonable and prudent parenting standard" and "normalcy" for children in foster care; and establish rules for permanency goals for foster children 16 years old and older. In addition, proposed amendments specify how individuals older than 14 years may be involved in meetings affecting future plans for them and add rules for adoption and foster care subsidies dispersed for individuals over the age of 18 years under Virginia's "Fostering Futures" program.

22VAC40-201-10. Definitions.

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

"Administrative panel review" means a review of a child in foster care that the local board conducts on a planned basis pursuant to § 63.2-907 of the Code of Virginia to evaluate the current status and effectiveness of the objectives in the service plan and the services being provided for the immediate care of the child and the plan to achieve a permanent home for the child. The administrative review may be attended by the birth parents or prior custodians and other interested individuals significant to the child and family as appropriate.

"Adoption" means a legal process that entitles the person being adopted to all of the rights and privileges, and subjects the person to all of the obligations of a birth child.

"Adoption assistance" means a money payment provided to adoptive parents or other persons on behalf of a child with special needs who meets federal or state requirements to receive such payments.

"Adoption assistance agreement" means a written agreement between the local board and the adoptive parents of a child with special needs or in cases in which the child is in the custody of a licensed child-placing agency, an agreement between the local board, the licensed child-placing agency, and the adoptive parents that sets out the payment and services that will be provided to benefit the child in accordance with Chapter 13 (§ 63.2-1300 et seq.) of Title 63.2 of the Code of Virginia.

"Adoption Progress Report" means a report filed with the juvenile court on the progress being made to place the child in an adoptive home. Section 16.1-283 of the Code of Virginia requires that an Adoption Progress Report be submitted to the juvenile court every six months following termination of parental rights until the adoption is final.

"Adoptive home" means any family home selected and approved by a parent, local board, or a licensed child-placing agency for the placement of a child with the intent of adoption.

"Adoptive home study" means an assessment of a family completed by a child-placing agency to determine the family's suitability for adoption.

"Adoptive parent" means any provider selected and approved by a parent or a child-placing agency for the placement of a child with the intent of adoption.

"Adoptive placement" means arranging for the care of a child who is in the custody of a child-placing agency in an approved home for the purpose of adoption.

Regulations

"Adult adoption" means the adoption of any person 18 years of age or older, carried out in accordance with § 63.2-1243 of the Code of Virginia.

"Agency placement adoption" means an adoption in which a child is placed in an adoptive home by a child-placing agency that has custody of the child.

"AREVA" means the Adoption Resource Exchange of Virginia that maintains a registry and photo-listing of children waiting for adoption and families seeking to adopt.

"Assessment" means an evaluation of the situation of the child and family to identify strengths and services needed.

"Birth family" means the child's biological family.

"Birth parent" means the child's biological parent and for purposes of adoptive placement means a parent by previous adoption.

"Birth sibling" means the child's biological sibling.

"Board" means the State Board of Social Services.

"Child" means any natural person under 18 years of age.

"Child-placing agency" means any person who places children in foster homes, adoptive homes, or independent living arrangements pursuant to § 63.2-1819 of the Code of Virginia or a local board that places children in foster homes or adoptive homes pursuant to §§ 63.2-900, 63.2-903, and 63.2-1221 of the Code of Virginia. Officers, employees, or agents of the Commonwealth, or any locality acting within the scope of their authority as such, who serve as or maintain a child-placing agency, shall not be required to be licensed.

"Child with special needs" as it relates to adoption assistance means a child who meets the definition of a child with special needs set forth in §§ 63.2-1300 or 63.2-1301 B of the Code of Virginia.

"Children's Services Act" or "CSA" means a collaborative system of services and funding that is child centered, family focused, and community based when addressing the strengths and needs of troubled and at-risk youth and their families in the Commonwealth.

"Claim for benefits," as used in § 63.2-915 of the Code of Virginia and 22VAC40-201-115, means (i) foster care maintenance, including enhanced maintenance; (ii) the services set forth in a court approved foster care service plan, the foster care services identified in an individual family service plan developed by a family assessment and planning team or other multi-disciplinary team pursuant to the Children's Services Act (§ 2.2-5200 et seq. of the Code of Virginia), or a transitional living plan for independent living services; (iii) the placement of a child through an agreement with the child's parents or guardians, where legal custody remains with the parents or guardians; (iv) foster care prevention services as set out in a prevention service plan; or

(v) placement of a child for adoption when an approved family is outside the locality with the legal custody of the child, in accordance with 42 USC § 671(a)(23).

"Close relative" means a grandparent, great-grandparent, adult nephew or niece, adult brother or sister, adult uncle or aunt, or adult great uncle or great aunt.

"Commissioner" means the commissioner of the department, his designee, or his authorized representative.

"Community Policy and Management Team" or "CPMT" means a team appointed by the local governing body pursuant to Chapter 52 (§ 2.2-5200 et seq.) of Title 2.2 of the Code of Virginia. The powers and duties of the CPMT are set out in § 2.2-5206 of the Code of Virginia.

"Concurrent permanency planning" means utilizing a structured case management approach in which reasonable efforts are made to achieve a permanency goal, usually a reunification with the family, simultaneously with an established alternative permanent plan for the child.

"Department" means the state Department of Social Services.

"Denied," as used in § 63.2-915 of the Code of Virginia and 22VAC40-201-115, means the refusal to provide a claim for benefits.

"Dually approved" means applicants have met the required standards to be approved as a foster and adoptive family home provider.

"Entrustment agreement" means an agreement that the local board enters into with the parent, parents, or guardian to place the child in foster care either to terminate parental rights or for the temporary care and placement of the child. The agreement specifies the conditions for the care of the child.

"Family assessment and planning team" or "FAPT" means the local team created by the CPMT (i) to assess the strengths and needs of troubled youths and families who are approved for referral to the team and (ii) to identify and determine the complement of services required to meet their unique needs. The powers and duties of the FAPT are set out in § 2.2-5208 of the Code of Virginia.

"Foster care" means 24-hour substitute care for children in the custody of the local board or who remain in the custody of their parents, but are placed away from their parents or guardians and for whom the local board has placement and care responsibility through a noncustodial agreement.

"Foster care maintenance payments" means payments to cover those expenses made on behalf of a child in foster care including the cost of, and the cost of providing, food, clothing, shelter, daily supervision, school supplies, a child's incidentals, reasonable travel to the child's home for visitation, and reasonable travel to remain in the school in which the child is enrolled at the time of the placement. The

term also includes costs for children in institutional care and costs related to the child of a child in foster care as set out in 42 USC § 675.

"Foster care plan" means a written document filed with the court in accordance with § 16.1-281 of the Code of Virginia that describes the programs, care, services, and other support that will be offered to the child and his parents and other prior custodians. The foster care plan defined in this definition is the case plan referenced in 42 USC § 675.

"Foster care prevention" means the provision of services to a child and family to prevent the need for foster care placement.

"Foster care services" means the provision of a full range of casework, treatment, and community services, including independent living services, for a planned period of time to a child meeting the requirements as set forth in § 63.2-905 of the Code of Virginia.

"Foster child" means a child for whom the local board has assumed placement and care responsibilities through a noncustodial foster care agreement, entrustment, or court commitment before 18 years of age.

"Foster home" means the place of residence of any natural person in which any child, other than a child by birth or adoption of such person, resides as a member of the household.

"Foster parent" means an approved provider who gives 24-hour substitute family care, room and board, and services for children or youth committed or entrusted to a child-placing agency.

"Independent living arrangement" means placement of a child at least 16 years of age who is in the custody of a local board or licensed child-placing agency and has been placed by the local board or licensed child-placing agency in a living arrangement in which he does not have daily substitute parental supervision.

"Independent living services" means services and activities provided to a child in foster care 14 years of age or older who was committed or entrusted to a local board of social services, child welfare agency, or private child-placing agency. Independent living services may also mean services and activities provided to a person who (i) was in foster care on his 18th birthday and has not yet reached the age of 21 years or (ii) is at least 18 years of age and who, immediately prior to his commitment to the Department of Juvenile Justice, was in the custody of a local department of social services. Such services shall include counseling, education, housing, employment, and money management skills development, access to essential documents, and other appropriate services to help children or persons prepare for self-sufficiency.

"Individual family service plan" or "IFSP" means the plan for services developed by the FAPT in accordance with § 2.2-5208 of the Code of Virginia.

"Intercountry placement" means the arrangement for the care of a child in an adoptive home or foster care placement into or out of the Commonwealth by a licensed child-placing agency, court, or other entity authorized to make such placements in accordance with the laws of the foreign country under which it operates.

"Interstate Compact on the Placement of Children" or "ICPC" means a uniform law that has been enacted by all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, which establishes orderly procedures for the interstate placement of children and sets responsibility for those involved in placing those children.

"Interstate placement" means the arrangement for the care of a child in an adoptive home, foster care placement, or in the home of the child's parent or with a relative or nonagency guardian, into or out of the Commonwealth, by a child-placing agency or court when the full legal right of the child's parent or nonagency guardian to plan for the child has been voluntarily terminated or limited or severed by the action of any court.

"Investigation" means the process by which the child-placing agency obtains information required by § 63.2-1208 of the Code of Virginia about the placement and the suitability of the adoption. The findings of the investigation are compiled into a written report for the circuit court containing a recommendation on the action to be taken by the court.

"Local board" means the local board of social services in each county and city in the Commonwealth required by § 63.2-300 of the Code of Virginia.

"Local department" means the local department of social services of any county or city in the Commonwealth.

"Nonagency placement adoption" means an adoption in which the child is not in the custody of a child-placing agency and is placed in the adoptive home directly by the birth parent or legal guardian.

"Noncustodial foster care agreement" means an agreement that the local department enters into with the parent or guardian of a child to place the child in foster care when the parent or guardian retains custody of the child. The agreement specifies the conditions for placement and care of the child.

"Nonrecurring expenses" means expenses of adoptive parents directly related to the adoption of a child with special needs as set out in § 63.2-1301 D of the Code of Virginia.

"Normalcy" means allowing children and youth in foster care to experience childhood and adolescence in ways similar to their peers who are not in foster care by empowering foster parents and congregate care staff to use the reasonable and prudent parent standard as referenced in Public Law 113-183 (42 USC §§ 671 and 675) when making decisions regarding extracurricular, enrichment, and social activities.

Regulations

"Parental placement" means locating or effecting the placement of a child or the placing of a child in a family home by the child's parent or legal guardian for the purpose of foster care or adoption.

"Permanency" means establishing family connections and placement options for a child to provide a lifetime of commitment, continuity of care, a sense of belonging, and a legal and social status that go beyond a child's temporary foster care placements.

"Permanency planning" means a social work practice philosophy that promotes establishing a permanent living situation for every child with an adult with whom the child has a continuous, reciprocal relationship within a minimum amount of time after the child enters the foster care system.

"Prior custodian" means the person who had custody of the child and with whom the child resided, other than the birth parent, before custody was transferred to or placement made with the child-placing agency when that person had custody of the child.

"Prior family" means the family with whom the child resided, including birth parents, relatives, or prior custodians, before custody was transferred to or placement made with the child-placing agency.

"Putative Father Registry" means a confidential database designed to protect the rights of a putative father who wants to be notified in the event of a proceeding related to termination of parental rights or adoption for a child he may have fathered.

"Reasonable and prudent parent standard," in accordance with 42 USC § 675(10), means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child that foster parents and congregate care staff shall use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

"Residential placement" means a placement in a licensed publicly or privately owned facility, other than a private family home, where 24-hour care is provided to children separated from their families. A residential placement includes placements in children's residential facilities as defined in § 63.2-100 of the Code of Virginia.

"Reunification" means the return of the child to his home after removal for reasons of child abuse and neglect, abandonment, child in need of services, parental request for relief of custody, noncustodial agreement, entrustment, or any other court-ordered removal.

"Service worker" means a worker responsible for case management or service coordination for prevention, foster care, or adoption cases.

"Sibling" means each of two or more children having one or more parents in common.

"SSI" means Supplemental Security Income.

"State pool funds" means the pooled state and local funds administered by CSA and used to pay for services authorized by the CPMT.

"Step-parent adoption" means the adoption of a child by a spouse or the adoption of a child by a former spouse of the birth or adoptive parent in accordance with § 63.2-1201.1 of the Code of Virginia.

"Title IV-E" means the title of the Social Security Act that authorizes federal funds for foster care and adoption assistance.

"Visitation and report" means the visits conducted pursuant to § 63.2-1212 of the Code of Virginia and the written report of the findings made in the course of the visitation. The report is filed in the circuit court in accordance with § 63.2-1212 of the Code of Virginia.

"Wrap around services" means an individually designed set of services and supports provided to a child and his family that includes treatment services, personal support services or any other supports necessary to achieve the desired outcome. Wrap around services are developed through a team approach.

"Youth" means any child in foster care between ~~14~~ 14 and 18 years of age or any person 18 to 21 years of age transitioning out of foster care and receiving independent living services pursuant to § 63.2-905.1 of the Code of Virginia. "Youth" may also mean an individual older than the age of 16 years who is the subject of an adoption assistance agreement.

22VAC40-201-35. Reentry into foster care from commitment.

A. In the event the ~~youth~~ child was in the custody of the local board immediately prior to his commitment to the Department of Juvenile Justice (DJJ) and has not attained the age of 18 years, the local board shall resume custody upon the ~~youth's~~ child's release from commitment, unless an alternative arrangement for the custody of the ~~youth~~ child has been made and communicated in writing to DJJ. At least 90 days prior to the ~~youth's~~ child's release from commitment on parole supervision the local department shall consult with the court service unit on the ~~youth's~~ child's return to the locality and collaborate to develop a foster care plan that prepares the ~~youth~~ child for successful transition back to the custody of the local department or to an alternative custody arrangement, if applicable. The plan shall identify services necessary for the transition and how the services are to be provided. If an alternative custody arrangement has been identified, such arrangement shall be described in the foster care plan to be

considered and approved by the court. Any transfer of custody of the child must be by order of the court.

B. The foster care plan shall be submitted to the court for approval within 45 days of the ~~youth's~~ child's reentry into foster care. Submission of a petition for approval of the foster care plan to the juvenile and domestic relations district court shall be made in accordance with § 16.1-281 of the Code of Virginia.

22VAC40-201-40. Foster care placements.

A. Within 30 days of the child being placed in the custody of the local board, the local department shall exercise due diligence to identify and notify in writing all adult relatives, including the parents of siblings who have legal custody of such siblings, that the child has been removed and explain the options to relatives to participate in the care and placement of the child including eligibility as a kinship foster parent and the services and supports that may be available for children placed in such a home. The local department may determine it is not in the child's best interest to notify relatives who have a history of domestic violence; have been convicted of barrier crimes as defined in § 63.2-1719 of the Code of Virginia other than those described in subsections E, F, G, and H of § 63.2-1721 of the Code of Virginia; or are listed on the Virginia State Police Sex Offender Registry. Additionally, if the birth father is unknown, the local department shall search the Virginia Birth Father Registry within 30 days of the child entering foster care.

B. The local department shall ensure a child in foster care is placed in an approved home or licensed facility that complies with all applicable federal and state requirements for safety and child well-being. Placements shall be made subject to the requirements of § 63.2-901.1 of the Code of Virginia. The following requirements shall be met when placing a child in an approved home or licensed facility:

1. The local department shall exercise due diligence to locate and assess relatives as a foster home placement for the child, including in emergency situations.
2. The local department shall place the child in the least restrictive, most family like setting consistent with the best interests and needs of the child.
3. The local department shall attempt to place the child in as close proximity as possible to the birth parent's or prior custodian's home to facilitate visitation, provide continuity of connections, and provide educational stability for the child.
4. The local department shall take reasonable steps to place the child with siblings unless such a joint placement would be contrary to the safety or well-being of the child or siblings.
5. The local department shall, when appropriate, consider placement in a dually approved home so that if

reunification fails, the placement is the best available placement to provide permanency through adoption for the child.

6. The local department shall not delay or deny placement of a child into a foster or adoptive family placement on the basis of race, color, or national origin of the foster or ~~resource~~ adoptive parent or child.

7. When a child being placed in foster care is of ~~native~~ Native American, Alaskan Eskimo, or Aleut heritage and is a member of a nationally recognized tribe, the local department shall follow all federal laws, regulations, and policies regarding the referral of the child. The local department may contact the Department of Historic Resources for information on contacting Virginia tribes and shall consider tribal culture and connections in the placement and care of a child of Virginia Indian heritage.

8. If a child is placed in a kinship foster placement pursuant to § 63.2-900.1 of the Code of Virginia, the child shall not be removed from the physical custody of the kinship foster parent, provided the child has been living with the kinship foster parent for six consecutive months and the placement continues to meet approval standards for foster care, unless (i) the kinship foster parent consents to the removal; (ii) removal is agreed upon at a family partnership meeting; (iii) removal is ordered by a court of competent jurisdiction; or (iv) removal is warranted pursuant to § 63.2-1517 of the Code of Virginia.

C. A service worker shall make a preplacement visit to any out-of-home placement to observe the environment where the child will be living and ensure that the placement is safe and capable of meeting the needs of the child. The preplacement visit shall precede the placement date except in cases of emergency. In cases of emergency, the visit shall occur on the same day as the placement.

D. Foster or adoptive homes shall meet standards established by the board and shall be approved by child-placing agencies. Prior to the placement of a child in a licensed child-placing agency (LCPA) foster home, the local department shall verify that the LCPA approved the foster home. Prior to the placement of a child in a children's residential facility, the local department shall verify that the facility is licensed to operate by the appropriate state regulatory authority.

E. Local departments shall receive notice of the approval from the department's office of the ICPC prior to placing a child out of state.

F. When the local department is considering placement of a child in a foster or adoptive home approved by another local department within Virginia, the local department intending to place the child shall consult with the approving local department about the placement of the child and shall also verify that the home is still approved.

Regulations

G. When a child is moving with a foster or adoptive family from one jurisdiction to another, the local department holding custody shall notify the local department in the jurisdiction to which the foster or adoptive family is moving.

H. When a child moves with a foster or adoptive family from one jurisdiction to another in Virginia, the local department holding custody shall continue supervision of the child unless supervision is transferred to the other local department.

I. A local department may petition the court to transfer custody of a child to another local department when the birth parent or prior custodian has moved to that locality.

J. In planned placement changes or relocation of foster parents, birth parents with residual parental rights or prior custodians and all other relevant parties shall be notified that a placement change or move is being considered if such notification is in the best interest of the child. The service worker shall consider the child's best interest and safety needs when involving the birth parent or prior custodian and all other relevant parties in the decision-making process regarding placement change or notification of the new placement.

K. In the case where an emergency situation requires an immediate placement change, the birth parent with residual parental rights or prior custodian and all other relevant parties shall be notified immediately of the placement change. The local department shall inform the birth parent or prior custodian why the placement change occurred and why the birth parent or prior custodian and all other relevant parties could not be involved in the decision-making process.

22VAC40-201-70. Foster care goals.

A. Foster care goals are established to assure permanency is achieved for the child. Permissible foster care goals are:

1. Transfer custody of the child to his prior family;
2. Transfer custody of the child to a relative other than his prior family;
3. Finalize adoption of the child;
4. Place the child in permanent foster care;
5. Transition to independent living if the child is admitted to the United States as a refugee or asylee or is 18 years of age or older; or
6. Place the child in another planned permanent living arrangement in accordance with § 16.1-282.1 A2 of the Code of Virginia.

B. When the permanency goal is changed to adoption, the local department shall file petitions with the court 30 days prior to the hearing to:

1. Approve the foster care service plan seeking to change the permanency goal to adoption; and
2. Terminate parental rights.

Upon termination of parental rights, the local department shall provide an array of adoption services to support obtaining a finalized adoption.

C. The local department shall engage in concurrent permanency planning in order to achieve timely permanency for the child. Permanency goals shall be considered and addressed from the beginning of placement and continuously evaluated.

D. The goal of another planned permanent living arrangement may be chosen when the court has found that:

1. The child has a severe and chronic emotional, physical, or neurological disabling condition;
2. The child requires long-term residential care for the condition; ~~and~~
3. None of the alternatives listed in clauses (i) through (v) of § 16.1-282.1 A of the Code of Virginia is achievable for the child at the time placement in another planned permanent living arrangement is approved as the permanent goal for the child; and
4. The youth is 16 years of age or older.

E. The goal of permanent foster care may be chosen when the court has found that:

1. The child is placed in a foster home;
2. The child has developed a clearly established and documented significant relationship with a foster parent;
3. None of the alternatives listed in clauses (i) through (v) of § 16.1-282.1 A of the Code of Virginia is achievable for the child at the time placement in permanent foster care is approved as the permanent goal for the child; and
4. The youth is 16 years of age and older.

E. If either the goal of permanent foster care or another planned permanent living arrangement is selected, the local department shall continue to continuously evaluate the best interest interests of the child in light of the changing circumstances of the child and extended family to determine whether a change in goal to return home, placement with relatives, or adoption can achieve permanency.

F. G. The goal of independent living services shall only be selected for those children admitted to the United States as a refugee or asylee ~~or~~, those youth age 18 years leaving foster care and meeting the requirements to receive independent living services, or youth participating in the Fostering Futures

program, as described in 22VAC40-201-105. For those youth with this goal, the service worker shall continue diligent efforts to search for a relative or other interested adult who will provide a permanent long-term family relationship for the youth.

22VAC40-201-80. Foster care plans.

A. Every child in foster care longer than 45 days shall have a written foster care plan approved by the court within 60 days of entry into foster care. The foster care plan shall specify the permanency goal and the concurrent permanency goal and shall meet all requirements set forth in federal law or state law § 16.1-282 of the Code of Virginia. ~~In the development of the foster care plan, the local department shall consider input from the child, the birth parents or prior custodians, the foster or adoptive parents, and any other interested individuals, who may include service providers. All of these persons shall be involved in sharing information for the purposes of well informed decisions and planning for the child with a focus on safety and permanence.~~

B. The foster care plan shall be written after the completion of the assessment. Foster care plans shall directly reference how the strengths identified in the foster care assessment will support the plan and the needs to be met to achieve the permanency goal, including the identified concurrent permanency goal, in a timely manner.

C. A plan for visitation with the birth parents or prior custodians and siblings for all children in foster care shall be developed and presented to the court as part of the foster care plan in accordance with § 63.2-900.2 of the Code of Virginia.

22VAC40-201-90. Service delivery.

A. Services shall be provided to support the safety and well-being of the child. Services to children and birth parents or prior custodians shall continue until evidence indicates the services are either not effective to reach the child's goal or no longer necessary because the goal has been achieved, or the birth parent or prior custodian has refused services.

B. Permanency planning for children and birth parents or prior custodians shall be an inclusive process providing full disclosure to the birth parents or prior custodians of the establishment of a concurrent permanency goal and the implications of concurrent permanency planning for the child and birth parents or prior custodians. Local departments shall notify the birth parents or prior custodians concerning placement changes, hearings and meetings regarding the child, and assessments of needs and case progress and shall be responsive to the requests of the child and birth parents or prior custodians.

C. In order to ensure that permanency is achieved for the child, services may be provided to relatives or other interested individuals who are assessed to be potential permanency

options for the child and may continue until an assessment indicates the services are no longer necessary.

D. Developmental and medical examinations shall be provided for the child in foster care in accordance with the Virginia Department of Medical Assistance Services' Early Periodic Screening Diagnosis and Treatment (EPSDT) schedule in the Virginia EPSDT Periodicity Chart. Dental examinations shall be provided for the child in accordance with the American Academy of Pediatric Dentistry's Periodicity and Anticipatory Guidance Recommendations (Dental Health Guidelines-Ages 0-18 Years, Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2002-2003)) as determined by the Virginia Department of Medical Assistance Services. As indicated through assessment, appropriate health care services shall include trauma, developmental, mental health, psychosocial, and substance abuse services and treatments. Local departments shall follow the protocols for appropriate and effective use of psychotropic medications for children in foster care disseminated by the department.

E. All children in foster care shall have a face-to-face contact with an approved service worker at least once per calendar month regardless of the child's permanency goal or placement. More than 50% of each child's visits shall be in his place of residency.

1. The purpose of the visits shall be to assess the child's progress, needs, adjustment to placement, and other significant information related to the health, safety, and well-being of the child.

2. The visits shall be made by individuals who meet the department's requirements consistent with 42 USC § 622(b).

F. The local department shall enter into a placement agreement developed by the department with the foster or adoptive parents. As required by § 63.2-900 of the Code of Virginia, the placement agreement shall include, at a minimum, a code of ethics and mutual responsibilities for all parties to the agreement.

1. Services to prevent placement disruptions shall be provided to the foster and adoptive parents.

2. Foster and adoptive parents who have children placed with them shall be contacted by a service worker as often as needed in accordance with 22VAC40-211-100 to assess service needs and progress.

3. Foster and adoptive parents shall be given full factual information about the child, including ~~but not limited to,~~ circumstances that led to the child's removal and complete educational, medical, and behavioral information. All information shall be kept confidential by the foster and adoptive parents.

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4. Foster and adoptive parents shall be given the foster care plan.

5. Respite care for foster and adoptive parents may be provided on an emergency or planned basis.

6. The department shall make funds available to provide reimbursement to local departments' foster parents for damages to property caused by children placed in the home. Provision of reimbursement is contingent upon the availability of funds.

G. Pursuant to § 63.2-904 of the Code of Virginia, the local department shall implement policies and procedures to support normalcy for children in foster care. Foster parents and group home and residential providers shall make day-to-day decisions regarding a child's participation in age-appropriate extracurricular, enrichment, cultural, and social activities based on the reasonable and prudent parent standard and in accordance with the agreement entered into between the provider and local department.

1. Pursuant to 42 USC § 671(a)(10)(B), the department shall ensure that foster parents and group home and residential providers are trained in normalcy and how to use and apply the reasonable and prudent parent standard. Each group home and residential provider shall designate at least one official staff member on site to be the caregiver who is authorized to apply the reasonable and prudent parent standard.

2. No other policy or procedure shall interfere with the ability to implement normalcy.

22VAC40-201-100. Providing independent living services: service for youth 14 years of age and older.

A. Independent living services shall be identified by the youth, foster or adoptive family, local department, service providers, legal community, and other interested individuals and shall be included in the service plan. Input from the youth in assembling these individuals and developing the services is required.

B. Independent living services shall be provided to all youth ages 14 to 18 years and shall be offered to any person between 18 and 21 years of age who is in the process of transitioning from foster care to self-sufficiency.

C. Independent living services include education, vocational training, employment, mental and physical health services, transportation, housing, financial support, daily living skills, counseling, and development of permanent connections with adults.

D. Local departments shall assess the youth's independent living skills and needs and incorporate the assessment results into the youth's service plan.

E. A youth placed in foster care before the age of 18 years who turns age 18 years prior to July 1, 2016, may continue to

receive independent living services from the local department between the ages of 18 and 21 years if:

1. The youth is making progress in an educational or vocational program, has employment, or is in a treatment or training program; and

2. The youth agrees to participate with the local department in (i) developing a service agreement and (ii) signing the service agreement. The service agreement shall require, ~~at a minimum, that the youth's living arrangement shall be approved by the local department~~ and that the youth shall cooperate with all services; or

3. The youth is in permanent foster care and is making progress in an educational or vocational program, has employment, or is in a treatment or training program.

F. A youth age 16 years and older is eligible to live in an independent living arrangement provided the local department utilizes the independent living arrangement placement criteria developed by the department to determine that such an arrangement is in the youth's best interest. An eligible youth may receive an independent living stipend to assist him with the costs of maintenance. The eligibility criteria for receiving an independent living stipend will be developed by the department.

G. Any person who was committed or entrusted to a local department, turned 18 years of age prior to July 1, 2016, and chooses to discontinue receiving independent living services after age 18 years may request a resumption of independent living services provided that (i) the person has not yet reached 21 years of age and (ii) the person has entered into a written agreement, less than 60 days after independent living services have been discontinued, with the local board regarding the terms and conditions of his receipt of independent living services. Local departments shall provide any person who chooses to leave foster care or terminate independent living services before his 21st birthday written notice of his right to request restoration of independent living services in accordance with § 63.2-905.1 of the Code of Virginia by including such written notice in the person's transition plan.

H. Local departments shall assist eligible youth in applying for educational and vocational financial assistance. Educational and vocational specific funding sources shall be used prior to using other sources.

I. Local departments shall provide independent living services to any person between 18 and 21 years of age who:

1. Turned 18 years of age prior to July 1, 2016;

2. Was in the custody of the local board immediately prior to his commitment to the Department of Juvenile Justice;

~~2.~~ 3. Is in the process of transitioning from a commitment to the Department of Juvenile Justice to self-sufficiency; and

~~3.~~ 4. Provides written notice of his intent to receive independent living services and enters into a written agreement which sets forth the terms and conditions for the provision of independent living services with the local board within 60 days of his release from commitment.

J. Every six months a supervisory review of service plans for youth receiving independent living services after age 18 years shall be conducted to assure the effectiveness of service provision.

K. A youth who has been in care six months or more and turns 18 years of age while in foster care shall receive a certified copy of his birth certificate, social security card, health insurance information, medical records, and state-issued identification or driver's license.

L. The local department shall run annual credit checks on all youth in foster care who are 14 years of age and older. The local department shall assist a youth in resolving any discrepancies in the youth's credit report. The local department shall assist a youth in foster care over 18 years of age in obtaining the youth's annual credit report.

22VAC40-201-105. Foster care for youth 18 to 21 years of age (Fostering Futures program).

A. Foster care services shall be provided to youth who turn 18 years of age while still in foster care on or after July 1, 2016, until they reach 21 years of age if they qualify and have chosen to participate in the Fostering Futures program.

B. Youth who qualify for the Fostering Futures program are those youth who (i) turn 18 years of age on or after July 1, 2016, and were in the custody of a local Virginia department of social services but have not yet turned 21 years of age, including those who were in foster care under an entrustment agreement and (ii) are:

1. Completing secondary education or an equivalent credential;
2. Enrolled in an institution that provides post-secondary or vocational education;
3. Participating in a program or activity designed to promote employment or remove barriers to employment;
4. Employed at least 80 hours a month; or
5. Are incapable of doing any of the activities described in subdivisions 1 through 4 of this subsection due to a medical condition, which incapability is supported by regularly updated information in the program participant's case plan.

C. Fostering Futures program participants are eligible for independent living services as well as placement services; placements in congregate care are not allowable.

D. Entry into the Fostering Futures program is considered a new foster care episode, and the youth shall be evaluated for Title IV-E funding or eligibility upon entering the program.

E. There is no limit to the number of times a youth may exit and reenter the Fostering Futures program prior to his 21st birthday.

F. Youth in foster care who are committed to the Department of Juvenile Justice prior to 18 years of age, turn 18 years of age on or after July 1, 2016, and are not yet 21 years of age, are eligible to enter the Fostering Futures program upon discharge from commitment.

22VAC40-201-110. Court hearings and case reviews.

A. For all court hearings, local departments shall:

1. Facilitate a meeting prior to the development of the foster care service plan and foster care service plan review to ensure participation and consider input from the child, the birth parents or prior custodians, the foster or adoptive parents, and any other interested individuals, who may include service providers, in the development of the service plan and service plan review. All youth 14 years of age and older shall be given the opportunity to choose up to two people to attend the meeting who are not the foster parent or caseworker. All of these persons shall be involved in sharing information for the purposes of well-informed decisions and planning for the child with a focus on safety and permanence.
2. File petitions in accordance with the requirements for the type of hearing.
- ~~2.~~ 3. Obtain and consider the child's input as to who should be included in the court hearing. If persons identified by the child will not be included in the court hearing, the service worker shall explain the reasons to the child for such a decision consistent with the child's developmental and psychological status.
- ~~3.~~ 4. Inform the court of reasonable efforts made to achieve concurrent permanency goals.
5. Document the appropriateness of the placement, including the continued appropriateness of an out-of-state placement if applicable.
6. Ensure the child or youth is present for the permanency planning hearing unless the court determines this not to be in the child's best interest.

B. The child or youth shall be consulted in an age-appropriate manner about his permanency plan at the permanency planning hearing and subsequent administrative panel reviews.

C. An administrative panel review shall be held six months after a permanency planning hearing when the goal of permanent foster care has been approved by the court. A

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foster care review hearing will be held annually. The child will continue to have administrative panel reviews or review hearings every six months until the child reaches age 18 years.

~~€~~ D. The local department shall invite the child; the child's birth parents or prior custodians when appropriate; and the child's foster or adoptive parents, placement providers, guardian ad litem, court appointed special advocate (~~CASA~~), relatives, and service providers to participate in the administrative panel reviews.

~~Đ~~ E. The local department shall consider all recommendations made during the administrative panel review in planning services for the child and birth parents or prior custodians and document the recommendations on the department approved form. Individuals who were invited, including those not in attendance, shall be given a copy of the results of the administrative panel review as documented on the department approved form.

~~Ɔ~~ F. A supervisory review is required every six months for youth ages 18 to 21 years who are receiving independent living services only.

G. An administrative panel review is required every six months for Fostering Futures program participants unless a court review is held.

~~Ɔ~~ H. In accordance with § 16.1-242.1 of the Code of Virginia, when a case is on appeal for termination of parental rights, the juvenile and domestic relations district court retains jurisdiction on all matters not on appeal. The circuit court appeal hearing may substitute for a review hearing if the circuit court addresses the future status of the child.

~~Ɔ~~ I. An adoption progress report shall be prepared every six months after a permanency planning hearing when the goal of adoption has been approved by the court. The adoption progress report shall be entered into the automated child welfare data system. The child will continue to have annual review hearings in addition to adoption progress reports until a final order of adoption is issued or the child reaches age 18 years.

~~Ɔ~~ J. If a child is in the custody of the local department and a preadoptive family has not been identified and approved for the child, the child's guardian ad litem or the local board of social services may file a petition to restore the previously terminated parental rights of the child's parent in accordance with § 16.1-283.2 of the Code of Virginia.

K. If a child has been in foster care 15 out of the last 22 months, the local department shall file a petition to terminate the parental rights.

22VAC40-201-130. Closing the foster care case.

A. Foster care cases are closed or transferred to another service category under the following circumstances:

1. When the foster care child turns 18 years of age and objects to continuing to receive foster care services for which he is eligible;

2. When the court releases the child from the local department's custody prior to the age of 18 years;

3. When a temporary entrustment or noncustodial agreement has expired, been revoked, or been terminated by the court;

4. When the foster care child is committed to the Department of Juvenile Justice; or

5. When the final order of adoption is issued.

B. When the foster care case is closed for services, the case record shall be maintained according to the record retention schedules established by the Library of Virginia.

C. Any foster care youth who has reached age 18 years has the right to request information from his records in accordance with state law.

22VAC40-201-140. Other foster care requirements.

~~A. The director of a local department or his designee may grant approval for a child to travel out of state and out of country. The approval must be in writing and maintained in the child's file.~~

~~B.~~ A. Pursuant to § 63.2-908 of the Code of Virginia, a foster parent may consent to a marriage or entry into the military if the child has been placed with him through a permanent foster care agreement that has been approved by the court.

~~Ɔ~~ B. An employee of a local department, including a relative, cannot serve as a foster, adoptive, or licensed child-placing agency parent for a child in the custody of that local department. In the event it is in the child's best interest that a local employee be the foster parent, the child's custody may be transferred to another local department.

~~Đ~~ C. The child of a foster child remains the responsibility of his parent, unless custody has been removed by the court.

1. The child is not subject to requirements for foster care plans, reviews, or hearings. However, the needs and safety of the child shall be considered and documented in the foster care plan for the foster child (parent).

2. The child is eligible for maintenance payments in accordance with 42 USC § 675(4)(B) and Medicaid in accordance with 42 USC § 672(h).

~~Ɔ~~ D. When a child in foster care is committed to the Department of Juvenile Justice, the local department no longer has custody or placement and care responsibility for the child. As long as the discharge or release plan for the child is to return to the local department prior to reaching age

18 years, the local department shall maintain a connection with the child.

~~F. E.~~ At least 90 days prior to a ~~youth's~~ child's release from commitment to the Department of Juvenile Justice, the local department shall:

1. Consult with the court services unit concerning the ~~youth's~~ child's return to the locality; and
2. Work collaboratively with the court services unit to develop a plan for the ~~youth's~~ child's successful transition back to the community, which will identify the services necessary to facilitate the transition and will describe how the services will be provided.

22VAC40-201-161. Adoption assistance.

A. The purpose of adoption assistance is to facilitate adoptive placements and ensure permanency for children with special needs.

B. For a child to be eligible for adoption assistance he must have been determined to be a child with special needs in accordance with §§ 63.2-1300 and 63.2-1301 of the Code of Virginia and meet the following criteria:

1. Be younger than 18 years of age and meet the requirements set forth in § 473 of Title IV-E of the Social Security Act (42 USC § 673); or
2. Be younger than 18 years of age and in the placement and care of a child-placing agency at the time the petition for adoption is filed and be placed by the child-placing agency with the prospective adoptive parents for the purpose of adoption, except for those situations in which the foster parents have filed a petition for adoption under § 63.2-1229 of the Code of Virginia.

C. Adoption assistance may include the following payments or services where appropriate:

1. Title IV-E maintenance payments if the child meets federal eligibility requirements.
2. State-funded maintenance payments when the local department determines that (i) the child does not meet the requirements in § 473 of Title IV-E of the Social Security Act (42 USC § 673) and (ii) the child is a child with special needs pursuant to § 63.2-1301 B of the Code of Virginia.
3. State-funded special service payments used to help meet the child's physical, mental, emotional, or dental needs (i) when the child is in the custody of the local board or in the custody of a licensed child-placing agency and placed for adoption, (ii) when the child meets the criteria of a child with special needs set out in § 63.2-1300 of the Code of Virginia, and (iii) when the adoptive parents are capable of providing permanent family relationships needed by the child in all respects except financial.

4. Nonrecurring expense payments when an adoption assistance agreement is entered into prior to or at the time of the finalization of the adoption. Claims for nonrecurring expense payments must be filed within two years of the date of the final decree of adoption.

D. For the child who meets the requirements in § 473 of Title IV-E of the Social Security Act (42 USC § 673) or who is receiving state-funded maintenance payments and has a special medical need as specified in § 32.1-325 of the Code of Virginia and in the Virginia DSS Medicaid Eligibility manual, M0310.102 2b, the adoption assistance agreement shall include a statement indicating the child's Medicaid eligibility status.

E. Additional criteria for the payments and services specified in subsection C of this section are as follows:

1. A maintenance payment, whether under Title IV-E or state funded, shall be approved for a child who is eligible for adoption assistance unless the adoptive parent indicates, or it is determined through negotiation, that the payment is not needed.

a. The amount of all payments shall be negotiated by a representative of the department with the adoptive parents, taking into consideration the needs of the child and circumstances of the adoptive parents.

b. The amount of maintenance payments made shall not exceed the foster care maintenance payment that would have been paid during the period if the child had been in a foster family home.

c. The maintenance payments shall not be reduced below the amount specified in the adoption assistance agreement without the concurrence of the adoptive parents or a statewide reduction.

d. The maintenance payment specified in the adoption assistance agreement may only be increased if the child is already receiving the maximum amount allowed and (i) the child reaches an age at which the foster care maintenance rate would increase or (ii) statewide increases are approved for foster care maintenance rates.

e. The adoptive parents shall be required under the adoption assistance agreement to keep the local department informed of the circumstances that would make them ineligible for a maintenance payment or eligible for a different amount of maintenance payment than that specified in the adoption assistance agreement.

f. Maintenance payments shall cease being made to the adoptive parents for the child who has not yet reached the age of 18 years if (i) the adoptive parents are no longer legally responsible for the support of the child or (ii) the child is no longer receiving any support from the adoptive parents.

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2. The special service payment shall be directly related to the child's special needs listed on the adoption assistance agreement. Special service payments shall be time limited based on the needs of the child and can be modified beyond the original provision of the agreement when the local department and the adoptive parents agree to the modification in a signed and dated addendum. Subsection K of this section addresses addendums to an existing agreement.

a. A special service payment may be used for a child eligible for Medicaid to supplement payments not covered by Medicaid.

b. Payments for special services are negotiated by a representative of the department with the adoptive parents, taking into consideration:

(1) The special needs of the child;

(2) Alternative resources available to fully or partially defray the cost of meeting the child's special needs; and

(3) The circumstances of the adoptive family, including the family's income.

c. The rate of payment shall not exceed the prevailing rate for the provision of such special services within the child's community.

d. The special services adoption assistance payments shall be separate and distinct from the maintenance payments and nonrecurring expenses on the adoption assistance form.

3. The adoptive parent shall be reimbursed, upon request, for the nonrecurring expenses of adopting a child with special needs.

a. The total amount of reimbursement shall be based on actual costs and shall not exceed \$2,000 per child per placement or an amount established by federal law.

b. Payment of nonrecurring expenses may begin as soon as the child is placed in the adoptive home and the adoption assistance agreement has been signed.

c. Nonrecurring expenses include those items set out in § 63.2-1301 D of the Code of Virginia.

4. When the adoptive parents decline a specific payment or agree to a reduced payment amount and their family circumstances or the child's needs change, the adoptive parents may request a change to the agreement and an addendum to the adoption assistance agreement can be negotiated. The requirements for addendums to an existing adoption assistance agreement are in subsection K of this section.

F. All adoption assistance payments, services, and agreements shall be negotiated with the adoptive parents by a representative of the department, taking into consideration the

needs of the child, the circumstances of the family, and the limitations specified in subsections B, C, and E of this section. Documentation supporting the requests for payments and services shall be provided by the adoptive parents and for consideration in the negotiation of the adoption assistance agreement. Income shall not be the sole factor in considering the family's circumstances during the negotiations. Available family and community resources shall be explored as an alternative or supplement to the adoption assistance payment.

G. An adoption assistance agreement shall be entered into by the local board and the adoptive parents or a child who has been determined eligible for adoption assistance. Local departments shall use the adoption assistance agreement form developed by the department. In cases in which the child is in the custody of a licensed child-placing agency, the agreement shall be entered into by the local board, the licensed child-placing agency, and the adoptive parents. All adoption assistance agreements shall be negotiated by a representative of the department.

H. When a child is determined to be eligible for adoption assistance prior to the adoption being finalized, the adoption assistance agreement shall:

1. Be signed prior to or at the time of entry of the final order of adoption;

2. Specify the payment types, monthly amounts, special services to be provided; and

3. Remain in effect and governed by the laws of the Commonwealth of Virginia regardless of the state to which the adoptive parents may relocate.

I. Application for adoption assistance after finalization of the adoption shall be for state-funded maintenance payments as set out in § 63.2-1301 B of the Code of Virginia. The application for adoption assistance shall be submitted within one year of diagnosis of the condition that establishes the child as a child with special needs.

J. The adoptive parents shall annually submit a signed adoption assistance affidavit to the local department by the end of the month in which the adoption assistance agreement was effective pursuant to § 63.2-1302 C of the Code of Virginia.

K. Adoption assistance agreements may be modified beyond the original provisions of the agreement to the extent provided by law when the local department and the adoptive parents agree in writing to new or renewed special services or provisions in an addendum signed and dated by the local department and the adoptive parents. The local departments shall use the addendum form provided by the department and the changes to the agreement shall be negotiated by a representative of the department.

L. The local department is responsible for:

1. Maintaining payments and services identified in the adoption assistance agreement and any addendum in effect, regardless of where the family resides;
2. Notifying adoptive parents who are receiving adoption assistance that the annual affidavit is due;
3. Discussing with the adoptive parents the child's unique needs and their ability to manage the needs of the child;
4. Assisting the adoptive parents in coordinating services to meet the child's special needs related to adoption assistance upon request;
5. Providing services to prevent disruption and strengthen family well-being, when requested by the adoptive parents; and
6. Providing training, when requested, to the adoptive parents as part of an already established local department curriculum. If the local department does not provide the necessary training when requested, the local department shall identify potential training sources and assist the adoptive parent in accessing the training.

M. Adoption assistance shall be terminated when the child reaches the age of 18 years unless ~~the~~:

1. The child has a physical or mental disability or an educational delay resulting from the child's disability that warrants continuation of the adoption assistance. If a child has a physical or mental disability that warrants continuation of the adoption assistance, the adoption assistance payments may continue until the child reaches the age of 21 years if the local department and adoptive parents sign an addendum to the agreement to extend the agreement to the specified age. If the sole reason for continuing the agreement beyond the age of 18 years is educational delay, then state-funded adoption assistance may continue until the youth graduates from high school or until the youth's 21st birthday, whichever is earlier, if the local department and the adoptive parents sign an addendum to the agreement to extend the agreement to the end of the month of high school graduation or until the youth's 21st birthday, whichever is earlier- or
2. The initial adoption assistance agreement became effective on or after the youth's 16th birthday and the youth turned 18 years of age on or after July 1, 2016. Adoption assistance may continue until the youth reaches 21 years of age if the youth meets one of the following criteria:
 - a. Completing secondary education or an equivalent credential;
 - b. Enrolled in an institution that provides post-secondary or vocational education;
 - c. Participating in a program or activity designed to promote employment or remove barriers to employment;

d. Employed at least 80 hours a month; or

e. Is incapable of doing any of the activities described in subdivisions 2 a through 2 d of this subsection due to a medical condition, which incapability is supported by regularly updated information in the program participant's case record.

N. Adoption assistance shall not be terminated before the child's 18th birthday without the consent of the adoptive parents unless:

1. The child is no longer receiving support from the adoptive parents; or
2. The adoptive parents are no longer legally responsible for the support of the child.

O. Local boards of social services are responsible for informing adoptive parents in writing of their right to appeal decisions relating to the child's eligibility for adoption assistance and decisions relating to payments and services to be provided within 30 days of receiving written notice of such decisions. In accordance with § 63.2-1304 of the Code of Virginia applicants for, and recipients of, adoption assistance shall have the right to appeal adoption assistance decisions by a local board or licensed child-placing agency in granting, denying, changing, or discontinuing adoption assistance.

VA.R. Doc. No. R17-4957; Filed September 11, 2017, 8:57 a.m.

GOVERNOR

EXECUTIVE ORDER NUMBER SEVENTY ONE (2017)

DIRECTING THE COMMISSIONER OF THE DEPARTMENT OF MOTOR VEHICLES TO EXTEND THE VALIDITY OF EXPIRING DRIVER'S LICENSES AND OTHER DOCUMENTS

Importance of the Issue

On Saturday, September 2, 2017, information technology equipment managed by Northrop Grumman failed, causing interruptions to the electronic services provided by the Commonwealth's data center. This disruption greatly impacted the ability of many Virginians to renew their driver's licenses and other documents. This unforeseen disruption of services places citizens at risk of suffering fines and other costs resulting from their inability to timely renew their driver's licenses and other documents.

In order to prevent any further hardship to the citizens of Virginia, and in accordance with my authority contained in §§ 46.2-330(A) and 46.2-345 of the Code of Virginia, I hereby order the following measures:

- I hereby direct the Commissioner of the Department of Motor Vehicles, and such other executive branch agencies as they may deem appropriate in their discretion, to extend the validity period of Virginia driver's licenses, learner's permits, commercial driver's licenses, and special identification cards issued by the Commonwealth that expire September 2, 2017, through September 4, 2017, until September 11, 2017.

Effective Date of this Executive Order

This Executive Order shall be effective retroactively from September 2, 2017, and shall remain in full force and effect until September 11, 2017.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 6th day of September, 2017.

/s/ Terence R. McAuliffe
Governor

EXECUTIVE ORDER NUMBER SEVENTY TWO (2017)

DECLARATION OF A STATE OF EMERGENCY FOR THE COMMONWEALTH OF VIRGINIA DUE TO HURRICANE IRMA AND IN SUPPORT OF STATES AFFECTED BY HURRICANE IRMA

Importance of the Issue

On this date, September 7, 2017, I am declaring a state of emergency to exist for the Commonwealth of Virginia based on forecasts projecting impacts from Hurricane Irma, the strongest storm on record in the Atlantic Ocean, that could produce injuries and catastrophic damage from high winds, heavy rainfall, flooding, and damage to infrastructure causing power outages, transportation disruptions, and

communications failures across the Commonwealth of Virginia. In order to prepare for Hurricane Irma, and to assist other parts of the United States impacted, I hereby authorize state preparations under the full authorities of this office.

The health and general welfare of the citizens require that state action be taken to help alleviate the conditions caused by this situation. The effects of this incident constitute a disaster wherein human life and public and private property are imperiled, as described in § 44-146.16 of the Code of Virginia.

Therefore, by virtue of the authority vested in me by § 44-146.17 of the Code of Virginia, as Governor and as Director of Emergency Management, and by virtue of the authority vested in me by Article V, Section 7 of the Constitution of Virginia and by § 44-75.1 of the Code of Virginia, as Governor and Commander-in-Chief of the armed forces of the Commonwealth, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby confirm, ratify, and memorialize in writing my verbal orders issued on this date, September 7, 2017, whereby I am proclaiming that a state of emergency exists, and I am directing that appropriate assistance be rendered by agencies of both state and local governments to prepare for potential impacts of Hurricane Irma, alleviate any conditions resulting from the incident, and to implement recovery and mitigation operations and activities so as to return impacted areas to pre-event conditions in so far as possible. Pursuant to § 44-75.1(A)(3) and (A)(4) of the Code of Virginia, I am also directing that the Virginia National Guard and the Virginia Defense Force be called forth to state active duty to be prepared to assist in providing such aid. This shall include Virginia National Guard assistance to the Virginia Department of State Police to direct traffic, prevent looting, and perform such other law enforcement functions as the Superintendent of State Police, in consultation with the State Coordinator of Emergency Management, the Adjutant General, and the Secretary of Public Safety and Homeland Security, may find necessary.

In order to marshal all public resources and appropriate preparedness, response, and recovery measures to meet this threat and recover from its effects, and in accordance with my authority contained in § 44-46.17 of the Code of Virginia, I hereby order the following protective and restoration measures:

A. Implementation by state agencies of the Commonwealth of Virginia Emergency Operations Plan (COVEOP), as amended, along with other appropriate state agency plans.

B. Activation of the Virginia Emergency Operations Center (VEOC) and the Virginia Emergency Support Team (VEST) to coordinate the provision of assistance to local governments. I am directing that the VEOC and VEST coordinate state actions in support of affected localities, other

mission assignments to agencies designated in the COVEOP, and others that may be identified by the State Coordinator of Emergency Management, in consultation with the Secretary of Public Safety and Homeland Security, which are needed to provide for the preservation of life, protection of property, and implementation of recovery activities.

C. The evacuation of areas threatened or stricken by effects of Hurricane Irma, as appropriate. Following a declaration of a local emergency pursuant to § 44-146.21 of the Code of Virginia, if a local governing body determines that evacuation is deemed necessary for the preservation of life or other emergency mitigation, response, or recovery effort, pursuant to § 44-146.17(1) of the Code of Virginia, I direct the evacuation of all or part of the populace therein from such areas and upon such timetable as the local governing body, in coordination with the VEOC, acting on behalf of the State Coordinator of Emergency Management, shall determine. Notwithstanding the foregoing, I reserve the right to direct and compel evacuation from the same and different areas and determine a different timetable both where local governing bodies have made such a determination and where local governing bodies have not made such a determination. Also, in those localities that have declared a local emergency pursuant to § 44-146.21 of the Code of Virginia, if the local governing body determines that controlling movement of persons is deemed necessary for the preservation of life, public safety, or other emergency mitigation, response, or recovery effort, pursuant to § 44-146.17(1) of the Code of Virginia, I authorize the control of ingress and egress at an emergency area, including the movement of persons within the area and the occupancy of premises therein upon such timetable as the local governing body, in coordination with the State Coordinator of Emergency Management and the VEOC, shall determine. Violations of any order to citizens to evacuate shall constitute a violation of this Executive Order and are punishable as a Class 1 misdemeanor.

D. The activation, implementation, and coordination of appropriate mutual aid agreements and compacts, including the Emergency Management Assistance Compact (EMAC), and the authorization of the State Coordinator of Emergency Management to enter into any other supplemental agreements, pursuant to § 44-146.17(5) and § 44-146.28:1 of the Code of Virginia, to provide for the evacuation and reception of injured and other persons and the exchange of medical, fire, police, National Guard personnel and equipment, public utility, reconnaissance, welfare, transportation, and communications personnel, equipment, and supplies. The State Coordinator of Emergency Management is hereby designated as Virginia's authorized representative within the meaning of the Emergency Management Assistance Compact, § 44-146.28:1 of the Code of Virginia.

E. The authorization of the Departments of State Police, Transportation, and Motor Vehicles to grant temporary

overweight, over width, registration, or license exemptions to all carriers transporting essential emergency relief supplies, including food, water, livestock or poultry, feed or other critical supplies for livestock or poultry, heating oil, motor fuels, or propane, or providing restoration of utilities (including but not limited to electricity, gas, phone, water, wastewater, and cable) or removal of waste to, through, and from any area of the Commonwealth in order to support the disaster response and recovery, regardless of their point of origin or destination. Weight exemptions are not valid on posted structures for restricted weight. Weight exemptions are also not valid on interstate highways unless there is an associated Federal emergency declaration.

All over width loads, up to a maximum of 12 feet, and over height loads up to a maximum of 14 feet must follow Virginia Department of Motor Vehicles (DMV) hauling permit and safety guidelines.

In addition to described overweight/over width transportation privileges, carriers are also exempt from vehicle registration with the Department of Motor Vehicles. This includes vehicles en route and returning to their home base. The above-cited agencies shall communicate this information to all staff responsible for permit issuance and truck legalization enforcement.

F. This Emergency Declaration implements limited relief from the provisions 49 CFR 390-399. Accordingly, the State Coordinator of Emergency Management recognizes the exemption for hours of service by any carrier when transporting essential emergency relief supplies, passengers, property, livestock, poultry, equipment, food, waste, feed for livestock or poultry, fuel, construction materials, and other critical supplies to, through, or from any portion of the Commonwealth for purpose of providing direct relief or assistance as a result of this disaster, pursuant to § 52-8.4 of the Code of Virginia and Title 49 Code of Federal Regulations, Section 390.23 and Section 395.3.

G. The foregoing overweight/over width transportation privileges as well as the regulatory exemption provided by § 52-8.4(A) of the Code of Virginia, and implemented in 19VAC30-20-40(B) of the "Motor Carrier Safety Regulations," shall remain in effect for 30 days from the onset of the disaster, or until emergency relief is no longer necessary, as determined by the Secretary of Public Safety and Homeland Security in consultation with the Secretary of Transportation, whichever is earlier.

H. The authorization of the Commissioner of Agriculture and Consumer Services to grant a temporary waiver of the maximum vapor pressure prescribed in regulation 2VAC5-425 et seq., and to prescribe a vapor pressure limit the Commissioner deems reasonable. The temporary waiver shall remain in effect until emergency relief is no longer necessary, as determined by the Commissioner of Agriculture and Consumer Services.

I. The implementation and discontinuance of the provisions authorized in paragraphs E through G above shall be disseminated by the publication of administrative notice to all affected and interested parties. I hereby delegate to the Secretary of Public Safety and Homeland Security, after consultation with other affected Cabinet Secretaries, the authority to implement and disseminate this order as set forth in § 2.2-104 of the Code of Virginia.

J. This state of emergency constitutes a major medical emergency under the Rules and Regulations of the Board of Health Governing Emergency Medical Services, pursuant to Article 3.01 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1, of the Code of Virginia, Statewide Emergency Medical Services System and Services, and exemptions specified in the Rules and Regulations regarding patient transport and provider certification during disasters applies.

K. The temporary waiver, for a period of 90 days, of the enforcement by the Board of Pharmacy of statutory and regulatory provisions which, in the judgment of the Director of the Department of Health Professions, impede the ability of Virginia pharmacies to provide assistance to patients who have been displaced by the effects of Hurricane Irma.

L. During this declared emergency, any person who holds a license, certificate, or other permit issued by any state, or political subdivision thereof, evidencing the meeting of qualifications for professional, mechanical, or other skills, the person, without compensation other than reimbursement for actual and necessary expenses, may render aid involving that skill in the Commonwealth during a disaster, and such person shall not be liable for negligently causing the death of, or injury to, any person or for the loss of, or damage to, the property of any person resulting from such service as set forth in Code of Virginia § 44-146.23(C).

M. The authorization of appropriate oversight boards, commissions, and agencies to ease building code restrictions and to permit emergency demolition, hazardous waste disposal, debris removal, emergency landfill siting, and operations and other activities necessary to address immediate health and safety needs without regard to time-consuming procedures or formalities and without regard to application or permit fees or royalties.

N. The authorization of the Marine Resources Commissioner to act on behalf of the Commission in issuing permits pursuant to Chapter 12 of Title 28.2 of the Code of Virginia when, in the judgment of the Commissioner, it is necessary to address immediate health and safety needs and the Commissioner would be unable to convene a meeting of the full Commission in a timely manner. In an effort to address the impacts attributable to Hurricane Irma on the health, safety and general welfare of the citizens of the Commonwealth, and in an attempt to expedite the return of impacted areas and structures to pre-event conditions insofar as possible, no permits for encroachments on State-owned

submerged lands, tidal wetlands and coastal primary sand dunes or beaches shall be required to replace previously permitted structures and for beach nourishment activities along public beaches.

O. The authorization of a maximum of \$3,850,000 in state sum sufficient funds for state and local governments mission assignments authorized and coordinated through the Virginia Department of Emergency Management that are allowable as defined by The Stafford Act. This funding is also available for state response and recovery operations and incident documentation. Out of this state disaster sum sufficient, an amount estimated at \$250,000, is authorized for the Department of Military Affairs for the state's portion of the eligible disaster-related costs incurred for salaries, travel, and meals during mission assignments authorized and coordinated through the Virginia Department of Emergency Management.

P. The authorization of a maximum of \$500,000 for matching funds for the Individuals and Household Program, authorized by The Stafford Act (when presidentially authorized), to be paid from state funds.

Q. The implementation by public agencies under my supervision and control of their emergency assignments as directed in the COVEOP without regard to normal procedures pertaining to performance of public work, entering into contracts, incurring of obligations or other logistical and support measures of the Emergency Services and Disaster Laws, as provided in § 44-146.28(b) of the Code of Virginia. § 44-146.24 of the Code of Virginia also applies to the disaster activities of state agencies.

R. Designation of members and personnel of volunteer, professional, auxiliary, and reserve groups including search and rescue (SAR), Virginia Associations of Volunteer Rescue Squads (VAVRS), Civil Air Patrol (CAP), member organizations of the Voluntary Organizations Active in Disaster (VOAD), Radio Amateur Civil Emergency Services (RACES), volunteer fire fighters, volunteer emergency medical services (EMS) providers, Citizen Corps Programs such as Medical Reserve Corps (MRCs), Community Emergency Response Teams (CERTs), Office of EMS Health and Medical Emergency Response Team (HMERT) and others identified and tasked by the State Coordinator of Emergency Management for specific disaster-related mission assignments as representatives of the Commonwealth engaged in emergency services activities within the meaning of the immunity provisions of § 44-146.23(a) and (f) of the Code of Virginia, in the performance of their specific disaster-related mission assignments.

S. The activation of the statutory provisions in § 59.1-525 et seq. of the Code of Virginia related to price gouging. Price gouging at any time is unacceptable. Price gouging is even more reprehensible during a time of disaster after issuance of a state of emergency. I have directed all applicable executive branch agencies to take immediate action to address any verified reports of price gouging of necessary goods or services. I make the same request of the Office of the

Attorney General and appropriate local officials. I further request that all appropriate executive branch agencies exercise their discretion to the extent allowed by law to address any pending deadlines or expirations affected by or attributable to this disaster event.

T. The following conditions apply to the deployment of the Virginia National Guard and the Virginia Defense Force:

1. The Adjutant General of Virginia, after consultation with the State Coordinator of Emergency Management, shall make available on state active duty such units and members of the Virginia National Guard and Virginia Defense Force and such equipment as may be necessary or desirable to assist in preparations for this incident and in alleviating the human suffering and damage to property.

2. Pursuant to § 52-6 of the Code of Virginia, I authorize the Superintendent of the Department of State Police to appoint any and all such Virginia Army and Air National Guard personnel called to state active duty as additional police officers as deemed necessary. These police officers shall have the same powers and perform the same duties as the State Police officers appointed by the Superintendent. However, they shall nevertheless remain members of the Virginia National Guard, subject to military command as members of the State Militia. Any bonds and/or insurance required by § 52-7 of the Code of Virginia shall be provided for them at the expense of the Commonwealth.

3. In all instances, members of the Virginia National Guard and Virginia Defense Force shall remain subject to military command as prescribed by § 44-78.1 of the Code of Virginia and are not subject to the civilian authorities of county or municipal governments. This shall not be deemed to prohibit working in close cooperation with members of the Virginia Departments of State Police or Emergency Management or local law enforcement or emergency management authorities or receiving guidance from them in the performance of their duties.

4. Should service under this Executive Order result in the injury or death of any member of the Virginia National Guard, the following will be provided to the member and the member's dependents or survivors:

a. Workers' Compensation benefits provided to members of the National Guard by the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof; and, in addition,

b. The same benefits, or their equivalent, for injury, disability, and/or death, as would be provided by the federal government if the member were serving on federal active duty at the time of the injury or death. Any such federal-type benefits due to a member and his or her dependents or survivors during any calendar month shall be reduced by any payments due under the Virginia Workers' Compensation Act during the same month. If and when the time period for payment of Workers' Compensation

benefits has elapsed, the member and his or her dependents or survivors shall thereafter receive full federal-type benefits for as long as they would have received such benefits if the member had been serving on federal active duty at the time of injury or death. Any federal-type benefits due shall be computed on the basis of military pay grade E-5 or the member's military grade at the time of injury or death, whichever produces the greater benefit amount. Pursuant to § 44-14 of the Code of Virginia, and subject to the availability of future appropriations which may be lawfully applied to this purpose, I now approve of future expenditures out of appropriations to the Department of Military Affairs for such federal-type benefits as being manifestly for the benefit of the military service.

5. The following conditions apply to service by the Virginia Defense Force:

a. Virginia Defense Force personnel shall receive pay at a rate equivalent to a National Guard soldier of like rank, not to exceed 25 years of service.

b. Lodging and meals shall be provided by the Adjutant General or reimbursed at standard state per diem rates;

c. All privately owned equipment, including, but not limited to, vehicles, boats, and aircraft, will be reimbursed for the expense of fuel. Damage or loss of said equipment will be reimbursed, minus reimbursement from personal insurance, if said equipment was authorized for use by the Adjutant General in accordance with § 44-54.12 of the Code of Virginia;

d. In the event of death or injury, benefits shall be provided in accordance with the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof.

Upon my approval, the costs incurred by state agencies and other agents in performing mission assignments through the VEOC of the Commonwealth as defined herein and in § 44-146.28 of the Code of Virginia, other than costs defined in the paragraphs above pertaining to the Virginia National Guard and pertaining to the Virginia Defense Force, in performing these missions shall be paid from state funds.

Effective Date of this Executive Order

This Executive Order shall be effective September 7, 2017, and shall remain in full force and effect until June 30, 2018 unless sooner amended or rescinded by further executive order. Termination of the Executive Order is not intended to terminate any federal-type benefits granted or to be granted due to injury or death as a result of service under this Executive Order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 7th day of September, 2017.

/s/ Terence R. McAuliffe
Governor

GENERAL NOTICES/ERRATA

BOARD OF ACCOUNTANCY

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Board of Accountancy conducted a small business impact review of **18VAC5-11, Public Participation Guidelines**, and determined that this regulation should be retained in its current form. The Board of Accountancy is publishing its report of findings dated August 31, 2017, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

The agency determined this regulation continues to be necessary as it is required by § 2.2-4007.02 of the Code of Virginia and establishes the mechanisms by which the agency will advise the public of the agency's regulatory actions. The agency has not received any comments or complaints regarding this regulation. The regulation is not complex and is easily understood. The regulation does not overlap, duplicate, or conflict with federal or state law or regulation. The regulation was promulgated in 2008 using the model public participation guidelines issued by the Department of Planning and Budget. This periodic review is the first evaluation of this regulation subsequent to its adoption in 2008. No factors have changed since 2008 that necessitate amending this regulation. This regulation places no economic burden on any small business.

Contact Information: 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.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

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 Agriculture and Consumer Services is currently reviewing each of the regulations listed below to determine whether the regulation should be repealed, amended, or retained in its current form. The review of each regulation will be guided by the principles in Executive Order 17 (2014). Public comment is sought on the review of any issue relating to each 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.

2VAC5-320, Regulations for the Enforcement of the Endangered Plant and Insect Species Act

2VAC5-321, Regulation of the Harvest and Purchase of Wild Ginseng

Contact Information: Debra Martin, Program Manager, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-3515, FAX (804) 371-7793, or email debra.martin@vdacs.virginia.gov.

The comment period begins October 2, 2017, and ends October 23, 2017.

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 Virginia Regulatory Town Hall, and a report of the small business impact review will be published in the Virginia Register of Regulations.

CHARITABLE GAMING 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 Charitable Gaming Board is conducting a periodic review and small business impact review of **11VAC15-40, Charitable Gaming Regulations**. 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 October 2, 2017, and ends October 23, 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 Michael Menefee, Program Manager, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-3983, FAX (804) 371-7479, or email michael.menefee@vdacs.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

Stagecoach Solar LLC Notice of Intent for Small Renewable Energy (Solar) Project Permit by Rule - Halifax County

Stagecoach Solar, LLC has provided 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 Halifax County, Virginia, pursuant to 9VAC15-60. Stagecoach Solar, LLC is a 15-megawatt alternating current (AC) solar project located on multiple parcels comprising approximately 318 acres south of Stage Coach Road near Nathalie in Halifax, Virginia. The project conceptually consists of approximately 162,000 120-watt modules across six 2.5 megawatt AC arrays.

Contact Information: Mary E. Major, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4423, FAX (804) 698-4510, or email mary.major@deq.virginia.gov.

STATE BOARD OF HEALTH

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 Health is conducting a periodic review and small business impact review of **12VAC5-650, Schedule of Civil Penalties**. 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 October 2, 2017, and ends October 23, 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 Allen Knapp, Office Director, Virginia Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7458, FAX (804) 864-7475, or email allen.knapp@vdh.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.

BOARD OF MEDICAL ASSISTANCE

Draft Durable Medical Equipment and Supplies Provider Manual for Stakeholder Input

The draft version of Chapter IV of the Durable Medical Equipment and Supplies (DME) Manual is posted on the Department of Medical Assistance Services website for public comment through October 1, 2017. For convenience of the public, the updates are marked in red and can be found on page 31 of the DME Manual. The draft DME Manual may be viewed at http://www.dmas.virginia.gov/Content_pgs/pd-pmnl.aspx.

The finalized version of the DME Manual will be officially posted by October 6, 2017, on the website at <https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/providermanual>.

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.

Draft Residential Treatment Services, Psychiatric Services, and Community Mental Health Rehabilitation Services Provider Manuals for Stakeholder Input

The draft Residential Treatment Services, Community Mental Health Rehabilitation Services (CMHRS), and Psychiatric Services provider manuals are posted on the Department of Medical Assistance Services website for public comment through October 7, 2017. Please see the overview and chart below for more details.

Overview of changes: The changes in the Residential Treatment Services Manual include adding language to the Therapeutic Passes section in Chapter IV and clarifying policy for seclusion and restraint to align with regulatory requirements. The changes in the Psychiatric Services and CMHRS manuals include the removal of the residential and group home coverage and reference to the new Residential Treatment Services Manual for policy on residential and therapeutic group home services.

View the draft manuals at http://www.dmas.virginia.gov/Content_pgs/pd-pmnl.aspx.

General Notices/Errata

Manual Name	Chapter/Appendix
Residential Treatment Services	Chapter IV
CMHRS	Chapter II
CMHRS	Chapter IV
CMHRS	Chapter VI
CMHRS	Appendix C
Psychiatric Services	Chapter II
Psychiatric Services	Chapter IV
Psychiatric Services	Appendix C

The finalized version of the manuals will be officially posted by October 16, 2017, at <https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/providermanual>.

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 Enforcement Action for Hydro-FS, LLC

An enforcement action has been proposed for Hydro-FS, LLC for violations of State Water Control Law that occurred in Falling Spring, 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, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23219, from October 2, 2017, through November 1, 2017.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information: *Mailing Address:* Virginia Code Commission, Pocahontas Building, 900 East Main Street, 8th 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/cumulatab.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.

ERRATA

STATE WATER CONTROL BOARD

Title of Regulation: **9VAC25-260. Water Quality Standards (amending 9VAC25-260-140, 9VAC25-260-155, 9VAC25-260-170).**

Publication: 34:2 VA.R. 193-236 September 18, 2017

Correction to Proposed Regulation:

Page 193, Public Hearing Information, replace "No public hearings are scheduled" with:

October 24, 2017 - 2 p.m. - Department of Environmental Quality, 629 East Main Street, 2nd Floor Conference Rooms, Richmond, VA 23219

VA.R. Doc. No. R18-2148; Filed September 22, 2017

Title of Regulation: **9VAC25-590. Petroleum Underground Storage Tank Financial Responsibility Requirements.**

Publication: 34:1 VA.R. 12-68 September 4, 2017

Correction to Titles of Regulations:

Page 12, column 2, line 9, after "9VAC25-590-260" add ", Appendices I, II, V, VI, VII, and XII"

VA.R. Doc. No. R18-4454