VIRGINIA
REGISTER OF REGULATIONS

VOL. 36 ISS. 11 PUBLISHED EVERY OTHER WEEK BY THE VIRGINIA CODE COMMISSION JANUARY 20, 2020

TABLE OF CONTENTS

THE VIRGINIA REGISTER OF REGULATIONS (USPS 001-831) is published biweekly for $263.00 per year by Matthew Bender & Company, Inc., 3 Lear Jet Lane, Suite 102, P.O. Box 1710, Latham, NY 12110. Periodical postage is paid at Easton, MD and at additional mailing offices. POSTMASTER: Send address changes to The Virginia Register of Regulations, 4810 Williamsburg Road, Unit 2, Hurlock, MD 21643.

Table of Contents

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. **34:8 VA.R. 763-832 December 11, 2017,** refers to Volume 34, Issue 8, pages 763 through 832 of the *Virginia Register* issued on December 11, 2017.

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

PUBLICATION SCHEDULE AND DEADLINES

This schedule is available on the Virginia Register of Regulations website (http://register.dls.virginia.gov).

February 2020 through December 2020

Volume: Issue	Material Submitted By Noon*	Will Be Published On
36:13	January 29, 2020	February 17, 2020
36:14	February 12. 2020	March 2, 2020
36:15	February 26, 2020	March 16, 2020
36:16	March 11, 2020	March 30, 2020
36:17	March 25, 2020	April 13, 2020
36:18	April 8, 2020	April 27, 2020
36:19	April 22. 2020	May 11, 2020
36:20	May 6, 2020	May 25, 2020
36:21	May 20, 2020	June 8, 2020
36:22	June 3, 2020	June 22, 2020
36:23	June 17, 2020	July 6, 2020
36:24	July 1, 2020	July 20, 2020
36:25	July 15, 2020	August 3, 2020
36:26	July 29, 2020	August 17, 2020
37:1	August 12, 2020	August 31, 2020
37:2	August 26, 2020	September 14, 2020
37:3	September 9, 2020	September 28, 2020
37:4	September 23, 2020	October 12, 2020
37:5	October 7, 2020	October 26, 2020
37:6	October 21, 2020	November 9, 2020
37:7	November 4, 2020	November 23, 2020
37:8	November 16, 2020 **(Monday)**	December 7, 2020
37:9	December 2, 2020	December 21, 2020

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 2. AGRICULTURE

BOARD OF AGRICULTURE AND CONSUMER SERVICES

Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Board of Agriculture and Consumer Services conducted a small business impact review of **2VAC5-20, Standards for Classification of Real Estate as Devoted to Agricultural Use and to Horticultural Use under the Virginia Land Use Assessment Law**, and determined that this regulation should be amended.

The proposed regulatory action to amend 2VAC5-20, which is published in this issue of the Virginia Register, serves as the report of findings.

Agency Contact: Kevin Schmidt, Director, Office of Policy, Planning and Research, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-1346, FAX (804) 371-7679, TTY (800) 828-1120, or email kevin.schmidt@vdacs.virginia.gov.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

BOARD OF CONSERVATION AND RECREATION

Agency Notice

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the following regulation is undergoing a periodic review: **4VAC3-11, Public Participation Guidelines**. The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018).

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.

Public comment period begins January 20, 2020, and ends February 10, 2020.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm or sent to the agency contact.

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.

Contact Information: Lisa McGee, Policy and Planning Director, Department of Conservation and Recreation, 600 East Main Street, 24th Floor, Richmond, VA 23219, telephone (804) 786-4378, FAX (804) 786-6141, or email lisa.mcgee@dcr.virginia.gov.

DEPARTMENT OF CONSERVATION AND RECREATION

Agency Notice

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the following regulation is undergoing a periodic review: **4VAC5-11, Public Participation Guidelines**. The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018).

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telephone (804) 786-4378, FAX (804) 786-6141, or email lisa.mcgee@dcr.virginia.gov.

TITLE 12. HEALTH

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the State Board of Behavioral Health and Developmental Services conducted a small business impact review of **12VAC35-180, Regulations to Assure the Protection of Subjects in Human Research**, and determined that this regulation should be amended.

The fast-track regulatory action to amend 12VAC35-180, which is published in this issue of the Virginia Register, serves as the report of findings.

Agency Contact: Ruth Anne Walker, Director of Regulatory Affairs, Department of Behavioral Health and Developmental Services, Jefferson Building, 1220 Bank Street, 11th Floor, Richmond, VA 23219, telephone (804) 225-2252, FAX (804) 786-8623, TTY (804) 371-8977, or email ruthanne.walker@dbhds.virginia.gov.

TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department for Aging and Rehabilitative Services conducted a small business impact review of **22VAC30-100, Adult Protective Services**, and determined that this regulation should be amended.

The proposed regulatory action to amend 22VAC30-100, which is published in this issue of the Virginia Register, serves as the report of findings.

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.

TITLE 24. TRANSPORTATION AND MOTOR VEHICLES

COMMONWEATH TRANSPORTATION BOARD

Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Commonwealth Transportation Board conducted a small business impact review of **24VAC30-530, Roadway and Structure Lighting**, and determined that this regulation should be repealed.

The final regulatory action to amend 24VAC30-530, which is published in this issue of the Virginia Register, serves as the report of findings.

Agency Contact: Jo Anne P. Maxwell, Regulatory Coordinator, Policy Division, Department of Transportation, 11th Floor, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-1830, or email joanne.maxwell@vdot.virginia.gov.

Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Commonwealth Transportation Board conducted a small business impact review of **24VAC30-580, Guidelines for Considering Requests for Restricting Through Trucks on Primary and Secondary Highways**, and determined that this regulation should be amended.

The final regulatory action to amend 24VAC30-580, which is published in this issue of the Virginia Register, serves as the report of findings.

Agency Contact: Jo Anne P. Maxwell, Regulatory Coordinator, Policy Division, Department of Transportation, 11th Floor, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-1830, or email joanne.maxwell@vdot.virginia.gov.

Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Commonwealth Transportation Board conducted a small business impact review of **24VAC30-590, Policies and Procedures for Control of Residential and Non-Residential Cut-Through Traffic**, and determined that this regulation should be repealed.

The final regulatory action to amend 24VAC30-590, which is published in this issue of the Virginia Register, serves as the report of findings.

Agency Contact: Jo Anne P. Maxwell, Regulatory Coordinator, Policy Division, Department of Transportation, 11th Floor, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-1830, or email joanne.maxwell@vdot.virginia.gov.

NOTICES OF INTENDED REGULATORY ACTION

TITLE 1. ADMINISTRATION

DEPARTMENT OF GENERAL 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 of General Services intends to consider amending **1VAC30-45, Certification of Noncommercial Environmental Laboratories** and **1VAC30-46, Accreditation for Commercial Environmental Laboratories**. 1VAC30-46 sets out the requirements to accredit commercial laboratories that analyze environmental samples used to determine compliance with State Water Control Law, Virginia Waste Management Act, and Virginia Pollution Control Law. 1VAC30-46 uses the National Environmental Laboratory Accreditation Conference (NELAC) Institute (TNI) standards for this accreditation. The TNI standards are revised every few years, and the proposed action replaces the 2009 TNI standards in the regulation with the 2016 TNI standards. Commercial environmental laboratories must meet these standards to remain accredited under the nationally-accepted TNI program. 1VAC30-45 sets out the requirements to certify noncommercial laboratories that analyze environmental samples used to determine compliance with the State Water Control Law, Virginia Waste Management Act, and the Virginia Air Pollution Control Law. The proposed action revises 1VAC30-45 to include proposed changes in the 2016 TNI Standards that provide more flexibility so that the standards for noncommercial environmental laboratories are no more stringent than the standards for commercial environmental laboratories.

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

Statutory Authority: § 2.2-1105 of the Code of Virginia.

Public Comment Deadline: February 19, 2020.

Agency Contact: Rhonda Bishton, Director's Executive Administrative Assistant, Department of General Services, 1100 Bank Street, Suite 420, Richmond, VA 23219, telephone (804) 786-3311, FAX (804) 371-8305, or email rhonda.bishton@dgs.virginia.gov.

VA.R. Doc. No. R20-6196; Filed December 19, 2019, 9:02 a.m.

TITLE 8. EDUCATION

STATE BOARD OF EDUCATION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Education intends to consider amending **8VAC20-543, Regulations Governing the Review and Approval of Education Programs in Virginia**. The purpose of the proposed action is to establish dual language endorsements for preK through grade 6 and an economics and personal finance add-on endorsement. Amendments to 8VAC20-23, Licensure Regulations for School Personnel, regarding these endorsements are proposed in a separate regulatory action; however, the endorsements also should be included in the Regulations Governing the Review and Approval of Education Programs in Virginia. The endorsement in dual language is required by Chapter 391 of the 2018 Acts of Assembly, and the endorsement in economics and personal finance will expand the number of teachers who may teach economics and personal finance.

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

Statutory Authority: § 22.1-298.2 of the Code of Virginia.

Public Comment Deadline: February 19, 2020.

Agency Contact: Patty Pitts, Assistant Superintendent for Teacher Education and Licensure, Department of Education, P.O. Box 2120, Richmond, VA 23219, telephone (804) 371-2522, or email patty.pitts@doe.virginia.gov.

VA.R. Doc. No. R20-6234; Filed December 23, 2019, 3:39 p.m.

TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Extension of Public Comment Deadline

EDITOR'S NOTICE: The State Water Control Board has extended the public comment deadline until February 19, 2020, for the Notice of Intended Regulatory Action previously published in 36:7 VA.R. 986 November 25, 2019. The notice is republished here.

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Water Control Board intends to consider amending **9VAC25-720, Water Quality Management Planning Regulation** and **9VAC25-820, General Virginia Pollutant Discharge Elimination System (VPDES) Watershed Permit Regulation for Total Nitrogen and Total Phosphorus Discharges and Nutrient**

Trading in the Chesapeake Bay Watershed in Virginia. The Water Quality Management Planning Regulation (9VAC25-720) includes wasteload allocations for dischargers of pollutants to various river basins throughout the Commonwealth of Virginia including total nitrogen (TN) and total phosphorus (TP) wasteload allocations necessary for the restoration of water quality in the Chesapeake Bay and its tidal tributaries. The purpose of the proposed action is to amend 9VAC25-720-50 C (Potomac-Shenandoah River Basin), 9VAC25-720-60 C (James River Basin), 9VAC25-720-70 C (Rappahannock River Basin), 9VAC25-720-110 C (Chesapeake Bay – Small Coastal – Eastern Shore River Basin), and 9VAC25-720-120 C (York River Basin) to (i) establish TN and TP wasteload allocations to meet revised water quality criteria for Chlorophyll-a in the tidal James River Basin; (ii) reallocate any unneeded significant industrial discharger allocations to other facilities registered under the General Virginia Pollutant Discharge Elimination System Watershed Permit Regulation for Total Nitrogen and Total Phosphorus Discharges and Nutrient Trading in the Chesapeake Bay Watershed in Virginia (9VAC25-820) or reserve any unneeded allocations for future use; and (iii) establish floating wasteload allocations for significant municipal dischargers based on the average daily flow treated by the facility in a given year and nutrient concentrations of 4.0 mg/l TN and 0.30 mg/l TP. Existing "primary" wasteload allocations will remain, and in any given year the facility will be required to meet the lesser of the primary or floating allocations. Facilities with special circumstances could be assigned alternative floating wasteload allocations or possibly no floating wasteload allocation. The board may consider exempting a subset of the smallest significant dischargers that in aggregate represent a minor percentage of the expected load reductions from this regulatory action. Special consideration may also be appropriate for treatment plants that reclaim and reuse a significant portion of their wastewater flow. The board may, if necessary to implement amendments to 9VAC25-720, also propose amendments to 9VAC25-820.

In addition, pursuant to Executive Order 14 (as amended, July 16, 2018) and § 2.2-4007.1 of the Code of Virginia, the agency is conducting a periodic review and small business impact review of 9VAC25-720 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; (ii) minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

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

Statutory Authority: § 62.1-44.15 of the Code of Virginia; 33 USC § 1313(e) of the Clean Water Act.

Public Comment Deadline: February 19, 2020.

Agency Contact: Gary E. Graham, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 689-4103, FAX (804) 698-4319, or email gary.graham@deq.virginia.gov.

VA.R. Doc. No. R20-6191; Filed January 2, 2020, 9:53 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD FOR HEARING AID SPECIALISTS AND OPTICIANS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board for Hearing Aid Specialists and Opticians intends to consider amending **18VAC80-20, Hearing Aid Specialists Regulations**. The purpose of the proposed action is to adjust hearing aid specialist licensing fees based on projected revenues and expenses to meet the requirements of § 54.1-113 of the Code of Virginia while being the least burdensome to the licensee population. The board must establish fees adequate to support the costs of board operations and a proportionate share of the Department of Professional and Occupational Regulation operations. By the close of the next biennium, current fees will not provide adequate revenue for those costs, and the board has no other source of revenue from which to fund its operations.

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

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

Public Comment Deadline: February 19, 2020.

Agency Contact: Stephen Kirschner, Executive Director, Board for Hearing Aid Specialists and Opticians, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8590 or email hearingaidspec@dpor.virginia.gov.

VA.R. Doc. No. R20-5959; Filed December 24, 2019, 9:36 a.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Social Services intends to consider amending **22VAC40-201, Permanency Services - Prevention, Foster Care, Adoption, and Independent Living**. The purpose of the proposed action is to (i) align the regulation with Chapters 282, 301, 437, 446, and 677 of the 2019 Acts of Assembly; (ii) align the regulation with changes in federal law resulting from the 2018 Family First Prevention Services Act; and (iii) make other changes the agency deems necessary after comments and review. The proposed action will include changes to regulations on credit freezes, notification of a child with a developmental disability, qualified residential treatment programs, relative search and notification, placement authority of the Commissioner of the Department of Social Services, a foster care complaint system, birth parent engagement, and caseload standard.

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

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

Public Comment Deadline: February 19, 2020.

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.

VA.R. Doc. No. R20-6266; Filed December 18, 2019, 10:09 a.m.

TITLE 1. ADMINISTRATION

STATE BOARD OF ELECTIONS

Fast-Track Regulation

Title of Regulation: **1VAC20-90. Campaign Finance and Political Advertisements (repealing 1VAC20-90-20).**

Statutory Authority: § 24.2-103 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 20, 2020.

Effective Date: April 1, 2020.

Agency Contact: Arielle Schneider, Policy Analyst, Department of Elections, 1100 Bank Street, Floor 1, Richmond, VA 23220, telephone (804) 864-8933, or email arielle.schneider@elections.virginia.gov.

Basis: The Virginia Department of Elections is promulgating this regulation on behalf of the State Board of Elections, which is authorized under the § 24.2-103 of the Code of Virginia, to make rules and regulations and issue instructions and provide information to promote the proper administration of election laws.

Purpose: The rationale for the regulatory change is compliance with the Campaign Finance Disclosure Act (§ 24.2-945 et seq.) of the Code of Virginia, in which the General Assembly has determined that the means by which campaign finance reports submitted to the State Board of Elections is electronic. The department's goal of protecting the health and safety of the public must be supported by its regulatory instructions to candidates and committees.

Rationale for Using Fast-Track Rulemaking Process: The State Board of Elections is the policy-making board responsible for election law regulations. This repeal is expected to be noncontroversial because the regulation under consideration applies to law that no longer exists.

Substance: The amendments repeal the obsolete filing provision and associated fee.

Issues: There are no primary advantages or disadvantages to the public. The primary advantage to the department is conformity with the Code of Virginia so that agency guidelines and regulations support existing law. There are no disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Board of Elections (Board) seeks to eliminate section 1VAC20-90-20 (Filing Fee) for campaign finance reports that are not filed electronically. This section was promulgated when campaign committees had the option to file nonelectronic campaign finance reports, upon payment of a $25 administrative fee to the Department of Elections to have the report transcribed. However, the Board has since transitioned to using electronic submissions exclusively, making the fee redundant.

Background. Section 24.2-947.5 of the Code of Virginia contains the campaign finance reporting requirements, including electronic submissions. The language in 1VAC20-90-20 directs campaign committees that file a nonelectronic campaign finance report with the Board under § 24.2-947.5 to pay a $25 administrative fee per report to the Board. It further says that the fee shall be paid by the filing deadline or upon filing the report, whichever is later, and that committees that are indigent may request a waiver from the Board.

The 2018 Acts of Assembly (Chapter 538) revised the Code of Virginia such that all regulants who would be required to file the report with the Board would have to do so electronically. Specifically, § 24.2-947.5 now says that candidates for statewide office and the General Assembly, as well as candidates for a local or constitutional office in any locality whose population exceeds 70,000, shall file campaign finance reports with the Board electronically. Candidates for local or constitutional offices in localities with fewer than 70,000 people may file electronically with the Board or file paper reports with the general registrar of the locality in which the candidate resides. Since candidates no longer have the option to file paper copies of the required reports with the Board, any associated administrative fees no longer apply. Hence the Board seeks to repeal the fee.

Estimated Benefits and Costs. The proposed amendment appears to benefit the public by aligning the Virginia Administrative Code with the Code of Virginia, and potentially reducing confusion for readers of the regulation. The proposed amendment does not create any new initial or ongoing cost to the public.

Businesses and Other Entities Affected. The proposed amendment does not appear to particularly affect any business or other entities.

Localities[2] Affected.[3] The proposed amendment does not appear to affect particular localities or introduce new costs for local governments. Accordingly, no additional funds would be required.

Projected Impact on Employment. The proposed amendment does not appear to affect total employment.

Effects on the Use and Value of Private Property. The proposed amendment has no effect on the use and value of private property, nor does it affect real estate development costs.

Adverse Effect on Small Businesses:[4] The proposed amendment does not adversely affect small businesses.

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[2]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[3]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[4]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."

Agency's Response to Economic Impact Analysis: The Virginia Department of Elections concurs with the economic impact analysis of the Department of Planning and Budget.

Summary:

The action repeals a fee associated with staff transcribing any nonelectronic campaign finance report submitted to the State Board of Elections by a candidate who opted to use the paper filing provision during the years that submitting campaign finance reports electronically was optional. Chapter 538 of the 2018 Acts of Assembly made electronic filing with the board mandatory, making the fee unnecessary.

1VAC20-90-20. ~~Filing fee.~~ (Repealed.)

~~Any campaign committee that files a nonelectronic, campaign finance report with the State Board of Elections under § 24.2-947.5 of the Code of Virginia shall pay a $25 administrative fee per report to the State Board of Elections. Such payment shall be due by the filing deadline for the report or upon filing the report, whichever is later. Any committee that is indigent may request a waiver from the State Board of Elections.~~

VA.R. Doc. No. R20-6151; Filed December 31, 2019, 2:32 p.m.

TITLE 2. AGRICULTURE

BOARD OF AGRICULTURE AND CONSUMER SERVICES

Proposed Regulation

Title of Regulation: **2VAC5-20. Standards for Classification of Real Estate as Devoted to Agricultural Use and to Horticultural Use under the Virginia Land Use Assessment Law (amending 2VAC5-20-10 through 2VAC5-20-40).**

Statutory Authority: § 58.1-3230 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: March 20, 2020.

Agency Contact: Kevin Schmidt, Director, Office of Policy, Planning and Research, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-1346, FAX (804) 371-7679, TTY (800) 828-1120, or email kevin.schmidt@vdacs.virginia.gov.

Basis: Section 3.2-102 A of the Code of Virginia states that the Commissioner of the Department of Agriculture and Consumer Services (VDACS) shall be vested with the powers and duties set out in §§ 2.2-601 and 3.2-102 of the Code of Virginia and such other powers and duties as may be prescribed by law.

Section 58.1-3230 of the Code of Virginia requires that the commissioner prescribe uniform standards in accordance with the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) for "real estate devoted to agricultural use" and "real estate devoted to horticultural use," and Chapter 504 of the 2018 Acts of Assembly expands the scope of the standards in § 58.1-3230 requiring the commissioner revise 2VAC5-20.

Purpose: The proposed change will bring the regulation into compliance with the changes made to Article 4 (§ 58.1-3229 et seq.) of Chapter 32 of the Code of Virginia by Chapter 504 of the 2018 Acts of Assembly. Additionally, VDACS staff has identified parts of the regulation that needs clarifying so that the commissioner is better able to provide opinions upon request by commissioners of the revenue or local assessing officers. This regulatory action does not impact public health or safety; however, general public welfare is protected when regulations are in compliance with statutory requirements. Additionally, commissioners of the revenue, local assessing officers, and individual landowners will all benefit from standards that are clear and consistent.

Substance: The proposed amendments to the regulation include standards for determining whether real estate meets the expanded definition of real estate devoted to agricultural use or real estate devoted to horticultural use. Specifically, the

amendments include standards for determining whether real estate is (i) devoted to the bona fide production for sale of plants and animals, or products made from such plants and animals on the real estate, that are useful to man; (ii) devoted to the bona fide production for sale of fruits of all kinds, including grapes, nuts, and berries; vegetables; nursery and floral products; and plants or products directly produced from fruits, vegetables, nursery and floral products, or plants on such real estate; or (iii) devoted to and meeting the requirements and qualifications for payments or other compensation pursuant to soil and water conservation programs under an agreement with an agency of the state or federal government under uniform standards prescribed by the commissioner in accordance with the Administrative Process Act. The proposed amendments also remove the existing requirement that real estate be used for a particular purpose for a minimum length of time before qualifying as real estate devoted to agricultural use or horticultural use.

Issues: As a result of recent requests from commissioners of the revenue and local assessing officers for the commissioner to issue opinions pursuant to 2VAC5-20-40, agency staff and legal counsel have identified language in the existing regulation that needs clarifying. The proposed amendments to this regulation provide that clarity. Landowners and other members of the public will also benefit from clarification as to what is required for a parcel of land to be considered real estate devoted to agricultural use or to horticultural use. The removal of the five-year previous use requirement may also encourage additional agricultural land that is not currently being farmed to be made available for agricultural use. There are no disadvantages to the public or the Commonwealth.

Small Business Impact Review Report of Findings: This proposed regulatory action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Commissioner of Agriculture and Consumer Services (Commissioner) proposes amendments to this regulation for consistency with changes to the Virginia Land Use Assessment Law (Law), § 58.1-3229 et seq., that occurred through Chapter 504 of the 2018 Acts of Assembly (Chapter 504).

Background. The regulation includes a preamble that states that the purpose of the regulation is to: 1) Encourage the proper use of real estate in order to assure a readily available source of agricultural, horticultural, and forest products, and of open space within reach of concentrations of population; 2) Conserve natural resources in forms that will prevent erosion; 3) Protect adequate and safe water supplies; 4) Preserve scenic natural beauties and open spaces; 5) Promote proper land-use planning and the orderly development of real estate for the accommodation of an expanding population; and 6) Promote a balanced economy and ease pressures that force the conversion of real estate to more intensive uses.

The Law authorizes localities that have adopted a land-use plan to adopt an ordinance to provide for the use value assessment and taxation of real estate classified in § 58.1-3230. Use value assessment is in contrast to fair market value assessment. Fair market value is essentially the amount one could expect to sell a parcel for if no further restrictions were placed on its use other than those placed on the parcel through the local political process. Use value is the amount that one would expect to sell the land for if it were restricted to a pre-defined use. For instance, agricultural use value is the amount one would expect to receive if the land were to be maintained solely in agricultural use. As the options for land use are restricted, one would typically find that use value is less than fair market value.[2]

In practice, localities often choose to have use value ordinances to discourage the conversion of land from a preferred purpose such as agriculture, to a less preferred purpose, such as an additional housing development. Since keeping real estate in agriculture may result in lower property value assessments with the use value, it may lower the real estate tax bill for the owner.

Section 58.1-3230 establishes four special classifications of real estate for the purposes of the Law, including "real estate devoted to agricultural use" and "real estate devoted to horticultural use." The definitions of both real estate devoted to agricultural use and real estate devoted to horticultural use in the Law require the Commissioner to prescribe uniform standards in accordance with the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). As directed by this requirement, the Commissioner promulgated thisregulation, which first became effective in 1988.

The regulation includes specified activities associated with agriculture or horticulture that must occur on the property for it to qualify as "real estate devoted to agricultural use" or "real estate devoted to horticultural use." In order for the property to qualify, the owner must certify that the real estate is being used in a planned program of practices that: 1) With respect to real estate devoted to a use that disturbs the soil or that affects water quality, is intended to (in the case of soil) reduce or prevent soil erosion and (in the case of water) improve water quality by best management practices, such as terracing, cover cropping, strip cropping, no-till planting, sodding waterways, diversions, water impoundments, and other best management practices, to the extent that best management practices exist for that use of the real estate; 2) With respect to real estate devoted to crops grown in the soil, is intended to maintain soil nutrients by the application of soil nutrients (organic and inorganic) needed to produce average yields of such crops or as recommended by soil tests; and 3) Is intended to control brush, woody growth, and noxious

weeds on row crops, hay, and pasture by the use of herbicides, biological controls, cultivation, mowing, or other normal cultural practices.

Estimated Benefits and Costs. The Commissioner proposes several amendments to the regulation that mirror changes to the Law from Chapter 504. The changes generally expand the situations where real estate qualifies as "real estate devoted to agricultural use" or "real estate devoted to horticultural use." To the extent that local commissioners of revenue and landowners are already aware of the changes to the Law, these proposed changes to the regulation should not have a large impact. The changes would be beneficial in that they would reduce the likelihood of confusion as toward the law in effect for readers of the regulation.

The current regulation includes a requirement that for real estate to qualify for designation as "real estate devoted to agricultural use" or "real estate devoted to horticultural use," it must have been devoted, for at least five consecutive years previously, to specified activities associated with agriculture or horticulture. The current regulation also specifies minimum field crop production and minimum sales over the previous three years. Chapter 504 inserted the following statement into the Law:

> If the uniform standards prescribed by the Commissioner of Agriculture and Consumer Services pursuant to § 58.1-3230 require real estate to have been used for a particular purpose for a minimum length of time before qualifying as real estate devoted to agricultural use or horticultural use, then (i) use of other similar property by a lessee of the owner shall be included in calculating such time and (ii) the Commissioner of Agriculture and Consumer Services shall include in the uniform standards a shorter minimum length of time for real estate with no prior qualifying use, provided that the owner submits a written document of the owner's intent regarding use of the real estate containing elements set out in the uniform standards. Localities are not required to maintain such written document.

The Commissioner proposes to eliminate the requirement that the land have been devoted, for at least five consecutive years previously, to specified activities associated with agriculture or horticulture and instead have the applicant certify that the real estate currently is devoted to the specified activities. Mirroring the Law, those activities are: 1) Be devoted to the bona fide production for sale of plants or animals that are useful to man; 2) Be devoted to the bona fide production for sale of products that are useful to man and that are made on the real estate from plants or animals produced on the real estate; 3) Be devoted to the bona fide production for sale of fruit of all kinds, including grapes, nuts, and berries; 4) Be devoted to the bona fide production for sale of vegetables; 5) Be devoted to the bona fide production for sale of nursery or floral products; 6) Be devoted to the bona fide production for sale of plants or products directly produced on such real estate from fruits, vegetables, nursery or floral products, or plants produced on such real estate; or 7) Be devoted to and meet the requirements and qualifications for payments or other compensation pursuant to a soil and water conservation program under an agreement with an agency of the state or federal government.

This proposed change would very likely increase the number of properties that qualify as "real estate devoted to agricultural use" or "real estate devoted to horticultural use," since meeting at least one of those activities in the present is substantially easier to achieve than to do so for five consecutive years. The Commissioner also proposes to remove the three-year requirements for minimum field crop production and minimum sales. These proposed amendments also make it easier for properties to qualify, and would likely increase the number of properties that are designated as "real estate devoted to agricultural use" or "real estate devoted to horticultural use." To the extent that the specified activities are preferable to alternative uses of the land such as building new houses or office buildings, and to the extent that the property owner maintains the best management practices required for qualification, the proposed amendments would be beneficial.

Since more properties would qualify, more real estate would be assessed at the typically lower use value rather than the fair market value. Owners of the qualified properties would often pay lower real estate taxes. Thus, localities that have ordinances for use value assessments for agricultural and/or horticultural real estate may receive lower revenue.

Businesses and Other Entities Affected. All owners of real estate in the Commonwealth that is not exempt from taxation are potentially affected. Owners of real estate located in a participating locality who would consider devoting the land to agriculture or horticulture use are particularly affected.

Localities[3] Affected.[4] Since all local governments may choose to have use value assessments for agricultural or horticultural real estate, all are potentially affected by the proposed amendments. As of 2017, the following local governments did have use value assessments for agricultural and/or horticultural real estate:[5]

Cities: Buena Vista, Chesapeake, Danville, Franklin, Fredericksburg, Hampton, Harrisonburg, Lynchburg, Petersburg, Radford, Roanoke, Staunton, Suffolk, Virginia Beach, Waynesboro, and Winchester.

Counties: Accomack, Albemarle, Alleghany, Amelia, Amherst, Appomattox, Augusta, Bath, Bedford, Bland, Botetourt, Campbell, Caroline, Carroll, Chesterfield, Clarke, Culpeper, Cumberland, Dinwiddie, Essex, Fairfax, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Greene, Greensville, Hanover, Henrico, Henry, Isle of Wight, James City, King George, King William,

Lancaster, Loudoun, Louisa, Madison, Middlesex, Montgomery, Nelson, New Kent, Northampton, Northumberland, Nottoway, Orange, Page, Pittsylvania, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Rappahannock, Richmond, Roanoke, Rockbridge, Rockingham, Russel, Shenandoah, Smyth, Southampton, Spotsylvania, Stafford, Tazewell, Warren, Washington, Westmoreland, Wise, Wythe, and York.

Towns: Altavista, Amherst, Blacksburg, Bridgewater, Chilhowie, Christiansburg, Dayton, Front Royal, Hillsville, Lebanon, Leesburg, Louisa, Lovettsville, Montross, New Market, Pulaski, Remington, Windsor, and Wytheville.

Eliminating the five-year consecutive use requirement and the three-year requirements for minimum field crop production and minimum sales would likely increase the number of properties that qualify for use value assessments. Since use value assessments are typically lower than fair market value assessments, there would likely be reduced revenue for participating localities.

Projected Impact on Employment. The proposals to eliminate the five-year consecutive use requirement and the three-year requirements would likely increase the use of land for agricultural or horticultural purposes versus for other purposes. Consequently, employment in agricultural and horticultural activities may increase, and employment associated with alternative uses of the land may decrease. It is not clear whether there would be a net increase or decrease in total employment.

Effects on the Use and Value of Private Property. The proposals to eliminate the five-year consecutive use requirement and the three-year requirements would likely increase the use of land for agricultural or horticultural purposes. Since the real estate taxes would likely be lower for the affected properties, the cost of developing the land for agricultural or horticultural purposes would likely be lower.

Adverse Effect on Small Businesses:[6] The proposed amendments do not directly adversely affect small businesses.

Agency's Response to Economic Impact Analysis: The agency concurs with the analysis of the Department of Planning and Budget.

Summary:

In response to Chapter 504 of the 2018 Acts of Assembly, the proposed amendments (i) clarify requirements by listing the specified activities associated with agriculture or horticulture that must occur on a property for it to qualify as "real estate devoted to agricultural use" or "real estate devoted to horticultural use"; (ii) require that the owner must certify to such; and (iii) eliminate the requirement that the land must have been devoted for at least five consecutive years previously to specified activities associated with agriculture or horticulture.

2VAC5-20-10. ~~Preamble~~ Purpose.

The Commissioner of Agriculture and Consumer Services adopts these Standards for Classification of Real Estate As Devoted to Agricultural Use and to Horticultural Use Under the Virginia Land Use Assessment Law to:

1. Encourage the proper use of real estate in order to assure a readily available source of agricultural, horticultural, and forest products~~,~~ and of open space within reach of concentrations of population.

2. Conserve natural resources in forms that will prevent erosion.

3. Protect adequate and safe water supplies.

4. Preserve scenic natural beauties and open spaces.

5. Promote proper land-use planning and the orderly development of real estate for the accommodation of an expanding population.

6. Promote a balanced economy and ease pressures ~~which~~ that force the conversion of real estate to more intensive uses.

The real estate must meet all of the ~~following~~ standards in this chapter to qualify for agricultural or for horticultural use.

2VAC5-20-20. ~~Previous and current use, and exceptions~~ Current use.

~~A. Previous use. The real estate sought to be qualified must have been devoted, for at least five consecutive years previous, to the production for sale of plants or animals, or to the production for sale of plant or animal products useful to man, or devoted to another qualifying use including, but not limited to:~~

~~1. Aquaculture~~

~~2. Forage crops~~

~~3. Commercial sod and seed~~

~~4. Grains and feed crops~~

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[2]Source for "use value" and "fair market value" definitions: Lamie, Dave and Gordon Groover, "A Citizens' Guide to The Use Value Taxation Program in Virginia," 2009, Virginia Cooperative Extension Publication 448-037.

[3]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[4]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[5]Source: Kulp, Stephen C. "Virginia Local Tax Rates, 2017: Information for All Cities and Counties and Selected Incorporated Towns," Weldon Cooper Center for Public Service.

[6]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."

~~5. Tobacco, cotton, and peanuts~~

~~6. Dairy animals and dairy products~~

~~7. Poultry and poultry products~~

~~8. Livestock, including beef cattle, sheep, swine, horses, ponies, mules, or goats, including the breeding and grazing of any or all such animals~~

~~9. Bees and apiary products~~

~~10. Commercial game animals or birds~~

~~11. Trees or timber products of such quantity and so spaced as to constitute a forest area meeting standards prescribed by the State Forester, if less than 20 acres, and produced incidental to other farm operations~~

~~12. Fruits and nuts~~

~~13. Vegetables~~

~~14. Nursery products and floral products.~~

~~If a tract of real estate is converted from nonproduction to agricultural or horticultural production, the tract may qualify without a five year history of agricultural or horticultural use only if the change expands or replaces production enterprises existing on other tracts of real estate owned by the applicant.~~

~~B. Current use. The real estate sought to be qualified must currently be devoted to the production for sale of plants or animals, or to the production for sale of plant or animal products useful to man, or devoted to another qualifying use including, but not limited to, the items in subsection A of this section; except that no~~ A. The applicant shall certify that the real estate sought to be qualified currently meets one or more of the following requirements:

1. Be devoted to the bona fide production for sale of plants or animals that are useful to man;

2. Be devoted to the bona fide production for sale of products that are useful to man and that are made on the real estate from plants or animals produced on the real estate;

3. Be devoted to the bona fide production for sale of fruit of all kinds, including grapes, nuts, and berries;

4. Be devoted to the bona fide production for sale of vegetables;

5. Be devoted to the bona fide production for sale of nursery or floral products;

6. Be devoted to the bona fide production for sale of plants or products directly produced on such real estate from fruits, vegetables, nursery or floral products, or plants produced on such real estate; or

7. Be devoted to and meet the requirements and qualifications for payments or other compensation pursuant to a soil and water conservation program under an agreement with an agency of the state or federal government.

B. No real estate devoted to the production of trees or timber products may qualify unless:

1. The real estate is less than 20 acres~~.~~;

2. The real estate meets the technical standards prescribed by the State Forester~~,~~; and

3. The real estate is producing tree or timber products incidental to other farm operations.

~~C. Exceptions.~~

~~1. Conversions by farm operator — nonqualifying real estate. If a tract of real estate is converted from other uses or nonproduction to agricultural or horticultural production, the tract may qualify without the five year history of agricultural or horticultural use when the change expands or replaces production enterprises existing on other tracts of real estate owned by the applicant, regardless of location.~~

~~2. Conversions by farm operator — qualifying real estate. If a tract of real estate is converted from a qualifying use (forestry or open space) to agricultural or horticultural production, the tract may qualify without the five year history of agricultural or horticultural use.~~

~~3. Government action. If a tract of real estate which has previously qualified for agricultural use taxation is not devoted to agricultural or horticultural production because of governmental actions, the tract or portions shall be considered productive for that period of time.~~

~~4. Crops that require more than two years. The tract of real estate may qualify without the five year history of agricultural or horticultural use if the tract of real estate is devoted to the production of any agricultural or horticultural crop that requires more than two years from initial planting until commercially feasible harvesting, and the locality in which the tract of real estate is located has waived with respect to such real estate the five year history of agricultural or horticultural use requirement.~~

2VAC5-20-30. Conservation of land resources; management and production.

A. Conservation of land resources. The applicant shall certify that the real estate is being used in a planned program of practices that:

1. With respect to real estate devoted to a use that disturbs the soil or that affects water quality, is intended to (in the case of soil) reduce or prevent soil erosion and (in the case of water) improve water quality by best management practices such as terracing, cover cropping, strip cropping, no-till planting, sodding waterways, diversions, water

impoundments, and other best management practices, to the extent that best management practices exist for that use of the real estate.

2. With respect to real estate devoted to crops grown in the soil, is intended to maintain soil nutrients by the application of soil nutrients (organic and inorganic) needed to produce average yields of such crops or as recommended by soil tests.

3. Is intended to control brush, woody growth, and noxious weeds on row crops, hay, and pasture by the use of herbicides, biological controls, cultivation, mowing, or other normal cultural practices.

B. Management and production. The applicant shall certify that the real estate is being used in a planned program of management and production ~~for sale of plants or animals (or plant or animal products useful to man), which include, but are not limited to, field crops, livestock, livestock products, poultry, poultry products, dairy, dairy products, aquaculture products, and horticultural products; or that the real estate is being used for any other thing that is a qualifying use pursuant to 2VAC5-20-20~~ that corresponds with the demonstration of at least one of the requirements in 2VAC5-20-20 A 1 through A 6.

C. Field crop production shall be primarily for commercial uses and the average crop yield per acre on each crop grown on the real estate ~~during the immediate three years previous,~~ shall be equal to at least one-half of the county (city) average for the past three years; except that the local government may prescribe lesser requirements when unusual circumstances prevail and such requirements are not realistic.

Livestock, dairy, poultry, or aquaculture production shall be primarily for commercial sale of livestock, dairy, poultry, and aquaculture products. Livestock, dairy, and poultry shall have a minimum of 12 animal unit-months of commercial livestock or poultry per five acres of open land in the previous year. One animal unit to be one cow, one horse, five sheep, five swine, 100 chickens, 66 turkeys, or 100 other fowl. (An animal unit-month means one mature cow or the equivalent on five acres of land for one month; therefore, 12 animal unit-months means the maintenance of one mature cow or the equivalent on each five acres for 12 months, or any combination of mature cows or the equivalent and months that would equal 12 animal unit-months, such as three mature cows or the equivalent for four months, four mature cows or the equivalent for three months, two mature cows or the equivalent for six months, etc.).

Horticultural production includes nursery, greenhouse, cut flowers, plant materials, orchards, vineyards, and small fruit products.

~~Timber production, in addition to crop, livestock, dairy, poultry, aquaculture, and horticultural production on the real estate must meet the standards prescribed by the Department of Forestry for forest areas and will be assessed at use value for forestry purposes.~~

2VAC5-20-40. Certification procedures.

A. Documentation. The commissioner of the revenue or the local assessing officer may require the applicant to document what the applicant must certify pursuant to 2VAC5-20-20 and 2VAC5-20-30. The commissioner of the revenue or local assessing officer may find one of the following documents useful in making his determination:

1. The assigned USDA/Farm Service Agency farm number and evidence of participating in a federal farm program;

2. Federal tax forms (1040F) Farm Expenses and Income, (4835) Farm Rental Income and Expenses, or (1040E) Cash Rent for Agricultural Land;

3. A ~~Conservation Farm Management Plan~~ conservation farm management plan prepared by a professional; ~~or~~

4. ~~Gross sales averaging more than $1,000 annually over the previous three years~~ Documentation demonstrating that the real estate sought to be qualified currently is devoted to the bona fide production for sale of one of the requirements in 2VAC5-20-20 A 1 through A 6; or

5. Documentation demonstrating that the real estate sought to be qualified currently is devoted to and meeting the requirements and qualifications for payments or other compensation pursuant to a soil and water conservation program under an agreement with a federal government or state government agency.

B. Interpretation of standards. In cases of uncertainty on the part of the commissioner of the revenue or the local assessing officer, the law authorizes him to request an opinion from the Commissioner of Agriculture and Consumer Services as to whether a particular property meets the criteria for agricultural or horticultural classification. The procedure for obtaining such an opinion is as follows:

1. The commissioner of the revenue or the local assessing officer shall address a letter to the Commissioner, Virginia Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, Virginia 23218, describing the use and situation, and requesting an opinion of whether the real estate qualifies as agricultural or horticultural real estate for the purpose of use-value taxation. The letter should include the following:

a. Owner's name and address.

b. Operator's name and address.

c. Total number of acres, acres in crops, acres in pastures, acres in a federal or state soil and water conservation ~~programs (Farm Service Agency, Natural Resources Conservation Service, Virginia Department of~~

~~Conservation and Recreation programs),~~ program, and acres in forest.

d. If more than one tract of real estate, the number of acres in each tract and whether the tracts are contiguous.

e. A copy of the application for land use assessment taxation.

~~f. In any case involving a question about the applicability of the exception to the five year history of agricultural or horticultural use requirement contained in 2VAC5-20-20 C 4 (relating to real estate devoted to the production of an agricultural or horticultural crop that requires more than two years from initial planting until commercially feasible harvesting), a statement as to whether the locality has waived with respect to such real estate, the five year history of agricultural or horticultural use requirement.~~

2. The commissioner may request additional information, if needed, directly from the applicant~~;~~ or ~~he may~~ hold a hearing at which the applicant and others may present additional information.

3. The commissioner will issue an opinion as soon as possible after all necessary information has been received.

VA.R. Doc. No. R19-5646; Filed December 17, 2019, 4:43 p.m.

TITLE 3. ALCOHOLIC BEVERAGES

ALCOHOLIC BEVERAGE CONTROL AUTHORITY

Proposed Regulation

Title of Regulation: **3VAC5-50. Retail Operations (adding 3VAC5-50-250).**

Statutory Authority: §§ 4.1-103 and 4.1-111 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: March 20, 2020.

Agency Contact: LaTonya D. Hucks-Watkins, Legal Liaison, Virginia Alcoholic Beverage Control Authority, 2901 Hermitage Road, Richmond, VA 23220, telephone (804) 213-4698, or email latonya.hucks-watkins@abc.virginia.gov.

Basis: Section 4.1-101 of the Code of Virginia establishes the Virginia Alcoholic Beverage Control Authority, and § 4.1-101.01 of the Code of Virginia establishes the Board of Directors of the Authority. Section 4.1-103 of the Code of Virginia enumerates the powers of the board, which include the authority to adopt regulations and to do all acts necessary or advisable to carry out the purposes of The Alcoholic Beverage Control Act (§ 4.1-100 et seq. of the Code of Virginia). Subdivision 7 of § 4.1-103 of the Code of Virginia states that the board may delegate or assign any duty or task to be performed by the authority to any officer or employee of the authority. Subdivision 24 of § 4.1-103 permits the board to promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and § 4.1-111 of the Code of Virginia, which provides the board with the authority to adopt regulations that it deems reasonable to carry out the provisions of the Alcoholic Beverage Control Act and to amend or repeal such regulations.

Purpose: The purpose of the regulation is to provide a definition of "confectionery" and to provide clarification as to the restrictions regarding the alcohol content, prohibition of sales to those younger than 21 years of age, and labeling requirements for confections containing alcohol.

Substance: The emergency regulation currently effective until June 29, 2020, reads:

3VAC5-50-250. Confectionery; definition; restrictions; labeling.

A. "Confectionery" means a general class of sweet foods and edibles, including baked goods and candies, having an alcohol content not more than 5.0% by volume.

B. Any alcohol contained in such confectionery shall not be in liquid form at the time such confectionery is sold. Such alcohol shall be fully integrated or blended into the confectionery product.

C. Any such confectionery shall only be sold to those individuals who can lawfully consume alcohol.

D. Any establishment licensed to sell confectioneries for off-premises consumption shall properly label the product with such label including:

1. Notice that the product contains alcohol;

2. Notice that the product can only be consumed off premises; and

3. Warning that the product should not be consumed by anyone under the age of 21.

The only difference between the emergency regulation and the proposed regulation is removal of the phrase "a general class of sweet foods and edibles including" in the definition of "confectionery." In the proposed regulation, "confectionery" is defined as "baked goods and candies having an alcohol content not more than 5.0% by volume."

Issues: The primary advantage to the public, the agency, and the Commonwealth is that the emergency regulation will be replaced with a permanent regulation. The permanent regulation is not confusing; the provisions are straightforward. The agency does not see any disadvantages to the public or the agency based on the proposed change.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to 2018 legislation, the Virginia Alcoholic Beverage Control Board of Directors (Board) proposes to establish a definition for "confectionery" and labeling requirements for such confectionery. This proposed permanent regulation replaces an emergency regulation that became effective on July 1, 2018 and expires on December 30, 2019.

Background. Chapters 173[2] and 334[3] of the 2018 Acts of Assembly created a confectionery license, which authorizes the licensee to prepare and sell on the licensed premises (for off-premises consumption) confectionery that contains five percent or less alcohol by volume. The Acts also stated that any alcohol contained in such confectionery shall not be in liquid form at the time such confectionery is sold.

An enactment clause in the legislation specified that the Board promulgate regulations to implement the provisions of the act, to include a definition of the term "confectionery" and labeling requirements for such confectionery. The Board proposes to define "confectionery" as "baked goods and candies, having an alcohol content not more than 5.0% by volume." Further, the Board proposes to require that the confectionaries be labeled with: 1) notice that the product contains alcohol, 2) notice that the product can only be consumed off premises, and 3) a warning that the product should not be consumed by anyone under the age of 21.

Estimated Benefits and Costs. Prior to the legislation and emergency regulation, it was illegal to sell confectioneries in the Commonwealth. Pursuant to Code of Virginia § 4.1-302[4] and § 4.1-100,[5] it would have been a Class 1 misdemeanor. Allowing the sale of confectionaries through licensure is beneficial in that consumers gain access to products that they may enjoy, and businesses gain the opportunity to sell potentially profitable additional products. The proposal to require that the labeling specify that the products contain alcohol is beneficial in that it greatly reduces the likelihood that people who would prefer to not consume alcohol-containing foods, or should not consume, would consume these products by mistake.

The legislation specified that the Board include labeling requirements. Given that labeling is required, the Board's proposed labeling requirements do not substantively add costs.

Businesses and Other Entities Affected. The proposal affects firms who may wish to produce and/or sell confectionaries, as well as consumers. Since the emergency regulation has been in effect (July 1, 2018), five firms have obtained confectionery licensure.

Localities[6] Affected.[7] The legislation and proposed regulation allow confectioneries to be prepared and sold with a license throughout the Commonwealth. Thus far, through the emergency regulation, there are five licensees. They are located in the Cities of Martinsville and Richmond (2), and the Counties of Henrico and York. The proposal does not produce costs for local governments.

Projected Impact on Employment. Allowing the sale of confectioneries through licensure may have a small positive impact on employment because more workers may be needed for the production and sale of the newly legal products.

Effects on the Use and Value of Private Property. Allowing the sale of confectioneries through licensure enables firms to gain the opportunity to sell potentially profitable additional products. This would likely increase the value of some such firms. The proposal does not appear to directly affect real estate development costs.

Adverse Effect on Small Businesses:[8] The proposed regulation does not appear to adversely affect small businesses.

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[2]See http://leg1.state.va.us/cgi-bin/legp504.exe?181+ful+CHAP0173

[3]See http://leg1.state.va.us/cgi-bin/legp504.exe?181+ful+CHAP0334

[4]See https://law.lis.virginia.gov/vacode/title4.1/chapter3/section4.1-302/

[5]Definition of "Alcoholic beverages" includes solids containing one-half of one percent or more of alcohol by volume. See https://law.lis.virginia.gov/vacode/title4.1/chapter1/section4.1-100/

[6]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[7]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[8]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."

Agency's Response to Economic Impact Analysis: The Virginia Alcoholic Beverage Control Authority concurs with the Department of Planning and Budget's economic impact analysis.

Summary:

The proposed action implements the confectionery license created by Chapters 173 and 334 of the 2018 Acts of Assembly, which authorizes the licensee to prepare and sell confectionery on the licensed premises for off-premises consumption. The proposed provisions require that the confectionery contain 5.0% or less alcohol by volume and that any alcohol contained in such confectionery shall not be in liquid form at the time such confectionery is sold. The regulation defines the term "confectionery" and includes labeling requirements for such confectionery.

3VAC5-50-250. Confectionery; definition; restrictions; labeling.

A. "Confectionery" means baked goods and candies having an alcohol content not more than 5.0% by volume.

B. Any alcohol contained in such confectionery shall not be in liquid form at the time such confectionery is sold. Such alcohol shall be fully integrated or blended into the confectionery product.

C. Any such confectionery shall only be sold to those individuals who can lawfully consume alcohol.

D. Any establishment licensed to sell confectioneries for off-premises consumption shall properly label the product with such label including:

1. Notice that the product contains alcohol;

2. Notice that the product can only be consumed off premises; and

3. Warning that the product should not be consumed by anyone younger than 21 years of age.

VA.R. Doc. No. R18-5486; Filed December 17, 2019, 4:41 p.m.

TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Notice of Effective Date

Title of Regulation: **9VAC25-260. Water Quality Standards (amending 9VAC25-260-310).**

Statutory Authority: § 62.1-44.15 of the Code of Virginia; 33 USC § 1251 et seq.; 40 CFR 131.

Effective Date: January 9, 2020.

On June 27, 2019, the State Water Control Board adopted revisions to the Water Quality Standards in 9VAC25-260-310**.** These revisions relate to numeric chlorophyll criteria for the tidal James River. The amendments were published as final regulations in 36:2 VA.R. 101-105 September 16, 2019, to be effective upon the board filing notice of U.S. Environmental Protection Agency (EPA) approval with the Registrar of Regulations. The State Water Control Board received a letter from Catherine Libertz, EPA Region III Regional Acting Director, Water Protection Division, dated January 6, 2020, that approved all of the amendments. Therefore, the amendments to 9VAC25-260-310 in this regulatory action are effective as regulation.

Agency Contact: Tish Robertson, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4309, FAX (804) 698-4116, or email tish.robertson@deq.virginia.gov.

VA.R. Doc. No. R12-2932; Filed January 9, 2020, 2:50 p.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Notice of Objection to Fast-Track Rulemaking Action

REGISTRAR'S NOTICE: Pursuant to § 2.2-4012.1 of the Code of Virginia, the State Board of Health has filed a notice of objection to the fast-track rulemaking action published in 36:6 VA.R. 453-474 November 11, 2019. The board intends to proceed with the standard promulgation process set out in Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2 of the Code of Virginia, with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

Title of Regulation: **12VAC5-90. Regulations for Disease Reporting and Control (amending 12VAC5-90-10, 12VAC5-90-80, 12VAC5-90-90, 12VAC5-90-103, 12VAC5-90-107, 12VAC5-90-140, 12VAC5-90-215, 12VAC5-90-225, 12VAC5-90-280, 12VAC5-90-370).**

Statutory Authority: §§ 32.1-12, 32.1-35, and 32.1-42 of the Code of Virginia.

The State Board of Health has filed a notice of objection to the fast-track rulemaking action for 12VAC5-90, Regulations for Disease Reporting and Control. The fast-track regulation was published in Volume 36, Issue 6, pages 453 through 474 of the Virginia Register of Regulations, on November 11, 2019. A 30-day public comment period was provided, and public comment was received through December 11, 2019.

The board received more than the requisite 10 objections to the amendments. Due to the objections, the board has discontinued using the fast-track rulemaking process. The board will proceed with adoption of the amendments using the standard process under Article 2 (§ 2.2-4006 et seq.) of the Administrative Process Act, and the publication on November 11, 2019, will serve as the Notice of Intended Regulatory Action in accordance with § 2.2-4012.1 of the Code of Virginia.

Agency Contact: Kristin Collins, Policy Analyst, Office of Epidemiology, Virginia Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7298, or email kristin.collins@vdh.virginia.gov.

VA.R. Doc. No. R20-5357; Filed December 20, 2019, 10:37 a.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Proposed Regulation

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

12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (adding 12VAC30-60-65).

12VAC30-120. Waivered Services (amending 12VAC30-120-766, 12VAC30-120-924, 12VAC30-120-930).

12VAC30-122. Community Waiver Services for Individuals with Developmental Disabilities (adding 12VAC30-122-125).

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: March 21, 2020.

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 12006 of the 21st Century Cures Act (Public Law 114-255) mandates the adoption of electronic visit verification (EVV) technology applicable to personal care services (effective January 1, 2019) and home health care services (effective January 1, 2023) as provided by Medicaid without regard to whether the services are covered via a waiver or the State Plan for Medical Assistance. Section 1 of Public Law 115-222 delayed the onset of fiscal penalties and the adoption of EVV technologies for one year past the original statute (i.e., until January 1, 2020).

The Department of Medical Assistance Services (DMAS) covers personal care, respite care, and companion services under the authority of Social Security Act § 1915(b) and (c) managed care and home and community based care waivers. Due to the highly similar nature of waiver companion services and waiver respite services to personal care services, DMAS is also requiring the use of EVV for these services under the authority of Item 303 LLL of Chapter 2 of the 2018 Acts of Assembly, Special Session I. Personal care, respite care, and companion services are designed to provide services in support of activities of daily living (e.g., bathing, dressing, toileting, transferring, and feeding) in slightly different circumstances. The Commonwealth also covers instrumental activities of daily living (e.g., meal preparation, money management, shopping, and community activities) under personal care, respite care, and companion services for those individuals who require this type of assistance.

Home health care services are federally mandated services for Title XIX programs under the authority of § 1905(a)(7) of the Social Security Act. This service provides skilled nursing services, aide services, and medical supplies and equipment for individuals in their residences, without requiring that they be homebound, upon the order of the physicians for such individuals. The application of EVV to home health services takes effect January 1, 2023, and is not reflected in this regulatory action.

Purpose: The purpose of this action is to implement the mandates of § 1903(l) of the Social Security Act regarding EVV as applicable to personal care services across all the waivers and State Plan covered services. Absent the Commonwealth's adoption of this requirement, § 1903(l) also mandates the reduction of federal matching funds for expenditures for personal care services ($869 million). Reductions in Medicaid federal funds, in the absence of EVV, would be expected to exceed several millions of dollars thereby substantially affecting the health, safety, and welfare of Medicaid individuals by service reductions and loss.

Action by the General Assembly in Item 303 LLL of Chapter 2 of the 2018 Acts of Assembly, Special Session I, applies this EVV requirement also to companion services and respite. The action that will apply EVV requirements to home health services is to be addressed in the near future in a separate regulatory action because of the January 1, 2023, effective date set out in federal law.

Substance: The sections of the State Plan for Medical Assistance affected by this action are (i) Standards Established and Methods Used to Assure High Quality of Care (12VAC30-60) and Amount, Duration, and Scope of Medical and Remedial Care Services (12VAC30-50). The state-only regulations affected by this action are the Commonwealth Coordinated Care Plus and Commonwealth Coordinated Care Plus Programs in Waivered Services (12VAC30-120) and Community Waiver Services for Individuals with Developmental Disabilities (12VAC30-122).

Currently, there are no such requirements in either the State Plan for Medical Assistance or any related waiver programs because electronic visit verification has not applied to Title XIX prior to the passage of the Cures Act.

The 21st Century Cures Act (Cures Act) was designed to improve the quality of services and supports provided to individuals through research, enhancing quality control, and strengthening mental health parity. This regulatory action addresses enhancing quality control of services provided to individuals.

One of the federal purposes of electronic visit verification is the reduction of potential fraud, waste, and abuse through validating that billed services to make sure they comport with an individual's plan of care using EVV data. Such validation ensures appropriate payment based on actual service delivery.

These systems will enable greater opportunities for enhanced care coordination, data sharing, and improved payment accuracy with the concomitant reduction of billing errors. The Department of Health and Human Services Office of the Inspector General has recognized EVV as a positive step toward safeguarding individuals.

Another federal purpose is the improvement of program efficiencies by reducing the need for paper documentation to verify services, speeding up provider electronic billing, and supporting individuals using self-direction services by permitting greater flexibility for appointments and services.

Analysis conducted by the Centers for Medicare and Medicaid Services (CMS) determined that the following system models exist:

• Provider choice model: major providers currently use different EVV systems that are Cures Act compliant.

• Managed care organization choice model: managed care organizations currently use different EVV systems that are Cures Act compliant.

• State mandated in-house model and state mandated external vendor model: providers not widely using EVV, or the EVV systems in use do not meet the state's needs, so the state intends to develop its own EVV system.

• Open vendor model: smaller providers are not widely using EVV but may have one or more larger providers using Cures Act compliant EVV system.

The Cures Act design of EVV requirements allows the states to select their design and implement quality control measures of their choosing. The states are required to consult with other affected entities, including (i) other state agencies providing personal care or home health care services and (ii) other stakeholders, such as family caregivers, individuals receiving and furnishing personal care and home health services, and providers of these services. EVV systems must be minimally burdensome and compliant with Health Insurance Portability and Accountability Act (HIPAA) privacy mandates. EVV systems are not intended to limit the services provided or provider selection, constrain individual caregiver choices, or impede the way care is rendered. EVV systems should accommodate personal care and home health care service delivery locations with limited or no internet access. EVV systems should allow individuals to schedule their services directly with their providers, allowing for last-minute changes based on individual needs. EVV systems should accommodate services at multiple approved locations, not just the individual's home, and allow for multiple service delivery locations in a single visit.

DMAS conducted a comprehensive review of the CMS alternatives permitted to meet the federal requirements and concluded that the open vendor model afforded the most provider flexibility for Virginia. The open vendor model allows providers that currently use EVV systems to maintain a working relationship with their claims processing vendors as well as permitting all providers to select a system that meets their business needs while being cost effective. In October 2017, DMAS issued a request for information (RFI) to learn more about EVV systems available in the marketplace. Several EVV vendors responded, providing information on their system capabilities. This was useful in identifying some of the system requirements included in this action.

DMAS recommends adoption of the open vendor model because it will enable providers, either large or small, to select the EVV system that best suits their business models and operational practices. Affected providers are expected to opt for EVV systems that will smoothly and efficiently link with the electronic billing systems they currently use in order to facilitate a quick, effective electronic billing process. DMAS is currently designing a computerized aggregator system to accept incoming data from multiple EVV systems and compile it into service utilization data in support of claims adjudication and payments processing. The DMAS EVV system regulatory requirements comport with § 12006(a)(5) of the Cures Act and do not exceed the minimum requirements contained in federal law. Implementing this system now for personal care services, respite care services, and companion services, as required by federal law, will facilitate the implementation of EVV applicable to home health services by 2023.

Issues: Providers are expected to experience faster claims processing with fewer denied claims and reduced numbers of post-payment review audit recoveries. The primary advantage to the agency and the Commonwealth is avoiding the reduction of federal matching funds for failure to comply. The advantage to Medicaid individuals is that the personal care services, respite care services, and companion care services that they receive will comport with their identified needs in their plans of care with few, if any, disruptions.

There are no disadvantages to the agency or the Commonwealth in this action. There are no advantages or disadvantages of this action to individual private citizens.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Medical Assistance Services (Board) proposes to amend 12VAC30-60 Standards Established and Methods Used to Assure High Quality Care in order to implement electronic visit verification (EVV) for personal care services, companion services, and respite services that are provided to qualifying Medicaid beneficiaries. EVV is a telephone and computer-based system by which providers of these services create an electronic record of their arrival and departure times, location, and the services provided at each visit. The electronic record is transmitted to the provider organizations,

who are required to submit the electronic records as part of the claim-filing process and then retain the records for a minimum of six years. EVV data can potentially be used to ascertain that every visit billed to Medicaid actually occurred and also validate that each visit conformed to the recipient's Plan of Care. The Board seeks to add a new section (65), which contains the specific requirements for the implementation of EVV, to 12VAC30-60. The bulk of the analysis presented here focuses on the proposed regulations put forth in this section.

In addition, the Board proposes multiple identical amendments to 12VAC30-50 Amount, Duration, and Scope of Medical and Remedial Care Services, 12VAC30-120 Waivered Services, and 12VAC30-122 Community Waiver Services for Individuals with Developmental Disabilities, each one being directed at a specific category of service providers. Each amendment instructs the relevant service providers to implement EVV and directs them to 12VAC30-60-65 for additional detail on the requirements. Specifically, these amendments apply to the following services:

- personal care for children receiving early preventative screening, diagnosis, and treatment (12VAC30-50-130);
- consumer-directed or agency-directed personal care or respite care specifically for activities of daily living (12VAC30-120-766);
- personal care or respite care for individuals under the Elderly or Disabled with Consumer-Direction Waiver, agency or consumer-directed companion services in the workplace or postsecondary school, and agency or consumer-directed respite services (12VAC30-120-924); and
- services for individuals with developmental disabilities receiving community waiver services (12VAC30-122-125).

Lastly, the Board seeks to include the amendment requiring EVV in 12VAC30-120-930, which provides general requirements for home and community-based providers, to clarify that all types of personal care providers are covered by the EVV requirements, without exception.

Background. The proposed action conforms the requirements of the Medicaid program with the federal 21st Century Cures Act as applicable to Title XIX concerning electronic visit verification. The 21st Century Cures Act was signed into law in December 2016 and added § 1903(1) to the Social Security Act (SSA). The Cures Act includes fiscal penalties for states that failed to implement the EVV requirement for personal care services by January 1, 2019. The 2018 Appropriation Act (2018 Special Session 1, Acts of Assembly Chapter 2, Item 303, LLL) gave the Department of Medical Assistance Services (DMAS) the authority to implement the EVV requirement prior to the completion of any regulatory process. In July 2018, Congress enacted H.R. 6042 to delay the onset of the penalties until January 1, 2020; subsequently in January 2019, the Budget Bill was amended (2019 Acts of Assembly Chapter 854) to allow DMAS until October 1, 2019, to implement EVV for personal care services. DMAS expects to meet this deadline and has been working with various stakeholders, including service providers and vendors, to ensure that they implement EVV well in advance of the federal deadline, so as to not risk facing any fiscal penalties.

Estimated Benefits and Costs. Failure to comply with the requirements of the Cures Act would have resulted in a small reduction in the Federal Medical Assistance Percentage (FMAP) rate for personal care expenditures in the first year and larger reductions in subsequent years. Given DMAS expended a total of $868 million in 2017 for personal care services (both agency-directed and consumer-directed) even a small decrease in the FMAP would have cost several million dollars. By implementing EVV before the deadline, in compliance with all the requirements of the federal Centers for Medicare and Medicaid Services, DMAS benefits from avoiding any such penalty. Avoiding the penalty is possibly the most readily quantifiable benefit of implementing this regulation.

Other benefits may accrue to providers, beneficiaries, and DMAS. Provider organizations may use EVV to manage and monitor the delivery of care and services, reduce paper-based recordkeeping, and streamline their own documentation process for submitting insurance claims, which could also lead to faster claim payments as payers use the EVV data to more efficiently detect fraud or waste. Medicaid beneficiaries who utilize personal care services and may have been harmed, either directly or indirectly, by improper payments (fraud or abuse) in personal care provision are now benefited by the increased transparency and accountability provided by EVV. To the extent that improper payments in personal care provision increased DMAS expenditures, the implementation of EVV could reduce those losses.

However, greater transparency and fraud reduction also incurs certain costs. Providers have to contract with vendors to adopt appropriate EVV tools that support their operations. In areas with limited wireless internet connectivity, this could mean using landline telephones or installing devices at the consumer's home that can be used by the care providers. In areas where wireless connectivity is stronger, EVV vendors may provide mobile applications deployed on the provider's smartphone or on a tablet or similar device given to the provider. These mobile applications may combine web-based timesheets with GPS-based location services to collect and transmit very precise data. Depending on the size of the provider organization and the locations in which they operate, these costs could vary widely but would include both the one-time cost of deploying the technology and training users and any recurring costs such as technology refresh, network or

connectivity charges, and charges for using a data clearinghouse to submit claims and receive remittances from the insurance companies.

Some small providers responded to queries by DPB staff saying that although EVV was not required for their customers with other insurance, they chose to implement it for all their clients so that each caregiver could use the same process for scheduling and entering visit data with all the individuals who they directly serve. These providers reported lower costs (less than $10 per member per month) and were located in areas with widespread wireless internet coverage and high rates of smartphone adoption. However, providers in areas without widespread internet coverage reported higher up-front costs of training staff in using multiple EVV tools (using landlines and Wi-Fi) as well as higher ongoing costs (approximately $20 per member per month) and said they could not afford to implement EVV for their non-Medicaid clients. None of the small providers who responded had adopted EVV as a business practice prior to the passage of the Cures Act. Furthermore, those who implemented it in time for the initial January 1, 2019, deadline expressed some frustration about the vendor fees that could have been avoided had they known that the deadline would be postponed to October 1, 2019.

In an effort to minimize costs to providers, DMAS convened an EVV Regulation Development Workgroup (Workgroup) and also issued a Request for Information (RFI) from service providers and EVV vendors seeking information on their capacity to implement EVV in the least disruptive manner. Based on the information received, DMAS chose to adopt an "open" model, in which they could parlay the requirements of the Cures Act to providers as a broad range of technical specifications, rather than a "closed" model in which providers would have to implement a specific system chosen by DMAS. Hence, providers were given the freedom to work with vendors of their choice, including vendors they were already using for scheduling or payroll.

Based on minutes from the Workgroup's deliberations, it appears that the fiscal/employers' agents (F/EA) for consumer-directed services have been able to transition their existing timesheets and payroll systems to one that meets EVV requirements. Given that DMAS contracted with an F/EA that for individuals covered by Medicaid fee-for-service receiving consumer-directed personal assistance, this might have set a precedent for other F/EAs acting on behalf of managed care organizations (MCOs). Finally, providers are incentivized to implement EVV simply because it is a required component of filing claims and receiving payments from DMAS. Providers who have been slow to implement EVV will not be paid until and unless they do so.

In the medium run to long run, regulatory requirements such as EVV could have consequences that may not be apparent in the short run. These requirements impose the greatest burden for the smallest provider groups who may have very minimal capacity for moving beyond the most basic payroll systems. Over time, regulatory requirements that involve significant technology upgrades can encourage market concentration in the industry because small providers eventually find it more cost effective to merge into larger organizations that can afford to have an in-house software development team or can contract with external vendors more competitively.

This process may be underway, as evidenced by the presence of groups such as the Partnership for Medicaid Home-Based Care, a consortium representing the largest home and personal care service providers, MCOs, and EVV vendors. The participating organizations are all corporations, some publicly-traded, that operate across multiple states. These groups, or their member organizations, are well-situated to participate in RFIs, such as the one conducted by DMAS, and submit compelling arguments in favor of the "open" model that promotes flexibility and efficiency for the providers.

Regulations targeting providers that require technology upgrades also create incentives for Managed Care Organizations (MCOs) to offer technology solutions to the providers in their network and absorb the up-front costs of developing and deploying the technology. Otherwise, they might face providers who want to be reimbursed for the additional costs accrued from complying with such regulations. This in turn will likely prompt MCOs to negotiate higher capitation rates or special payments that cover the cost of regulatory compliance. It would be impossible to isolate the effect of just the EVV requirement on any marginal increase to capitation rates in the future or determine whether any rate increases are offset by decreases in improper payments, but it offers an illustration of the process by which one technological upgrade, in this case through regulatory action, could lead to increases in health care costs.

Businesses and Other Entities Affected. The proposed amendments affect numerous organizations providing personal care or assistance as well as the individuals receiving these services and possibly their families. In state fiscal year 2017, DMAS estimates that about 68,000 people who used these services would be affected per year. This includes roughly 34,000 individuals in managed care who were eligible for personal care, respite care, and companion care services. (According to DMAS, managed care information is reported as encounter data, without user counts.) In the fee-for-service system, roughly 27,780 individuals used personal care services.

Based on the fee-for-service claims, DMAS estimates that about 600 provider organizations of agency-directed personal care would be affected. DMAS estimates that 90% of these are likely to be small businesses. Other private entities affected include Adult Rehabilitation Centers, Area Agencies on Aging, disability support organizations, and organizations

with religious affiliations that provide support services, to the extent that the population they serve receives Medicaid coverage. The proposed amendments would also affect vendors that develop and provide software services.

Localities[2] Affected.[3] The proposed amendments do not immediately introduce new costs for local governments. However, these requirements would affect Community Services Boards and Area Agencies on Aging, which are administered by local governments in conjunction with the Department of Behavioral Health and Developmental Services and the Department for Aging and Rehabilitative Services respectively, to the extent that the population they serve receives Medicaid coverage. Localities with greater proportions of Medicaid recipients who utilize personal care services would be disproportionately affected by the proposed regulations.

Projected Impact on Employment. The proposed amendments are unlikely to affect total employment. In the short run, more jobs may have been created by the demand for new software solutions to meet the EVV requirements. This regulation is unlikely to affect the ongoing shortage of home health care and personal care workers.

Effects on the Use and Value of Private Property. The value of managed care organizations and information technology vendors that provide EVV solutions may increase. Real estate development costs are not affected.

Adverse Effect on Small Businesses:[4]

Types and Estimated Number of Small Businesses Affected. Based on the fee-for-service claims, DMAS estimates that about 600 provider organizations of agency-directed personal care will be affected. DMAS estimates that 90% of these are likely to be small businesses.

Costs and Other Effects. The EVV requirements impose the greatest burden for the smallest provider groups who may have very minimal capacity for engaging with more sophisticated software requirements moving beyond the most basic payroll systems. Over time, regulatory requirements that involve significant technology upgrades can encourage market concentration in the industry because small providers eventually find it more cost effective to merge into larger organizations that can afford to have an in-house software development team or can contract with external vendors more competitively.

Alternative Method that Minimizes Adverse Impact. Given the potential for millions of dollars in reduced federal funding for failing to require EVV, there are no clear alternative methods that would meet the requirements of the Cures Act. In the absence of the Cures Act, alternative systems to reduce fraud or waste such as random site audits, or automated random remote audits could have been considered.

[2]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[3]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[4]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."

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

Summary:

For personal care, companion care, and respite care services, the proposed amendments establish the requirements for electronic visit verification (EVV), which is a telephone and computer-based system by which providers of services to qualifying Medicaid individuals create an electronic record of their arrival and departure times, locations, and services provided at each visit. Additional proposed amendments require the implementation of EVV for specific categories of service providers, including those providing (i) personal care services for children receiving early preventative screening, diagnosis, and treatment; (ii) consumer-directed or agency-directed personal care or respite care services specifically for activities of daily living; (iii) personal care or respite care services for individuals under the Elderly or Disabled with Consumer-Direction Waiver, agency-directed or consumer-directed companion services in the workplace or postsecondary school, and agency-directed or consumer-directed respite care services; and (iv) services for individuals with developmental disabilities receiving community waiver services. The proposed amendments are in conformance with the 21st Century Cures Act (Public Law 114-255), Public Law 115-222, and Item 303 LLL of Chapter 2 of the 2018 Acts of Assembly, Special Session I.

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. General provisions for early and periodic screening, diagnosis, and treatment (EPSDT) of individuals younger than 21 years of age and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals 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 departments of social services 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. DMAS shall place appropriate utilization controls upon this service.

4. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, 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 that are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients 21 years of age and older, provided for by § 1905(a) of the Social Security Act.

C. Community mental health services provided through early and periodic screening diagnosis and treatment (EPSDT) for individuals younger than 21 years of age. 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) shall be reflected in provider records and on provider claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

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

"Adolescent" means the individual receiving the services described in this section. For the purpose of the use of this term, adolescent means an individual 12 through 20 years of age.

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

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

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

"Child" means an individual ages birth through 11 years.

"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 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 the Department of Health Professions in the document entitled Approved Degrees in Human Services and Related Fields for QMHP Registration, adopted November 3, 2017, revised February 9, 2018.

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

"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.

"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.

"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. 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.

"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.

"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.

"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 including a "QMHP-trainee" as defined by the Department of Health Professions.

"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 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 or 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 or 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.

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

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

2. Intensive in-home services (IIH) to children and adolescents younger than 21 years of age 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 and provide modeling and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote benefits of psychoeducation 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 the individual's 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.

a. 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.

b. Service-specific provider intakes shall be required prior to the start of services 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.

c. These services shall only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

3. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions (a unit is defined in 12VAC30-60-61 D 11). Day treatment programs 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.

a. Service authorization shall be required for Medicaid reimbursement.

b. Service-specific provider intakes shall be required prior to the start 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.

c. These services shall be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

D. Therapeutic group home services and psychiatric residential treatment facility (PRTF) services for early and periodic screening diagnosis and treatment (EPSDT) of individuals younger than 21 years of age.

1. Definitions. The following words and terms when used in this subsection shall have the following meanings:

"Active treatment" means implementation of an initial plan of care (IPOC) and comprehensive individual plan of care (CIPOC).

"Assessment" means the face-to-face interaction by an LMHP, LMHP-R, LMHP-RP, or LMHP-S to obtain information from the child or adolescent and parent, guardian, or other family member, as appropriate, utilizing a tool or series of tools to provide a comprehensive evaluation and review of the child's or adolescent's mental health status. The assessment shall include a documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.

"Certificate of need" or "CON" means a written statement by an independent certification team that services in a therapeutic group home or PRTF are or were needed.

"Combined treatment services" means a structured, therapeutic milieu and planned interventions that promote (i) the development or restoration of adaptive functioning, self-care, and social skills; (ii) community integrated activities and community living skills that each individual requires to live in less restrictive environments; (iii) behavioral consultation; (iv) individual and group therapy; (v) skills restoration, the restoration of coping skills, family living and health awareness, interpersonal skills, communication skills, and stress management skills; (vi) family education and family therapy; and (vii) individualized treatment planning.

"Comprehensive individual plan of care" or "CIPOC" means a person centered plan of care that meets all of the requirements of this subsection and is specific to the individual's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Crisis" means a deteriorating or unstable situation that produces an acute, heightened emotional, mental, physical, medical, or behavioral event.

"Crisis management" means immediately provided activities and interventions designed to rapidly manage a crisis. The activities and interventions include behavioral health care to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity. Activities shall include assessment and short-term counseling designed to stabilize the individual. Individuals are referred to long-term services once the crisis has been stabilized.

"Daily supervision" means the supervision provided in a PRTF through a resident-to-staff ratio approved by the Office of Licensure at the Department of Behavioral Health and Developmental Services with documented supervision checks every 15 minutes throughout a 24-hour period.

"Discharge planning" means family and locality-based care coordination that begins upon admission to a PRTF or therapeutic group home with the goal of transitioning the individual out of the PRTF or therapeutic group home to a less restrictive care setting with continued, clinically-appropriate, and possibly intensive, services as soon as possible upon discharge. Discharge plans shall be recommended by the treating physician, psychiatrist, or treating LMHP responsible for the overall supervision of the plan of care and shall be approved by the DMAS contractor.

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

"Emergency admissions" means those admissions that are made when, pending a review for the certificate of need, it appears that the individual is in need of an immediate admission to a therapeutic group home or PRTF and likely does not meet the medical necessity criteria to receive crisis intervention, crisis stabilization, or acute psychiatric inpatient services.

"Emergency services" means unscheduled and sometimes scheduled crisis intervention, stabilization, acute psychiatric inpatient services, and referral assistance provided over the telephone or face-to-face if indicated, and available 24 hours a day, seven days per week.

"Family engagement" means a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, achieving desired outcomes, and promoting safety, permanency, and well-being for children, adolescents, and families. Family engagement requires ongoing opportunities for an individual to build and maintain meaningful relationships with family members, for example, frequent, unscheduled, and noncontingent telephone calls and visits between an individual and family members. Family engagement may also include enhancing or facilitating the development of the individual's relationship with other family members and supportive adults responsible for the individual's care and well-being upon discharge.

"Family engagement activity" means an intervention consisting of family psychoeducational training or coaching, transition planning with the family, family and independent living skills, and training on accessing community supports as identified in the plan of care. Family engagement activity does not include and is not the same as family therapy.

"Family therapy" means counseling services involving the individual's family and significant others to advance the treatment goals when (i) the counseling with the family member and significant others is for the direct benefit of the individual, (ii) the counseling is not aimed at addressing treatment needs of the individual's family or significant others, and (iii) the individual is present except when it is clinically appropriate for the individual to be absent in order to advance the individual's treatment goals. Family therapy shall be aligned with the goals of the individual's plan of care. All family therapy services furnished are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery.

"FAPT" means the family assessment and planning team.

"ICD-10" means International Statistical Classification of Diseases and Related Health Problems, 10th Revision, published by the World Health Organization.

"Independent certification team" means a team that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; has knowledge of the individual's situation; and is composed of at least one physician and one LMHP. The independent certification team shall be a DMAS-authorized contractor with contractual or employment relationships with the required team members.

"Individual" means the child or adolescent younger than 21 years of age who is receiving therapeutic group home or PRTF services.

"Individual and group therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnosis for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating plans of care using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.

"Initial plan of care" or "IPOC" means a person centered plan of care established at admission that meets all of the requirements of this subsection and is specific to the individual's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Intervention" means scheduled therapeutic treatment such as individual or group psychoeducation; skills restoration; structured behavior support and training activities; recreation, art, and music therapies; community integration activities that promote or assist in the child's or adolescent's ability to acquire coping and functional or self-regulating behavior skills; day and overnight passes; and family engagement activities. Interventions shall not include individual, group, and familytherapy; medical or dental appointments; or physician services, medication evaluation, or management provided by a licensed clinician or physician and shall not include school attendance. Interventions shall be provided in the therapeutic group home or PRTF and, when clinically necessary, in a community setting or as part of a therapeutic pass. All interventions and settings of the intervention shall be established in the plan of care.

"Plan of care" means the initial plan of care (IPOC) and the comprehensive individual plan of care (CIPOC).

"Physician" means an individual licensed to practice medicine or osteopathic medicine in Virginia, as defined in § 54.1-2900 of the Code of Virginia.

"Psychiatric residential treatment facility" or "PRTF" means the same as defined in 42 CFR 483.352 and is a 24-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to provide

necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual younger than 21 years of age in order to prevent or minimize the need for more intensive treatment.

"Recertification" means a certification for each applicant or recipient for whom therapeutic group home or PRTF services are needed.

"Room and board" means a component of the total daily cost for placement in a licensed PRTF. Residential room and board costs are maintenance costs associated with placement in a licensed PRTF and include a semi-private room, three meals and two snacks per day, and personal care items. Room and board costs are reimbursed only for PRTF settings.

"Services provided under arrangement" means services including physician and other health care services that are furnished to children while they are in a freestanding psychiatric hospital or PRTF that are billed by the arranged practitioners separately from the freestanding psychiatric hospital's or PRTF's per diem.

"Skills restoration" means a face-to-face service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the beneficiary's plan of care. Services include assisting the individual in restoring self-management, interpersonal, communication, and problem solving skills through modeling, coaching, and cueing.

"Therapeutic group home" means a congregate residential service providing 24-hour supervision in a community-based home having eight or fewer residents.

"Therapeutic pass" means time at home or time with family consisting of partial or entire days of time away from the therapeutic group home or psychiatric residential treatment facility as clinically indicated in the plan of care and as paired with facility-based and community-based interventions to promote discharge planning, community integration, and family engagement activities. Therapeutic passes are not recreational but are a therapeutic component of the plan of care and are designed for the direct benefit of the individual.

"Treatment planning" means development of a person centered plan of care that is specific to the individual's unique treatment needs and acuity levels.

2. Therapeutic group home services pursuant to 42 CFR 440.130(d).

a. Therapeutic group home services for children and adolescents younger than 21 years of age shall provide therapeutic services to restore or maintain appropriate skills necessary to promote prosocial behavior and healthy living, including skills restoration, family living and health awareness, interpersonal skills, communication skills, and stress management skills. Therapeutic services shall also engage families and reflect family-driven practices that correlate to sustained positive outcomes post-discharge for youth and their family members. Each component of therapeutic group home services is provided for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery. These services are provided under 42 CFR 440.130(d) in accordance with the rehabilitative services benefit.

b. The plan of care shall include individualized activities, including a minimum of one intervention per 24-hour period in addition to individual, group, and family therapies. Daily interventions are not required when there is documentation to justify clinical or medical reasons for the individual's deviations from the plan of care. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC. Any deviation from the plan of care shall be documented along with a clinical or medical justification for the deviation.

c. Medical necessity criteria for admission to a therapeutic group home. The following requirements for severity of need and intensity and quality of service shall be met to satisfy the medical necessity criteria for admission.

(1) Severity of need required for admission. All of the following criteria shall be met to satisfy the criteria for severity of need:

(a) The individual's behavioral health condition can only be safely and effectively treated in a 24-hour therapeutic milieu with onsite behavioral health therapy due to significant impairments in home, school, and community functioning caused by current mental health symptoms consistent with a DSM-5 diagnosis.

(b) The certificate of need must demonstrate all of the following: (i) ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual; (ii) proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and (iii) the services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

(c) The state uniform assessment tool shall be completed. The assessment shall demonstrate at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. A moderate impairment is

evidenced by, but not limited to (i) frequent conflict in the family setting such as credible threats of physical harm, where "frequent" means more than expected for the individual's age and developmental level; (ii) frequent inability to accept age-appropriate direction and supervision from caretakers, from family members, at school, or in the home or community; (iii) severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions; (iv) impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community; (v) limited ability to consider the effect of one's inappropriate conduct on others; and (vi) interactions consistently involving conflict, which may include impulsive or abusive behaviors.

(d) Less restrictive community-based services have been given a fully adequate trial and were unsuccessful or, if not attempted, have been considered, but in either situation were determined to be unable to meet the individual's treatment needs and the reasons for that are discussed in the certificate of need.

(e) The individual's symptoms, or the need for treatment in a 24 hours a day, seven days a week level of care (LOC), are not primarily due to any of the following: (i) intellectual disability, developmental disability, or autistic spectrum disorder; (ii) organic mental disorders, traumatic brain injury, or other medical condition; or (iii) the individual does not require a more intensive level of care.

(f) The individual does not require primary medical or surgical treatment.

(2) Intensity and quality of service necessary for admission. All of the following criteria shall be met to satisfy the criteria for intensity and quality of service:

(a) The therapeutic group home service has been prescribed by a psychiatrist, psychologist, or other LMHP who has documented that a residential setting is the least restrictive clinically appropriate service that can meet the specifically identified treatment needs of the individual.

(b) The therapeutic group home is not being used for clinically inappropriate reasons, including (i) an alternative to incarceration or preventative detention; (ii) an alternative to a parent's, guardian's, or agency's capacity to provide a place of residence for the individual; or (iii) a treatment intervention when other less restrictive alternatives are available.

(c) The individual's treatment goals are included in the service specific provider intake and include behaviorally defined objectives that require and can reasonably be achieved within a therapeutic group home setting.

(d) The therapeutic group home is required to coordinate with the individual's community resources, including schools and FAPT as appropriate, with the goal of transitioning the individual out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.

(e) The therapeutic group home program must incorporate nationally established, evidence-based, trauma-informed services and supports that promote recovery and resiliency.

(f) Discharge planning begins upon admission, with concrete plans for the individual to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the plan of care.

(3) Continued stay criteria. The following criteria shall be met in order to satisfy the criteria for continued stay:

(a) All of the admission guidelines continue to be met and continue to be supported by the written clinical documentation.

(b) The individual shall meet one of the following criteria: (i) the desired outcome or level of functioning has not been restored or improved in the timeframe outlined in the individual's plan of care or the individual continues to be at risk for relapse based on history or (ii) the nature of the functional gains is tenuous and use of less intensive services will not achieve stabilization.

(c) The individual shall meet one of the following criteria: (i) the individual has achieved initial CIPOC goals, but additional goals are indicated that cannot be met at a lower level of care; (ii) the individual is making satisfactory progress toward meeting goals but has not attained plan of care goals, and the goals cannot be addressed at a lower level of care; (iii) the individual is not making progress, and the plan of care has been modified to identify more effective interventions; or (iv) there are current indications that the individual requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.

(d) There is a written, up-to-date discharge plan that (i) identifies the custodial parent or custodial caregiver at discharge; (ii) identifies the school the individual will attend at discharge, if applicable; (iii) includes individualized education program (IEP) and FAPT recommendations, if necessary; (iv) outlines the aftercare treatment plan (discharge to another residential level of care is not an acceptable discharge goal); and (v) lists

barriers to community reintegration and progress made on resolving these barriers since last review.

(e) The active plan of care includes structure for combined treatment services and activities to ensure the attainment of therapeutic mental health goals as identified in the plan of care. Combined treatment services reinforce and practice skills learned in individual, group, and family therapy such as community integration skills, coping skills, family living and health awareness skills, interpersonal skills, and stress management skills. Combined treatment services may occur in group settings, in one-on-one interactions, or in the home setting during a therapeutic pass. In addition to the combined treatment services, the child or adolescent must also receive psychotherapy services, care coordination, family-based discharge planning, and locality-based transition activities. The child or adolescent shall receive intensive family interventions at least twice per month, although it is recommended that the intensive family interventions be provided at a frequency of one family therapy session per week. Family involvement begins immediately upon admission to therapeutic group home. If the minimum requirement cannot be met, the reasons must be reported, and continued efforts to involve family members must also be documented. Other family members or supportive adults may be included as indicated in the plan of care.

(f) Less restrictive treatment options have been considered but cannot yet meet the individual's treatment needs. There is sufficient current clinical documentation or evidence to show that therapeutic group home level of care continues to be the least restrictive level of care that can meet the individual's mental health treatment needs.

(4) Discharge shall occur if any of the following applies: (i) the level of functioning has improved with respect to the goals outlined in the plan of care, and the individual can reasonably be expected to maintain these gains at a lower level of treatment; (ii) the individual no longer benefits from service as evidenced by absence of progress toward plan of care goals for a period of 60 days; or (iii) other less intensive services may achieve stabilization.

d. The following clinical activities shall be required for each therapeutic group home resident:

(1) An assessment be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S.

(2) A face-to-face evaluation shall be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 calendar days prior to admission with a documented DSM-5 or ICD-10 diagnosis.

(3) A certificate of need shall be completed by an independent certification team according to the requirements of subdivision D 4 of this section. Recertification shall occur at least every 60 calendar days by an LMHP, LMHP-R, LMHP-RP, or LMHP-S acting within his scope of practice.

(4) An IPOC that is specific to the individual's unique treatment needs and acuity levels. The IPOC shall be completed on the day of admission by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be signed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual and a family member or legally authorized representative. The IPOC shall include all of the following:

(a) Individual and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

(b) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(c) A description of the functional level of the individual;

(d) Treatment objectives with short-term and long-term goals;

(e) Orders for medications, psychiatric, medical, dental, and any special health care needs whether or not provided in the facilities, treatments, restorative and rehabilitative services, activities, therapies, therapeutic passes, social services, community integration, diet, and special procedures recommended for the health and safety of the individual;

(f) Plans for continuing care, including review and modification to the plan of care; and

(g) Plans for discharge.

(5) A CIPOC shall be completed no later than 14 calendar days after admission. The CIPOC shall meet all of the following criteria:

(a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and shall reflect the need for therapeutic group home care;

(b) Be based on input from school, home, other health care providers, FAPT if necessary, the individual, and the family or legal guardian;

(c) Shall state treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

(d) Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

(e) Include a comprehensive discharge plan with necessary, clinically appropriate community services to ensure continuity of care upon discharge with the individual's family, school, and community.

(6) The CIPOC shall be reviewed, signed, and dated every 30 calendar days by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual or a family member or primary caregiver. Updates shall be signed and dated by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual or a family member or legally authorized representative. The review shall include all of the following:

(a) The individual's response to the services provided;

(b) Recommended changes in the plan as indicated by the individual's overall response to the CIPOC interventions; and

(c) Determinations regarding whether the services being provided continue to be required.

(7) Crisis management, clinical assessment, and individualized therapy shall be provided to address both behavioral health and substance use disorder needs as indicated in the plan of care to address intermittent crises and challenges within the therapeutic group home setting or community settings as defined in the plan of care and to avoid a higher level of care.

(8) Care coordination shall be provided with medical, educational, and other behavioral health providers and other entities involved in the care and discharge planning for the individual as included in the plan of care.

(9) Weekly individual therapy shall be provided in the therapeutic group home, or other settings as appropriate for the individual's needs, by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61.

(10) Weekly (or more frequently if clinically indicated) group therapy shall be provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the plan of care.

(11) Family treatment shall be provided as clinically indicated, provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, and documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the plan of care.

(12) Family engagement activities shall be provided in addition to family therapy or counseling. Family engagement activities shall be provided at least weekly as outlined in the plan of care, and daily communication with the family or legally authorized representative shall be part of the family engagement strategies in the plan of care. For each service authorization period when family engagement is not possible, the therapeutic group home shall identify and document the specific barriers to the individual's engagement with the individual's family or legally authorized representatives. The therapeutic group home shall document on a weekly basis the reasons why family engagement is not occurring as required. The therapeutic group home shall document alternative family engagement strategies to be used as part of the interventions in the plan of care and request approval of the revised plan of care by DMAS. When family engagement is not possible, the therapeutic group home shall collaborate with DMAS on a weekly basis to develop individualized family engagement strategies and document the revised strategies in the plan of care.

(13) Therapeutic passes shall be provided as clinically indicated in the plan of care and as paired with facility-based and community-based interventions to promote discharge planning, community integration, and family engagement activities.

(a) The provider shall document how the family was prepared for the therapeutic pass to include a review of the plan of care goals and objectives being addressed by the planned interventions and the safety and crisis plan in effect during the therapeutic pass.

(b) If a facility staff member does not accompany the individual on the therapeutic pass and the therapeutic pass exceeds 24 hours, the provider shall make daily contacts with the family and be available 24 hours per day to address concerns, incidents, or crises that may arise during the pass.

(c) Contact with the family shall occur within seven calendar days of the therapeutic pass to discuss the accomplishments and challenges of the therapeutic pass along with an update on progress toward plan of care goals and any necessary changes to the plan of care.

(d) Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating LMHP and documented in the plan of care. Additional therapeutic passes shall require service authorization. Any unauthorized therapeutic passes shall result in retraction for those days of service.

(14) Discharge planning shall begin at admission and continue throughout the individual's stay at the therapeutic group home. The family or guardian, the community services board (CSB), the family assessment and planning team (FAPT) case manager, and the DMAS contracted care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and available

services in the community. Prior to discharge, the therapeutic group home shall submit an active and viable discharge plan to the DMAS contractor for review. Once the DMAS contractor approves the discharge plan, the provider shall begin actively collaborating with the family or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The therapeutic group home shall request permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The therapeutic group home shall request information from post-discharge providers to establish that the planning of pending services and transition planning activities has begun, shall establish that the individual has been enrolled in school, and shall provide individualized education program recommendations to the school if necessary. The therapeutic group home shall inform the DMAS contractor of all scheduled appointments within 30 calendar days of discharge and shall notify the DMAS contractor within one business day of the individual's discharge date from the therapeutic group home.

(15) Room and board costs shall not be reimbursed. Facilities that only provide independent living services or nonclinical services that do not meet the requirements of this subsection are not eligible for reimbursement.

(16) Therapeutic group home services providers shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(17) Individuals shall be discharged from this service when treatment goals are met or other less intensive services may achieve stabilization.

(18) Services that are based upon incomplete, missing, or outdated service-specific provider intakes or plans of care shall be denied reimbursement.

(19) Therapeutic group home services may only be rendered by and within the scope of practice of an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH as defined in 12VAC35-105-20.

(20) The psychiatric residential treatment facility or therapeutic group home shall coordinate necessary services and discharge planning with other providers as medically and clinically necessary. Documentation of this care coordination shall be maintained by the facility or group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, what information was transmitted, and recommended next steps.

(21) Failure to perform any of the items described in this subsection shall result in a retraction of the per diem for each day of noncompliance.

3. PRTF services are a 24-hour, supervised, clinically and medically necessary out-of-home program designed to provide necessary support and address mental health, behavioral, substance use, cognitive, or other treatment needs of an individual younger than 21 years of age in order to prevent or minimize the need for more inpatient treatment. Active treatment and comprehensive discharge planning shall begin prior to admission. In order to be covered for individuals younger than 21 years of age, these services shall (i) meet DMAS-approved psychiatric medical necessity criteria or be approved as an EPSDT service based upon a diagnosis made by an LMHP, LMHP-R, LMHP-RP, or LMHP-S who is practicing within the scope of his license and (ii) be reflected in provider records and on the provider's claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. PRTF services shall be covered for the purpose of diagnosis and treatment of mental health and behavioral disorders when such services are rendered by a psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the state.

b. Providers of PRTF services shall be licensed by DBHDS.

c. PRTF 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 42 CFR 441.152 through 42 CFR 441.156 and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G. Each admission must be service authorized, and the treatment must meet DMAS requirements for clinical necessity.

d. The PRTF 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 PRTF services at the earliest possible time. The PRTF services benefit shall include services provided under arrangement furnished by Medicaid enrolled providers other than the PRTF, as long as the PRTF (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 PRTF. 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.

e. PRTFs, 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) nonemergency transportation services; and (x) emergency services.

f. PRTF services shall include assessment and reassessment; room and board; daily supervision; combined treatment services; individual, family, and group therapy; care coordination; interventions; general or special education; medical treatment (including medication, coordination of necessary medical services, and 24-hour onsite nursing); specialty services; and discharge planning that meets the medical and clinical needs of the individual.

g. Medical necessity criteria for admission to a PRTF. The following requirements for severity of need and intensity and quality of service shall be met to satisfy the medical necessity criteria for admission:

(1) Severity of need required for admission. The following criteria shall be met to satisfy the criteria for severity of need:

(a) There is clinical evidence that the individual has a DSM-5 disorder that is amenable to active psychiatric treatment.

(b) There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

(c) Either (i) there is clinical evidence that the individual would be a risk to self or others if the individual were not in a PRTF or (ii) as a result of the individual's mental disorder, there is an inability for the individual to adequately care for his own physical needs, and caretakers, guardians, or family members are unable to safely fulfill these needs, representing potential serious harm to self.

(d) The individual requires supervision seven days per week, 24 hours per day to develop skills necessary for daily living; to assist with planning and arranging access to a range of educational, therapeutic, and aftercare services; and to develop the adaptive and functional behavior that will allow the individual to live outside of a PRTF setting.

(e) The individual's current living environment does not provide the support and access to therapeutic services needed.

(f) The individual is medically stable and does not require the 24-hour medical or nursing monitoring or procedures provided in a hospital level of care.

(2) Intensity and quality of service necessary for admission. The following criteria shall be met to satisfy the criteria for intensity and quality of service:

(a) The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.

(b) The program provides supervision seven days per week, 24 hours per day to assist with the development of skills necessary for daily living; to assist with planning and arranging access to a range of educational, therapeutic, and aftercare services; and to assist with the development of the adaptive and functional behavior that will allow the individual to live outside of a PRTF setting.

(c) An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour nursing services availability. This plan includes (i) at least once-a-week psychiatric reassessments; (ii) intensive family or support system involvement occurring at least once per week or valid reasons identified as to why such a plan is not clinically appropriate or feasible; (iii) psychotropic medications, when used, are to be used with specific target symptoms identified; (iv) evaluation for current medical problems; (v) evaluation for concomitant substance use issues; and (vi) linkage or coordination with the individual's community resources, including the local school division and FAPT case manager, as appropriate, with the goal of returning the individual to his regular social environment as soon as possible, unless contraindicated. School contact should address an individualized educational plan as appropriate.

(d) A urine drug screen is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

(3) Criteria for continued stay. The following criteria shall be met to satisfy the criteria for continued stay:

(a) Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following: (i) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs); (ii) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs); or (iii) that disposition planning or attempts at therapeutic reentry into the community have resulted in or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued PRTF treatment. Subjective opinions without objective clinical information or evidence are not sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

(b) There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the individual can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

(c) There is evidence that the plan of care is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the individual's ability to return to a less-intensive level of care.

(d) The current or revised plan of care can be reasonably expected to bring about significant improvement in the problems meeting the criteria in subdivision 3 c (3) (a) of this subsection, and this is documented in weekly progress notes written and signed by the provider.

(e) There is evidence of intensive family or support system involvement occurring at least once per week, unless there is an identified valid reason why it is not clinically appropriate or feasible.

(f) A discharge plan is formulated that is directly linked to the behaviors or symptoms that resulted in admission and begins to identify appropriate post-PRTF resources including the local school division and FAPT case manager as appropriate.

(g) All applicable elements in admission-intensity and quality of service criteria are applied as related to assessment and treatment if clinically relevant and appropriate.

(4) Discharge criteria. Discharge shall occur if any of the following applies: (i) the level of functioning has improved with respect to the goals outlined in the plan of care, and the individual can reasonably be expected to maintain these gains at a lower level of treatment; (ii) the individual no longer benefits from service as evidenced by absence of progress toward plan of care goals for a period of 30 days; or (iii) other less intensive services may achieve stabilization.

h. The following clinical activities shall be required for each PRTF resident:

(1) A face-to-face assessment shall be performed by an LMHP, LMHP-R, LMHP-RS, or LMHP-S within 30 calendar days prior to admission and weekly thereafter and shall document a DSM-5 or ICD-10 diagnosis.

(2) A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130 D 4. Recertification shall occur at least every 30 calendar days by a physician acting within his scope of practice.

(3) The initial plan of care (IPOC) shall be completed within 24 hours of admission by the treatment team. The IPOC shall include:

(a) Individual and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

(b) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(c) A description of the functional level of the individual;

(d) Treatment objectives with short-term and long-term goals;

(e) Any orders for medications, psychiatric, medical, dental, and any special health care needs, whether or not provided in the facility; education or special education; treatments; interventions; and restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the individual;

(f) Plans for continuing care, including review and modification to the plan of care;

(g) Plans for discharge; and

(h) Signature and date by the individual, parent, or legally authorized representative, a physician, and treatment team members.

(4) The CIPOC shall be completed and signed no later than 14 calendar days after admission by the treatment team. The PRTF shall request authorizations from families to release confidential information to collect information from medical and behavioral health treatment providers, schools, FAPT, social services, court services, and other relevant parties. This information shall be used when considering changes and updating the

CIPOC. The CIPOC shall meet all of the following criteria:

(a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and must reflect the need for PRTF care;

(b) Be developed by an interdisciplinary team of physicians and other personnel specified in subdivision 3 d 4 of this subsection who are employed by or provide services to the individual in the facility in consultation with the individual, family member, or legally authorized representative, or appropriate others into whose care the individual will be released after discharge;

(c) Shall state treatment objectives that shall include measurable, evidence-based, and short-term and long-term goals and objectives; family engagement activities; and the design of community-based aftercare with target dates for achievement;

(d) Prescribe an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the individual and family treatment needs; and

(e) Describe comprehensive transition plans and coordination of current care and post-discharge plans with related community services to ensure continuity of care upon discharge with the recipient's family, school, and community.

(5) The CIPOC shall be reviewed every 30 calendar days by the team specified in subdivision 3 d 4 of this subsection to determine that services being provided are or were required from a PRTF and to recommend changes in the plan as indicated by the individual's overall adjustment during the time away from home. The CIPOC shall include the signature and date from the individual, parent, or legally authorized representative, a physician, and treatment team members.

(6) Individual therapy shall be provided three times per week (or more frequently based upon the individual's needs) provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the plan of care and progress notes in accordance with the requirements in this subsection and 12VAC30-60-61.

(7) Group therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the plan of care and progress notes in accordance with the requirements in this subsection.

(8) Family therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the plan of care and progress notes in accordance with the individual and family or legally authorized representative's goals and the requirements in this subsection.

(9) Family engagement shall be provided in addition to family therapy or counseling. Family engagement shall be provided at least weekly as outlined in the plan of care and daily communication with the treatment team representative and the treatment team representative and the family or legally authorized representative shall be part of the family engagement strategies in the plan of care. For each service authorization period when family engagement is not possible, the PRTF shall identify and document the specific barriers to the individual's engagement with his family or legally authorized representatives. The PRTF shall document on a weekly basis the reasons that family engagement is not occurring as required. The PRTF shall document alternate family engagement strategies to be used as part of the interventions in the plan of care and request approval of the revised plan of care by DMAS. When family engagement is not possible, the PRTF shall collaborate with DMAS on a weekly basis to develop individualized family engagement strategies and document the revised strategies in the plan of care.

(10) Three interventions shall be provided per 24-hour period including nights and weekends. Family engagement activities are considered to be an intervention and shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the plan of care. Any deviation from the plan of care shall be documented along with a clinical or medical justification for the deviation based on the needs of the individual.

(11) Therapeutic passes shall be provided as clinically indicated in the plan of care and as paired with community-based and facility-based interventions to promote discharge planning, community integration, and family engagement. Therapeutic passes include activities as listed in subdivision 2 d (13) of this ~~section~~ subsection. Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating physician and documented in the plan of care. Additional therapeutic passes shall require service authorization from DMAS. Any unauthorized therapeutic passes not approved by the provider or DMAS shall result in retraction for those days of service.

(12) Discharge planning shall begin at admission and continue throughout the individual's placement at the PRTF. The parent or legally authorized representative, the community services board (CSB), the family assessment planning team (FAPT) case manager, if

appropriate, and the DMAS contracted care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and identify the available services in the community. Prior to discharge, the PRTF shall submit an active discharge plan to the DMAS contractor for review. Once the DMAS contractor approves the discharge plan, the provider shall begin collaborating with the parent or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The PRTF shall request written permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The PRTF shall request information from post-discharge providers to establish that the planning of services and activities has begun, shall establish that the individual has been enrolled in school, and shall provide individualized education program recommendations to the school if necessary. The PRTF shall inform the DMAS contractor of all scheduled appointments within 30 calendar days of discharge and shall notify the DMAS contractor within one business day of the individual's discharge date from the PRTF.

(13) Failure to perform any of the items as described in subdivisions 3 h (1) through 3 h (12) of this subsection up until the discharge of the individual shall result in a retraction of the per diem and all other contracted and coordinated service payments for each day of noncompliance.

i. The team developing the CIPOC shall meet the following requirements:

(1) At least one member of the team must have expertise in pediatric behavioral health. Based on education and experience, preferably including competence in child or adolescent psychiatry, the team must be capable of all of the following: assessing the individual's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the individual's family or legally authorized representative; setting treatment objectives; and prescribing therapeutic modalities to achieve the CIPOC's objectives.

(2) The team shall include one of the following:

(a) A board-eligible or board-certified psychiatrist;

(b) A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy; or

(c) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed clinical psychologist.

(3) The team shall also include one of the following: an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

4. Requirements for independent certification teams applicable to both therapeutic group homes and PRTFs:

a. The independent certification team shall certify the need for PRTF or therapeutic group home services and issue a certificate of need document within the process and timeliness standards as approved by DMAS under contractual agreement with the DMAS contractor.

b. The independent certification team shall be approved by DMAS through a memorandum of understanding with a locality or be approved under contractual agreement with the DMAS contractor. The team shall initiate and coordinate referral to the family assessment and planning team (FAPT) as defined in §§ 2.2-5207 and 2.2-5208 of the Code of Virginia to facilitate care coordination and for consideration of educational coverage and other supports not covered by DMAS.

c. The independent certification team shall assess the individual's and family's strengths and needs in addition to diagnoses, behaviors, and symptoms that indicate the need for behavioral health treatment and also consider whether local resources and community-based care are sufficient to meet the individual's treatment needs, as presented within the previous 30 calendar days, within the least restrictive environment.

d. The LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP, as part of the independent certification team, shall meet with an individual and the individual's parent or legally authorized representative within two business days from a request to assess the individual's needs and begin the process to certify the need for an out-of-home placement.

e. The independent certification team shall meet with an individual and the individual's parent or legally authorized representative within 10 business days from a request to certify the need for an out-of-home placement.

f. The independent certification team shall assess the treatment needs of the individual to issue a certificate of need (CON) for the most appropriate medically necessary services. The certification shall include the dated signature and credentials for each of the team members who rendered the certification. Referring or treatment providers shall not actively participate during the certification process but may provide supporting clinical documentation to the certification team.

g. The CON shall be effective for 30 calendar days prior to admission.

h. The independent certification team shall provide the completed CON to the facility within one calendar day of completing the CON.

i. The individual and the individual's parent or legally authorized representative shall have the right to freedom of choice of service providers.

j. If the individual or the individual's parent or legally authorized representative disagrees with the independent certification team's recommendation, the parent or legally authorized representative may appeal the recommendation in accordance with 12VAC30-110.

k. If the LMHP, as part of the independent certification team, determines that the individual is in immediate need of treatment, the LMHP shall refer the individual to an appropriate Medicaid-enrolled crisis intervention provider, crisis stabilization provider, or inpatient psychiatric provider in accordance with 12VAC30-50-226 or shall refer the individual for emergency admission to a PRTF or therapeutic group home under subdivision 4 m of this subsection and shall also alert the individual's managed care organization.

l. For individuals who are already eligible for Medicaid at the time of admission, the independent certification team shall be a DMAS-authorized contractor with competence in the diagnosis and treatment of mental illness, preferably in child psychiatry, and have knowledge of the individual's situation and service availability in the individual's local service area. The team shall be composed of at least one physician and one LMHP, including LMHP-S, LMHP-R, and LMHP-RP. An individual's parent or legally authorized representative shall be included in the certification process.

m. For emergency admissions, an assessment must be made by the team responsible for the comprehensive individual plan of care (CIPOC). Reimbursement shall only occur when a certificate of need is issued by the team responsible for the CIPOC within 14 calendar days after admission. The certification shall cover any period of time after admission and before claims are made for reimbursement by Medicaid. After processing an emergency admission, the therapeutic group home, PRTF, or institution for mental diseases (IMD) shall notify the DMAS contractor within five calendar days of the individual's status as being under the care of the facility.

n. For all individuals who apply and become eligible for Medicaid while an inpatient in a facility or program, the certification team shall refer the case to the DMAS contractor for referral to the local FAPT to facilitate care coordination and consideration of educational coverage and other supports not covered by DMAS.

o. For individuals who apply and become eligible for Medicaid while an inpatient in the facility or program, the certification shall be made by the team responsible for the CIPOC and shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. Upon the individual's enrollment into the Medicaid program, the therapeutic group home, PRTF, or IMD shall notify the DMAS contractor of the individual's status as being under the care of the facility within five calendar days of the individual becoming eligible for Medicaid benefits.

5. Service authorization requirements applicable to both therapeutic group homes and PRTFs:

a. Authorization shall be required and shall be conducted by DMAS using medical necessity criteria specified in this subsection.

b. An individual shall have a valid psychiatric diagnosis and meet the medical necessity criteria as defined in this subsection to satisfy the criteria for admission. The diagnosis shall be current, as documented within the past 12 months. If a current diagnosis is not available, the individual will require a mental health evaluation prior to admission by an LMHP affiliated with the independent certification team to establish a diagnosis and recommend and coordinate referral to the available treatment options.

c. At authorization, an initial length of stay shall be agreed upon by the individual and parent or legally authorized representative with the treating provider, and the treating provider shall be responsible for evaluating and documenting evidence of treatment progress, assessing the need for ongoing out-of-home placement, and obtaining authorization for continued stay.

d. Information that is required to obtain authorization for these services shall include:

(1) A completed state-designated uniform assessment instrument approved by DMAS;

(2) A certificate of need completed by an independent certification team specifying all of the following:

(a) The ambulatory care and Medicaid or FAPT-funded services available in the community do not meet the specific treatment needs of the individual;

(b) Alternative community-based care was not successful;

(c) Proper treatment of the individual's psychiatric condition requires services in a 24-hour supervised setting under the direction of a physician; and

(d) The services can reasonably be expected to improve the individual's condition or prevent further regression so that a more intensive level of care will not be needed;

(3) Diagnosis as defined in the DSM-5 and based on (i) an evaluation by a psychiatrist or LMHP that has been completed within 30 calendar days of admission or (ii) a diagnosis confirmed in writing by an LMHP after review of a previous evaluation completed within one year of admission;

(4) A description of the individual's behavior during the seven calendar days immediately prior to admission;

(5) A description of alternate placements and community mental health and rehabilitation services and traditional behavioral health services pursued and attempted and the outcomes of each service;

(6) The individual's level of functioning and clinical stability;

(7) The level of family involvement and supports available; and

(8) The initial plan of care (IPOC).

6. Continued stay criteria requirements applicable to both therapeutic group homes and PRTFs. For a continued stay authorization or a reauthorization to occur, the individual shall meet the medical necessity criteria as defined in this subsection to satisfy the criteria for continuing care. The length of the authorized stay shall be determined by DMAS. A current plan of care and a current (within 30 calendar days) summary of progress related to the goals and objectives of the plan of care shall be submitted to DMAS for continuation of the service. The service provider shall also submit:

a. A state uniform assessment instrument, completed no more than 30 business days prior to the date of submission;

b. Documentation that the required services have been provided as defined in the plan of care;

c. Current (within the last 14 calendar days) information on progress related to the achievement of all treatment and discharge-related goals; and

d. A description of the individual's continued impairment and treatment needs, problem behaviors, family engagement activities, community-based discharge planning and care coordination, and need for a residential level of care.

7. EPSDT services requirements applicable to therapeutic group homes and PRTFs. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT. EPSDT services may involve service modalities not available to other individuals, such as applied behavioral analysis and neuro-rehabilitative services. Individualized services to address specific clinical needs identified in an EPSDT screening shall require authorization by a DMAS contractor. In unique EPSDT cases, DMAS may authorize specialized services beyond the standard therapeutic group home or PRTF medical necessity criteria and program requirements, as medically and clinically indicated to ensure the most appropriate treatment is available to each individual. Treating service providers authorized to deliver medically necessary EPSDT services in therapeutic group homes and PRTFs on behalf of a Medicaid-enrolled individual shall adhere to the individualized interventions and evidence-based progress measurement criteria described in the plan of care and approved for reimbursement by DMAS. All documentation, independent certification team, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT PRTF or therapeutic group home service.

8. Inpatient psychiatric services shall be covered for individuals younger than 21 years of age 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 meet the requirements set forth in subdivision 7 of this subsection.

a. Inpatient psychiatric services shall be provided under the direction of a physician.

b. Inpatient psychiatric services shall be provided by (i) a psychiatric hospital that undergoes a state survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in 42 CFR 482.60 or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by the Centers for Medicare and Medicaid Services (CMS); or (ii) a hospital with an inpatient psychiatric program that undergoes a state survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in 42 CFR part 482 or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

c. Inpatient psychiatric 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.

d. PRTF 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 42 CFR 441.151 (b) and 42 CFR 441.152 through 42 CFR 441.156 and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G. Each admission must be service authorized and the treatment must meet DMAS requirements for clinical necessity.

e. The inpatient psychiatric benefit for individuals younger than 21 years of age shall include services that are provided 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 individual's discharge from inpatient status at the earliest possible time. The inpatient psychiatric 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 inpatient psychiatric facility who is licensed to prescribe drugs shall be considered the referral.

f. State freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order pharmacy services and emergency services. Private freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order the following 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) nonemergency transportation services; and (viii) emergency services. (Emergency services means the same as is set forth in 12VAC30-50-310 B.)

E. 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, C, and E 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 shall (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, 19, and 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, 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.

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 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.

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 12 of this subsection shall be eligible to bill and receive reimbursement from DMAS for mental health family support partner services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS. 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 meet the requirements set forth in 12VAC30-50-226 B 7 l.

F. 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.

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

H. Services facilitators shall be required for all consumer-directed personal care services consistent with the requirements set out in 12VAC30-120-935.

I. Behavioral therapy services shall be covered for individuals younger than 21 years of age.

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

"Behavioral therapy" means systematic interventions provided by licensed practitioners acting within the scope of practice defined under a Virginia Department of Health Professions regulatory board and covered as remedial care under 42 CFR 440.130(d) to individuals younger than 21 years of age. Behavioral therapy includes applied behavioral analysis. Family training related to the implementation of the behavioral therapy shall be included as part of the behavioral therapy service. Behavioral therapy services shall be subject to clinical reviews and determined as medically necessary. Behavioral therapy may be provided in the individual's home and community settings as deemed by DMAS as medically necessary treatment.

"Counseling" means a professional mental health service that can only be provided by a person holding a license issued by a health regulatory board at the Department of Health Professions, which includes conducting assessments, making diagnoses of mental disorders and conditions, establishing treatment plans, and determining treatment interventions.

"Individual" means the child or adolescent younger than 21 years of age who is receiving behavioral therapy services.

"Primary care provider" means a licensed medical practitioner who provides preventive and primary health care and is responsible for providing routine EPSDT screening and referral and coordination of other medical services needed by the individual.

2. Behavioral therapy services shall be designed to enhance communication skills and decrease maladaptive patterns of behavior, which if left untreated, could lead to more complex problems and the need for a greater or a more intensive level of care. The service goal shall be to ensure the individual's family or caregiver is trained to effectively manage the individual's behavior in the home using modification strategies. All services shall be provided in accordance with the ISP and clinical assessment summary.

3. Behavioral therapy services shall be covered when recommended by the individual's primary care provider or other licensed physician, licensed physician assistant, or licensed nurse practitioner and determined by DMAS to be medically necessary to correct or ameliorate significant impairments in major life activities that have resulted from either developmental, behavioral, or mental disabilities. Criteria for medical necessity are set out in 12VAC30-60-61 F. Service-specific provider intakes shall be required at the onset of these services in order to receive authorization for reimbursement. Individual service plans (ISPs) shall be required throughout the entire duration of services. The services shall be provided in accordance with the individual service plan and clinical assessment summary. These services shall be provided in settings that are natural or normal for a child or adolescent without a disability, such as the individual's home, unless there is justification in the ISP, which has been authorized for reimbursement, to include service settings that promote a generalization of behaviors across different settings to maintain the targeted functioning outside of the treatment setting in the individual's home and the larger community within which the individual resides. Covered behavioral therapy services shall include:

a. Initial and periodic service-specific provider intake as defined in 12VAC30-60-61 F;

b. Development of initial and updated ISPs as established in 12VAC30-60-61 F;

c. Clinical supervision activities. Requirements for clinical supervision are set out in 12VAC30-60-61 F;

d. Behavioral training to increase the individual's adaptive functioning and communication skills;

e. Training a family member in behavioral modification methods as established in 12VAC30-60-61 F;

f. Documentation and analysis of quantifiable behavioral data related to the treatment objectives; and

g. Care coordination.

4. All personal care services rendered to children under the authority of 42 CFR 440.40(b) shall comply with the requirements of 12VAC30-60-65 with regard to electronic visit verification.

J. 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. 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. 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 and 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 dressing changes, maintaining patent airways, medication administration or 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 or developmental 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 professional develops a written plan for meeting the needs of the individual, 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. Individuals 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 an individual'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 an individual 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 individual is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the individual's IEP. Individuals 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 an individual'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 individual 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 an individual is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

K. 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.

12VAC30-60-65. Electronic visit verification.

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

"Aide" means the person who is employed by an agency to provide hands-on care.

"Agency-directed services" means a model of service delivery where an agency is responsible for providing direct support staff, for maintaining an individual's records, and for scheduling the dates and times of the direct support staff's presence in the individual's home for personal care services, respite care services, and companion services.

"Attendant" means the person who is hired by the individual consumer to provide hands-on care.

"Companion services" means nonmedical care, supervision, and socialization provided to an adult individual (ages 18 years and older). The provision of companion services shall not entail hands-on care but shall be provided in accordance with a therapeutic goal in the individual support plan and is not purely diversional in nature.

"Consumer-directed attendant" means a person who provides consumer-directed personal care services, respite care services, companion services, or any combination of these three services, who is also exempt from workers' compensation.

"Consumer-directed services" or "CD services" means the model of service delivery for which the individual enrolled in the waiver or the individual's employer of record, as appropriate, is responsible for hiring, training, supervising, and firing of an attendant who renders the services that are reimbursed by DMAS.

"DMAS" means the Department of Medical Assistance Services.

"Electronic visit verification" or "EVV" means a system by which personal care services, companion services, or respite care services home visits are electronically verified with respect to (i) the type of service performed, (ii) the individual receiving the service, (iii) the date of the service, (iv) the location of service delivery, (v) the individual providing the service, and (vi) the time the service begins and ends.

"Individual" means the person who has applied for and been approved to receive services for which EVV is required.

"Personal care services" means a range of support services that includes assistance with activities of daily living and instrumental activities of daily living, access to the community, and self-administration of medication or other medical needs and the monitoring of health status and physical condition provided through the agency-directed or consumer-directed model of service. Personal care services shall be provided by a personal care attendant or aide within the scope of the attendant's or aide's license or certification, as appropriate.

"Respite care services" means services provided to waiver individuals who are unable to care for themselves that are

furnished on a short-term basis because of the absence of or need for the relief of the unpaid primary caregiver who normally provides the care.

B. Applicable services. All of the requirements for an electronic visit verification system shall apply to all providers, both agency-directed and consumer-directed, of personal care services, respite care services, and companion services.

1. Agency providers shall choose the EVV system that best suits the provider business model, meets regulatory requirements established in this section, and provides reliable functionality for the geographic area in which it is to be used.

2. For consumer-directed services, the DMAS designee (the fiscal employer agent) shall select and operate an EVV system to support an individual, or the employer of record, in managing the individual's care, meeting regulatory requirements established in this section, and providing reliable functionality for the geographic area in which it is to be used.

3. Providers of consumer-directed personal care services, respite care services, and companionservices shall comply with all EVV requirements.

4. Providers of agency-directed personal care services, respite care services, and companion services shall comply with all EVV requirements.

5. Individuals shall not be restricted from receiving a combination of agency-directed and consumer-directed services. Nothing in this section shall be construed to limit personal care, respite care, or companion services; an individual's selection of a provider attendant or aide; or impede the manner or location in which services are delivered subject to subsection C of this section.

C. The following entities shall be exempt from EVV requirements:

1. A DBHDS-licensed provider in a DBHDS-licensed program site, such as a group home or sponsored residential home or a supervised living, supported living, or similar facility or location licensed to provide respite care services;

2. The Regional Educational Assessment Crisis Response and Habilitation (REACH) Program; and

3. Schools where personal care services are rendered under the authority of an individual education program.

D. System requirements.

1. The EVV system shall be capable of capturing required data in real time and producing such data as requested by DMAS in electronic format. The following information shall be retained:

a. The type of the service being performed;

b. The individual who receives the service;

c. The date of the service, including month, day, and year;

d. The time the service begins and ends;

e. The location of the service delivery at the beginning and the end of the service. EVV systems shall not restrict locations where individuals may receive services; and

f. The attendant or aide who provides the service.

2. In the event the time of service delivery needs to be adjusted, the start or end time may be modified by someone who has the provider's authority to adjust the aide's or attendant's hours.

a. For agency-directed providers, this may be a supervisor or the agency owner or a designee who has authority to make independent verifications. In no case shall workers be allowed to adjust a peer worker's reported time.

b. For consumer-directed attendants, the fiscal employer agent shall have this authority.

3. All EVV systems shall be compliant with the requirements of the American with Disabilities Act (42 USC § 12101 et seq.) and Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

4. All EVV systems shall employ electronic devices that are capable of recording the required data described in subdivision D 1 of this section, producing it upon demand, and safeguarding the data both physically and electronically.

5. All EVV systems shall be accessible for input or service delivery 24 hours per day, seven days per week.

6. All EVV systems shall provide for data backups in the event of emergencies; disasters, natural or otherwise; and system malfunctions, both in the location services are being delivered and the backup server location.

7. All EVV systems shall be capable of handling:

a. Multiple work shifts per day per individual or aide or attendant combination;

b. Aides or attendants who work for multiple individuals;

c. Individuals who use multiple aides or attendants;

d. Multiple individuals and multiple aides or attendants or both in the same location at the same time and date. In such situations, the EVV shall be capable of separately documenting the services, as well as the other elements set out in subdivision D 1 of this section, that are provided to each individual; and

e. At minimum, daily backups of the most recent data that has been entered.

8. All EVV systems shall be capable of electronically transmitting information to DMAS in the required format or electronically transferring it to the provider's billing system.

E. EVV data shall be submitted to DMAS with the provider's billing claim.

F. Agency-directed provider records, audits, and reports.

1. Providers shall select and obtain an EVV system that meets the functional requirements of DMAS or its designee.

2. All providers shall retain EVV data for at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception is resolved. Policies regarding retention of records shall apply even if the provider discontinues operation.

a. In the event a provider discontinues services, DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise.

b. The location, agent, or trustee shall be within the Commonwealth.

3. All providers shall retain records of minor individuals for at least six years after such minor individual has reached 18 years of age.

4. All providers shall produce their archived EVV data in a timely manner and in an electronic format when requested by DMAS or its designee.

5. In the event that a telephone or other verification option that the provider uses is not available or accessible in the individual's home or location, and delayed data input is utilized, the provider shall have information on file documenting the reason that the aide or attendant did not use EVV for the service delivered.

12VAC30-120-766. Personal care and respite care services.

A. Service description. Services may be provided either through an agency-directed or consumer-directed model.

1. Personal care services means services offered to individuals in their homes and communities to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. This service shall provide care to individuals with activities of daily living (eating, drinking, personal hygiene, toileting, transferring, and ~~bowel/bladder~~ bowel or bladder control), instrumental activities of daily living (IADL), access to the community, monitoring of self-medication or other medical needs, and the monitoring of health status or physical condition. In order to receive personal care services, the individual must require assistance with their ADLs. When specified in the plan of care, personal care services may include assistance with IADL. Assistance with IADL must be essential to the health and welfare of the individual, rather than the individual's ~~family/caregiver~~ family or caregiver. An additional component to personal care is work or school-related personal care. This allows the personal care provider to provide assistance and supports for individuals in the workplace and for those individuals attending postsecondary educational institutions. Workplace or school supports through the IFDDS Waiver are not provided if they are services that should be provided by DARS, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act, the Virginians with Disabilities Act, or § 504 of the Rehabilitation Act. Work-related personal care services cannot duplicate services provided under supported employment.

2. Respite care means services provided for unpaid caregivers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons who routinely provide the care.

3. Both agency-directed and consumer-directed personal care services and respite care services shall be subject to the requirements of electronic visit verification set out in 12VAC30-60-65.

B. Criteria.

1. In order to qualify for personal care services, the individual must demonstrate a need in activities of daily living, reminders to take medication, or other medical needs, or monitoring health status or physical condition.

2. In order to qualify for respite care, individuals must have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual.

3. Individuals choosing the consumer-directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-770.

C. Service units and service limitations.

1. The unit of service is one hour.

2. Effective July 1, 2011, respite care services are limited to a maximum of 480 hours per year. Individuals who are receiving services through both the agency-directed and

consumer-directed models cannot exceed 480 hours per year combined.

3. Individuals may have personal care, respite care, and in-home residential support services in their plan of care but cannot receive in-home residential supports and personal care or respite care services at the same time.

4. Each individual receiving personal care services must have a back-up plan in case the personal care aide or consumer-directed (CD) employee does not show up for work as expected or terminates employment without prior notice.

5. Individuals must need assistance with ADLs in order to receive IADL care through personal care services.

6. Individuals shall be permitted to share personal care service hours with one other individual (receiving waiver services) who lives in the same home.

7. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, personal and respite care providers must meet the following provider requirements:

1. Services shall be provided by:

a. For the agency-directed model, a DMAS enrolled personal care/respite care provider or by a DBHDS-licensed residential supportive in-home provider. All personal care aides must pass an objective standardized test of knowledge, skills, and abilities approved by DBHDS and administered according to DBHDS' defined procedures.

Providers must demonstrate a prior successful health care delivery business and operate from a business office.

b. For the consumer-directed model, a service facilitation provider meeting the requirements found in 12VAC30-120-770.

2. For DBHDS-licensed providers, a residential supervisor shall provide ongoing supervision for all personal care aides. For DMAS-enrolled personal care/respite care providers, the provider must employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all aides. The supervising RN must be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.

3. The RN supervisor or case manager/services facilitator must make a home visit to conduct an initial assessment prior to the start of care for all individuals requesting services. The RN supervisor or case manager/service facilitator must also perform any subsequent reassessments or changes to the supporting documentation. Under the consumer-directed model, the initial comprehensive visit is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.

4. The RN supervisor or case manager/services facilitator must make supervisory visits as often as needed to ensure both quality and appropriateness of services.

a. For personal care the minimum frequency of these visits is every 30 to 90 calendar days depending on individual needs. For respite care offered on a routine basis, the minimum frequency of these visits is every 30 to 90 calendar days under the agency-directed model and every six months or upon the use of 240 respite care hours (whichever comes first) under the consumer-directed model.

b. Under the agency-directed model, when respite care services are not received on a routine basis, but are episodic in nature, the RN is not required to conduct a supervisory visit every 30 to 90 calendar days. Instead, the RN supervisor must conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period.

c. When respite care services are routine in nature and offered in conjunction with personal care, the 30-day to 90-day supervisory visit conducted for personal care may serve as the RN supervisor or case manager/service facilitator visit for respite care. However, the RN supervisor or case manager/services facilitator must document supervision of respite care separately. For this purpose, the same record can be used with a separate section for respite care documentation.

5. Under the agency-directed model, the supervisor shall identify any gaps in the aide's ability to provide services as identified in the individual's plan of care and provide training as indicated based on continuing evaluations of the aide's performance and the individual's needs.

6. The supervising RN or case manager/services facilitator must maintain current documentation. This may be done as a summary and must note:

a. Whether personal and respite care services continue to be appropriate;

b. Whether the supporting documentation is adequate to meet the individual's needs or if changes are indicated in the supporting documentation;

c. Any special tasks performed by the aide/CD employee and the aide's/CD employee's qualifications to perform these tasks;

d. Individual's satisfaction with the service;

e. Any hospitalization or change in the individual's medical condition or functioning status;

f. Other services received and their amount; and

g. The presence or absence of the aide in the home during the RN's visit.

7. Qualification of aides/CD employees. Each aide/CD employee must:

a. Be 18 years of age or older and possess a valid social security number;

b. For the agency-directed model, be able to read and write English to the degree necessary to perform the tasks required. For the consumer-directed model, possess basic math, reading and writing skills;

c. Have the required skills to perform services as specified in the individual's plan of care;

d. Not be the parents of individuals who are minors, or the individual's spouse. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who are approved to be reimbursed for providing this service must meet the qualifications. In addition, under the consumer-directed model, ~~family/caregivers~~ family or caregivers acting as the employer on behalf of the individual may not also be the CD employee;

e. Additional aide requirements under the agency-directed model:

(1) Complete an appropriate aide training curriculum consistent with DMAS standards. Prior to assigning an aide to an individual, the provider must ensure that the aide has satisfactorily completed a training program consistent with DMAS standards. DMAS requirements may be met in any of the following ways:

(a) Registration as a certified nurse aide (DMAS-enrolled personal care/respite care providers);

(b) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistant or home health aide (DMAS-enrolled personal care/respite care providers);

(c) Completion of provider-offered training that is consistent with the basic course outline approved by DMAS (DMAS-enrolled personal care/respite care providers);

(d) Completion and passing of the DBHDS standardized test (DBHDS-licensed providers);

(2) Have a satisfactory work record as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children; and

(3) Be evaluated in his job performance by the supervisor.

f. Additional CD employee requirements under the consumer-directed model:

(1) Submit to a criminal records check and, if the individual is a minor, the child protective services registry. The employee will not be compensated for services provided to the individual if the records check verifies the employee has been convicted of crimes described in § 37.2-314 of the Code of Virginia or if the employee has a complaint confirmed by the DSS child protective services registry;

(2) Be willing to attend training at the request of the individual or his ~~family/caregivers~~ family or caregiver, as appropriate;

(3) Understand and agree to comply with the DMAS consumer-directed services requirements; and

(4) Receive an annual TB screening.

8. Provider inability to render services and substitution of aides (agency-directed model). When an aide is absent, the provider may either obtain another aide, obtain a substitute aide from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another provider.

9. Retention, hiring, and substitution of employees (consumer-directed model). Upon the individual's request, the CD services facilitator shall provide the individual or his ~~family/caregiver~~ family or caregiver, as appropriate, with a list of consumer-directed employees on the consumer-directed employee registry that may provide temporary assistance until the employee returns or the individual or his ~~family/caregiver~~ family or caregiver, as appropriate, is able to select and hire a new employee. If an individual or his ~~family/caregiver~~ family or caregiver, as appropriate, is consistently unable to hire and retain an employee to provide consumer-directed services, the services facilitator must contact the case manager and DBHDS to transfer the individual, at the choice of the individual or his ~~family/caregiver~~ family or caregiver, as appropriate, to a provider that provides Medicaid-funded

agency-directed personal care or respite care services. The CD services facilitator will make arrangements with the case manager to have the individual transferred.

10. Required documentation in individuals' records. The provider must maintain all records of each individual receiving services. Under the agency-directed model, these records must be separated from those of other nonwaiver services, such as home health services. At a minimum these records must contain:

a. The most recently updated plan of care and supporting documentation, all provider documentation, and all DMAS-225 forms;

b. Initial assessment by the RN supervisory nurse or case manager/services facilitator completed prior to or on the date services are initiated, subsequent reassessments, and changes to the supporting documentation by the RN supervisory nurse or case manager/services facilitator;

c. Nurses' or case manager/services facilitator summarizing notes recorded and dated during any contacts with the aide or CD employee and during supervisory visits to the individual's home;

d. All correspondence to the individual, to DBHDS, and to DMAS;

e. Contacts made with family, physicians, DBHDS, DMAS, formal and informal service providers, and all professionals concerning the individual;

f. Under the agency-directed model, all aide records. The aide record must contain:

(1) The specific services delivered to the individual by the aide and the individual's responses;

(2) The aide's arrival and departure times;

(3) The aide's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered;

(4) The aide's and individual's weekly signatures to verify that services during that week have been rendered;

(5) Signatures, times, and dates; these signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered; and

(6) Copies of all aide records; these records shall be subject to review by state and federal Medicaid representatives.

g. Additional documentation requirements under the consumer-directed model:

(1) All management training provided to the individuals or their family caregivers, as appropriate, including responsibility for the accuracy of the timesheets.

(2) All documents signed by the individual or his ~~family/caregivers~~ family or caregiver, as appropriate, that acknowledge the responsibilities of the services.

12VAC30-120-924. Covered services; limits on covered services.

A. Covered services in the EDCD Waiver shall include: adult day health care, personal care (both consumer-directed and agency-directed), respite services (both consumer-directed and agency-directed), PERS, PERS medication monitoring, limited assistive technology, limited environmental modifications, transition coordination, and transition services.

1. The services covered in this waiver shall be appropriate and medically necessary to maintain the individual in the community in order to prevent institutionalization and shall be cost effective in the aggregate as compared to the alternative NF placement.

2. EDCD services shall not be authorized if another entity is required to provide the services (e.g., schools, insurance). Waiver services shall not duplicate services available through other programs or funding streams.

3. Assistive technology and environmental modification services shall be available only to those EDCD Waiver individuals who are also participants in the Money Follows the Person (MFP) demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.).

4. An individual receiving EDCD Waiver services who is also getting hospice care may receive Medicaid-covered personal care (agency-directed and consumer-directed), respite care (agency-directed and consumer-directed), adult day health care, transition services, transition coordination, and PERS services, regardless of whether the hospice provider receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Such dual waiver/hospice individuals shall only be able to receive assistive technology and environmental modifications if they are also participants in the MFP demonstration program.

5. Agency-directed and consumer-directed personal care services and respite care services shall be subject to the electronic visit verification requirements set out in 12VAC30-60-65.

B. ~~Voluntary/involuntary~~ Voluntary or involuntary disenrollment from consumer-directed services. In either voluntary or involuntary disenrollment situations, the waiver individual shall be permitted to select an agency from which to receive his agency-directed personal care and respite services.

1. A waiver individual may be found to be ineligible for CD services by either the Preadmission Screening Team, DMAS-enrolled hospital provider, DMAS, its designated

agent, or the CD services facilitator. An individual may not begin or continue to receive CD services if there are circumstances where the waiver individual's health, safety, or welfare cannot be assured, including ~~but not limited to~~:

a. It is determined that the waiver individual cannot be the EOR and no one else is able to assume this role;

b. The waiver individual cannot ensure his own health, safety, or welfare or develop an emergency backup plan that will ensure his health, safety, or welfare; or

c. The waiver individual has medication or skilled nursing needs or medical or behavioral conditions that cannot be met through CD services or other services.

2. The waiver individual may be involuntarily disenrolled from consumer direction if he or the EOR, as appropriate, is consistently unable to retain or manage the attendant as may be demonstrated by, but not necessarily limited to, a pattern of serious discrepancies with the attendant's timesheets.

3. In situations where either (i) the waiver individual's health, safety, or welfare cannot be assured or (ii) attendant timesheet discrepancies are known, the services facilitator shall assist as requested with the waiver individual's transfer to agency-directed services as follows:

a. Verify that essential training has been provided to the waiver individual or EOR;

b. Document, in the waiver individual's case record, the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator;

c. Discuss with the waiver individual or the EOR, as appropriate, the agency-directed option that is available and the actions needed to arrange for such services and offer choice of potential providers, and

d. Provide written notice to the waiver individual of the right to appeal such involuntary termination of consumer direction. Such notice shall be given at least 10 calendar days prior to the effective date of this change. In cases when the individual's or the provider personnel's safety may be jeopardy, the 10 calendar days notice shall not apply.

C. Adult day health care (ADHC) services. ADHC services shall only be offered to waiver individuals who meet preadmission screening criteria as established in 12VAC30-60-303 and 12VAC30-60-307 and for whom ADHC services shall be an appropriate and medically necessary alternative to institutional care. ADHC services may be offered to individuals in a VDSS-licensed adult day care center (ADCC) congregate setting. ADHC may be offered either as the sole home and community-based care service or in conjunction with personal care (either agency-directed or consumer-directed), respite care (either agency-directed or consumer-directed), or PERS. A multi-disciplinary approach to developing, implementing, and evaluating each waiver individual's POC shall be essential to quality ADHC services.

1. ADHC services shall be designed to prevent institutionalization by providing waiver individuals with health care services, maintenance of their physical and mental conditions, and coordination of rehabilitation services in a congregate daytime setting and shall be tailored to their unique needs. The minimum range of services that shall be made available to every waiver individual shall be: assistance with ADLs, nursing services, coordination of rehabilitation services, nutrition, social services, recreation, and socialization services.

a. Assistance with ADLs shall include supervision of the waiver individual and assistance with management of the individual's POC.

b. Nursing services shall include the periodic evaluation, at least every 90 days, of the waiver individual's nursing needs; provision of indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervision of the waiver individual in self-administered medication; support of families in their home care efforts for the waiver individuals through education and counseling; and helping families identify and appropriately utilize health care resources. Periodic evaluations may occur more frequently than every 90 days if indicated by the individual's changing condition. Nursing services shall also include the general supervision of provider staff, who are certified through the Board of Nursing, in medication management and administering medications.

c. Coordination and implementation of rehabilitation services to ensure the waiver individual receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include physical therapy, occupational therapy, and speech therapy.

d. Nutrition services shall be provided to include~~, but not necessarily be limited to,~~ one meal per day that meets the daily nutritional requirements pursuant to 22VAC40-60-800. Special diets and nutrition counseling shall be provided as required by the waiver individuals.

e. Recreation and social activities shall be provided that are suited to the needs of the waiver individuals and shall be designed to encourage physical exercise, prevent physical and mental deterioration, and stimulate social interaction.

f. ADHC coordination shall involve implementing the waiver individuals' POCs, updating such plans, recording 30-day progress notes, and reviewing the waiver individuals' daily logs each week.

2. Limits on covered ADHC services.

a. A day of ADHC services shall be defined as a minimum of six hours.

b. ADCCs that do not employ professional nursing staff on site shall not be permitted to admit waiver individuals who require skilled nursing care to their centers. Examples of skilled nursing care may include: (i) tube feedings; (ii) Foley catheter irrigations; (iii) sterile dressing changing; or (iv) any other procedures that require sterile technique. The ADCC shall not permit its aide employees to perform skilled nursing procedures.

c. At any time that the center is no longer able to provide reliable, continuous care to any of the center's waiver individuals for the number of hours per day or days per week as contained in the individuals' POCs, then the center shall contact the waiver individuals or ~~family/caregivers~~ their family or caregivers, as appropriate, to initiate other care arrangements for these individuals. The center may either subcontract with another ADCC or may transfer the waiver individual to another ADCC. The center may discharge waiver individuals from the center's services but not from the waiver. Written notice of discharge shall be provided, with the specific reason or reasons for discharge, at least 10 calendar days prior to the effective date of the discharge. In cases when the individual's or the center personnel's safety may be jeopardy, the 10 calendar days notice shall not apply.

d. ADHC services shall not be provided, for the purpose of Medicaid reimbursement, to individuals who reside in NFs, ICFs/IID, hospitals, assisted living facilities that are licensed by VDSS, or group homes that are licensed by DBHDS.

D. Agency-directed personal care services. Agency-directed personal care services shall only be offered to persons who meet the preadmission screening criteria at 12VAC30-60-303 and 12VAC30-60-307 and for whom it shall be an appropriate alternative to institutional care. Agency-directed personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include~~, but shall not necessarily be limited to,~~ assistance with ADLs, access to the community, assistance with medications in accordance with VDH licensing requirements or other medical needs, supervision, and the monitoring of health status and physical condition. Where the individual requires assistance with ADLs, and when specified in the POC, such supportive services may include assistance with IADLs. This service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC90-20. Agency-directed personal care services may be provided in a home or community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based care service or in conjunction with adult day health care, respite care (agency-directed or consumer-directed), or PERS. The provider shall document, in the individual's medical record, the waiver individual's choice of the agency-directed model.

1. Criteria. In order to qualify for this service, the waiver individual shall have met the NF LOC criteria as set out in 12VAC30-60-303 and 12VAC30-60-307 as documented on the UAI assessment form, and for whom it shall be an appropriate alternative to institutional care.

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be needed if the waiver individual were receiving personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

c. The individual or ~~family/caregiver~~ family or caregiver shall have a backup plan for the provision of services in the event the agency is unable to provide an aide.

2. Limits on covered agency-directed personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. DMAS shall reimburse for services delivered, consistent with the approved POC, for personal care that the personal care aide provides to the waiver individual to assist him while he is at work or postsecondary school.

(1) DMAS or the designated Srv Auth contractor shall review the waiver individual's needs and the complexity of the disability, as applicable, when determining the services that are provided to him in the workplace or postsecondary school or both.

(2) DMAS shall not pay for the personal care aide to assist the enrolled waiver individual with any functions or tasks related to the individual completing his job or postsecondary school functions or for supervision time during either work or postsecondary school or both.

c. Supervision services shall only be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no

one else in the home competent and able to call for help in case of an emergency.

d. There shall be a maximum limit of eight hours per 24-hour day for supervision services. Supervision services shall be documented in the POC as needed by the individual.

e. Agency-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.

f. Electronic visit verification requirements set out in 12VAC30-60-65 shall apply to these agency-directed respite care services.

E. Agency-directed respite care services. Agency-directed respite care services shall only be offered to waiver individuals who meet the preadmission screening criteria at 12VAC30-60-303 and 12VAC30-60-307 and for whom it shall be an appropriate alternative to institutional care. Agency-directed respite care services may be either skilled nursing or unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include~~, but shall not be limited to,~~ assistance with ADLs, access to the community, assistance with medications in accordance with VDH licensing requirements or other medical needs, supervision, and monitoring health status and physical condition.

1. Respite care shall only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. Respite care services may be provided in the individual's home or other community settings.

2. When the individual requires assistance with ADLs, and where such assistance is specified in the waiver individual's POC, such supportive services may also include assistance with IADLs.

3. The unskilled care portion of this service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC90-20.

4. Limits on service.

a. The unit of service shall be one hour. Respite care services shall be limited to 480 hours per individual per state fiscal year, to be service authorized. If an individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment for individuals who change waiver programs. Additionally, individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per state fiscal year combined.

b. If agency-directed respite care service is the only service received by the waiver individual, it must be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the provider agency shall notify the local department of social services for its redetermination of eligibility for the waiver individual.

c. The individual or ~~family/caregiver~~ family or caregiver shall have a backup plan for the provision of services in the event the agency is unable to provide an aide.

d. Electronic visit verification requirements set out in 12VAC30-60-65 shall apply to these agency-directed respite care services.

F. Services facilitation for consumer-directed services. Consumer-directed personal care and respite care services shall only be offered to persons who meet the preadmission screening criteria at 12VAC30-60-303 and 12VAC30-60-307 and for whom there shall be appropriate alternatives to institutional care.

1. Individuals who choose CD services shall receive support from a DMAS-enrolled CD services facilitator as required in conjunction with CD services. The services facilitator shall document the waiver individual's choice of the CD model and whether there is a need for another person to serve as the EOR on behalf of the individual. The CD services facilitator shall be responsible for assessing the waiver individual's particular needs for a requested CD service, assisting in the development of the POC, providing training to the EOR on his responsibilities as an employer, and for providing ongoing support of the CD services.

2. Individuals who are eligible for CD services shall have, or have an EOR who has, the capability to hire and train the personal care attendant or attendants and supervise the attendant's performance, including approving the attendant's timesheets.

a. If a waiver individual is unwilling or unable to direct his own care or is younger than 18 years of age, ~~a family/caregiver/designated~~ family, a caregiver, or a designated person shall serve as the EOR on behalf of the waiver individual in order to perform these supervisory and approval functions.

b. Specific employer duties shall include checking references of personal care attendants and determining that personal care attendants meet qualifications.

3. The individual or ~~family/caregiver~~ family or caregiver shall have a backup plan for the provision of services in case the attendant does not show up for work as scheduled or terminates employment without prior notice.

4. The CD services facilitator shall not be the waiver individual, a CD attendant, a provider of other Medicaid-covered services, spouse of the individual, parent of the individual who is a minor child, or the EOR who is employing the CD attendant.

5. DMAS shall either provide for fiscal employer/agent services or contract for the services of a fiscal employer/agent for CD services. The fiscal employer/agent shall be reimbursed by DMAS or DMAS contractor (if the fiscal/employer agent service is contracted) to perform certain tasks as an agent for the EOR. The fiscal employer/agent shall handle responsibilities for the waiver individual including~~, but not limited to,~~ employment taxes and background checks for attendants. The fiscal employer/agent shall seek and obtain all necessary authorizations and approvals of the Internal Revenue Service in order to fulfill all of these duties.

G. Consumer-directed personal care services. CD personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include assistance with ADLs and may include~~, but shall not be limited to,~~ access to the community, monitoring of self-administered medications or other medical needs, supervision, and monitoring health status and physical condition. Where the waiver individual requires assistance with ADLs and when specified in the POC, such supportive services may include assistance with IADLs. This service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g. catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC 90-20 and as permitted by Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. CD personal care services may be provided in a home or community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based service or in conjunction with adult day health care, respite care (agency-directed or consumer-directed), or PERS.

1. In order to qualify for this service, the waiver individual shall have met the NF LOC criteria as set out in 12VAC30-60-303 and 12VAC30-60-307 as documented on the UAI assessment instrument, and for whom it shall be an appropriate alternative to institutional care.

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the waiver individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be otherwise authorized had the individual chosen to receive personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

2. Limits on covered CD personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. There shall be a limit of eight hours per 24-hour day for supervision services included in the POC. Supervision services shall be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no one else in the home who is competent and able to call for help in case of an emergency.

c. Consumer-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.

d. Electronic visit verification requirements as set out in 12VAC30-60-65 shall apply to these CD personal care services.

3. CD personal care services at work or school shall be limited as follows:

a. DMAS shall reimburse for services delivered, consistent with the approved POC, for CD personal care that the attendant provides to the waiver individual to assist him while he is at work or postsecondary school or both.

b. DMAS or the designated Srv Auth contractor shall review the waiver individual's needs and the complexity of the disability, as applicable, when determining the services that will be provided to him in the workplace or postsecondary school or both.

c. DMAS shall not pay for the personal care attendant to assist the waiver individual with any functions or tasks related to the individual completing his job or postsecondary school functions or for supervision time during work or postsecondary school or both.

H. Consumer-directed respite care services. CD respite care services are unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include~~, but shall not be limited to,~~ assistance with ADLs, access to the community, monitoring of self-administration of medications or other medical needs, supervision, monitoring health status and physical condition, and personal care services in a work environment.

1. In order to qualify for this service, the waiver individual shall have met the NF LOC criteria as set out in 12VAC30-

60-303 and 12VAC30-60-307 as documented on the UAI assessment instrument, and for whom it shall be an appropriate alternative to institutional care.

2. CD respite care services shall only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. This service shall be provided in the waiver individual's home or other community settings.

3. When the waiver individual requires assistance with ADLs, and where such assistance is specified in the individual's POC, such supportive services may also include assistance with IADLs.

4. Electronic visit verification requirements as set out in 12VAC30-60-65 shall apply to these CD respite care services.

5. Limits on covered CD respite care services.

a. The unit of service shall be one hour. Respite care services shall be limited to 480 hours per waiver individual per state fiscal year. If a waiver individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. Individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per state fiscal year combined.

b. CD respite care services shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC90-20 and as permitted by Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia).

c. If consumer-directed respite care service is the only service received by the waiver individual, it shall be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the services facilitator shall refer the waiver individual to the local department of social services for its redetermination of eligibility for the waiver individual.

I. Personal emergency response system (PERS).

1. Service description. PERS is a service that monitors waiver individual safety in the home and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line or system. PERS may also include medication monitoring devices.

a. PERS may be authorized only when there is no one else in the home with the waiver individual who is competent or continuously available to call for help in an emergency or when the individual is in imminent danger.

b. The use of PERS equipment shall not relieve the backup caregiver of his responsibilities.

c. Service units and service limitations.

(1) PERS shall be limited to waiver individuals who are ages 14 years and older who also either live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time. PERS shall only be provided in conjunction with receipt of personal care services (either agency-directed or consumer-directed), respite services (either agency-directed or consumer-directed), or adult day health care. A waiver individual shall not receive PERS if he has a cognitive impairment as defined in 12VAC30-120-900.

(2) A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, monitoring, and adjustments of the PERS. A unit of service shall be the one-month rental price set by DMAS in its fee schedule. The one-time installation of the unit shall include installation, account activation, individual and ~~family/caregiver~~ family or caregiver instruction, and subsequent removal of PERS equipment when it is no longer needed.

(3) PERS services shall be capable of being activated by a remote wireless device and shall be connected to the waiver individual's telephone line or system. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be (i) waterproof, (ii) able to automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, (iii) able to be worn by the waiver individual, and (iv) automatically reset by the response center after each activation, thereby ensuring that subsequent signals can be transmitted without requiring manual resetting by the waiver individual.

(4) All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard.

(5) Medication monitoring units shall be physician ordered. In order to be approved to receive the medication monitoring service, a waiver individual shall also receive PERS services. Physician orders shall be maintained in the waiver individual's record. In cases where the medical monitoring unit must be filled by the provider, the person who is filling the unit shall be either an RN or an LPN. The units may be filled as frequently as a minimum of every 14 days. There must be

documentation of this action in the waiver individual's record.

J. Transition coordination and transition services. Transition coordination and transition services, as defined at 12VAC30-120-2000 and 12VAC30-120-2010, provide for applicants to move from institutional placements or licensed or certified provider-operated living arrangements to private homes or other qualified settings. The applicant's transition from an institution to the community shall be coordinated by the facility's discharge planning team. The discharge planner shall coordinate with the transition coordinator to ensure that EDCD Waiver eligibility criteria shall be met.

1. Transition coordination and transition services shall be authorized by DMAS or its designated agent in order for reimbursement to occur.

2. For the purposes of transition services, an institution must meet the requirements as specified by CMS in the Money Follows the Person demonstration program at http://www.ssa.gov/OP_Home/comp2/F109-171.html#ft 262.

3. Transition coordination shall be authorized for a maximum of 12 consecutive months upon discharge from an institutional placement and shall be initiated within 30 days of discharge from the institution.

4. Transition coordination and transition services shall be provided in conjunction with personal care (agency-directed or consumer-directed), respite care (agency-directed or consumer-directed), or adult day health care services.

K. Assistive technology (AT).

1. Service description. Assistive technology (AT), as defined in 12VAC30-120-900, shall only be available to waiver individuals who are participating in the MFP program pursuant to Part XX (12VAC30-120-2000 et seq.).

2. In order to qualify for these services, the individual shall have a demonstrated need for equipment for remedial or direct medical benefit primarily in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. AT shall be covered in the least expensive, most cost-effective manner.

3. Service units and service limitations.

a. All requests for AT shall be made by the transition coordinator to DMAS or the Srv Auth contractor.

b. The maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be $5,000 per year for individuals regardless of waiver, or regardless of whether the individual changes waiver programs, for which AT is approved. The service unit shall always be one, for the total cost of all AT being requested for a specific timeframe.

c. AT may be provided in the individual's home or community setting.

d. AT shall not be approved for purposes of convenience of the ~~caregiver/provider~~ caregiver or provider or restraint of the individual.

e. An independent, professional consultation shall be obtained from a qualified professional who is knowledgeable of that item for each AT request prior to approval by the Srv Auth contractor and may include training on such AT by the qualified professional. The consultation shall not be performed by the provider of AT to the individual.

f. All AT shall be prior authorized by the Srv Auth contractor prior to billing.

g. Excluded shall be items that are reasonable accommodation requirements, for example, of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), or the Rehabilitation Act (20 USC § 794) or that are required to be provided through other funding sources.

h. AT services or equipment shall not be rented but shall be purchased.

L. Environmental modifications (EM).

1. Service description. Environmental modifications (EM), as defined herein, shall only be available to waiver individuals who are participating in the MFP program pursuant to Part XX (12VAC30-120-2000 et seq.). Adaptations shall be documented in the waiver individual's POC and may include~~, but shall not necessarily be limited to,~~ the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the waiver individual. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, flooring, roof repairs, central air conditioning, or decks. Adaptations that add to the total square footage of the home shall be excluded from this benefit, except when necessary to complete an authorized adaptation, as determined by DMAS or its designated agent. All services shall be provided in the individual's primary home in accordance with applicable state or local building codes. All modifications must be prior authorized by the Srv Auth contractor. Modifications may only be

made to a vehicle if it is the primary vehicle being used by the waiver individual. This service does not include the purchase or lease of vehicles.

2. In order to qualify for these services, the waiver individual shall have a demonstrated need for modifications of a remedial or medical benefit offered in his primary home or primary vehicle used by the waiver individual to ensure his health, welfare, or safety or specifically to improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program. EM shall be covered in the least expensive, most cost-effective manner.

3. Service units and service limitations.

a. All requests for EM shall be made by the MFP transition coordinator to DMAS or the Srv Auth contractor.

b. The maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be $5,000 per year for individuals regardless of waiver, or regardless of whether the individual changes waiver programs, for which EM is approved. The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.

c. All EM shall be authorized by the Srv Auth contractor prior to billing.

d. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards. Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), and the Rehabilitation Act (20 USC§ § 794).

e. Transition coordinators shall, upon completion of each modification, meet face-to-face with the waiver individual and his ~~family/caregiver~~ family or caregiver, as appropriate, to ensure that the modification is completed satisfactorily and is able to be used by the individual.

f. EM shall not be approved for purposes of convenience of the ~~caregiver/provider~~ caregiver or provider or restraint of the waiver individual.

12VAC30-120-930. General requirements for home and community-based participating providers.

A. Requests for participation shall be screened by DMAS or the designated DMAS contractor to determine whether the provider applicant meets the requirements for participation, as set out in the provider agreement, and demonstrates the abilities to perform, at a minimum, the following activities:

1. Screen all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal health care programs, including Medicaid (i.e., via the United States Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately report in writing to DMAS any exclusion information discovered to: DMAS, ATTN: Program Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219, or email to providerexclusions@dmas.virginia.gov;

2. Immediately notify DMAS in writing of any change in the information that the provider previously submitted to DMAS;

3. Except for waiver individuals who are subject to the DMAS Client Medical Management program Part VIII (12VAC30-130-800 et seq.) of 12VAC30-130 or are enrolled in a Medicaid managed care program, ensure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the ~~service or~~ services required and participating in the Medicaid Program at the time the ~~service or~~ services are performed;

4. Ensure the individual's freedom to refuse medical care, treatment, and services;

5. Accept referrals for services only when staff is available to initiate and perform such services on an ongoing basis;

6. Provide services and supplies to individuals in full compliance with Title VI (42 USC § 2000d et seq.) of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973 (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act of 1990 (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

7. Provide services and supplies to individuals of the same quality and in the same mode of delivery as are provided to the general public;

8. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS payment methodology beginning with the individual's authorization date for the waiver services;

9. Use only DMAS-designated forms for service documentation. The provider shall not alter the DMAS forms in any manner without prior written approval from DMAS;

10. Use DMAS-designated billing forms for submission of charges;

11. Perform no type of direct marketing activities to Medicaid individuals;

12. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

a. In general, such records shall be retained for a period of at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for a period of at least six years after such minor has reached 18 years of age.

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth;

13. Furnish information on the request of and in the form requested to DMAS, the Attorney General of Virginia or their authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement;

14. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid;

15. Pursuant to 42 CFR 431.300 et seq., § 32.1-325.3 of the Code of Virginia, and the Health Insurance Portability and Accountability Act (HIPAA), safeguard and hold confidential all information associated with an applicant or enrollee or individual that could disclose the ~~applicant's/enrollee's/individual's~~ applicant's, enrollee's, or individiual's identity. Access to information concerning the ~~applicant/enrollee/individual~~ applicant, enrollee, or individual shall be restricted to persons or agency representatives who are subject to the standards of confidentiality that are consistent with that of the agency and any such access must be in accordance with the provisions found in 12VAC30-20-90;

16. When ownership of the provider changes, notify DMAS in writing at least 15 calendar days before the date of change;

17. Pursuant to §§ 63.2-100, 63.2-1509, and 63.2-1606 of the Code of Virginia, if a participating provider or the provider's staff knows or suspects that a home and community-based waiver services individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge or suspicion of such knowledge to the local department of social services adult or child protective services worker as applicable or to the toll-free, 24-hour hotline as described on the local department of social services' website. Employers shall ensure and document that their staff is aware of this requirement;

18. In addition to compliance with the general conditions and requirements, adhere to the conditions of participation outlined in the individual provider's participation agreements, in the applicable DMAS provider manual, and in other DMAS laws, regulations, and policies. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies. A provider's noncompliance with DMAS policies and procedures may result in a retraction of Medicaid payment or termination of the provider agreement, or both;

19. Meet minimum qualifications of staff.

a. For reasons of Medicaid individuals' safety and welfare, all employees shall have a satisfactory work record, as evidenced by at least two references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children. In instances of employees who have worked for only one employer, such employees shall be permitted to provide one appropriate employment reference and one appropriate personal reference including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children.

b. Criminal record checks for both employees and volunteers conducted by the Virginia State Police. Proof that these checks were performed with satisfactory results shall be available for review by DMAS staff or its designated agent who are authorized by the agency to review these files. DMAS shall not reimburse the provider for any services provided by an employee or volunteer who has been convicted of committing a barrier crime as defined in § 32.1-162.9:1 of the Code of Virginia. Providers shall be responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. Provider staff shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the criminal

record check confirms the provider's staff person or volunteer was convicted of a barrier crime.

c. Provider staff and volunteers who serve waiver individuals who are minor children shall also be screened through the VDSS Child Protective Services (CPS) Central Registry. Provider staff and volunteers shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the VDSS CPS Central Registry check confirms the provider's staff person or volunteer has a finding.

20. Comply with the electronic visit verification requirements set out in 12VAC30-60-65.

B. DMAS shall terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. territories shall within 30 days of such conviction notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations, subject to applicable appeal rights, shall conform to § 32.1-325 D and E of the Code of Virginia and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20.

C. For DMAS to approve provider agreements with home and community-based waiver providers, the following standards shall be met:

1. Staffing, financial solvency, disclosure of ownership, and ensuring comparability of services requirements as specified in the applicable provider manual;

2. The ability to document and maintain waiver individuals' case records in accordance with state and federal requirements;

3. Compliance with all applicable laws, regulations, and policies pertaining to EDCD Waiver services.

D. The waiver individual shall have the option of selecting the provider of his choice from among those providers who are approved and who can appropriately meet his needs.

E. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification to DMAS.

F. DMAS may terminate at will a provider's participation agreement on 30 days' written notice as specified in the DMAS participation agreement. DMAS may immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the Medicaid program. Such action precludes further payment by DMAS for services provided to individuals on or after the date specified in the termination notice.

G. The provider shall be responsible for completing the DMAS-225 form. The provider shall notify the designated Srv Auth contractor, as appropriate, and the local department of social services, in writing, when any of the following events occur. Furthermore, it shall be the responsibility of the designated Srv Auth contractor to also update DMAS, as requested, when any of the following events occur:

1. Home and community-based waiver services are implemented;

2. A waiver individual dies;

3. A waiver individual is discharged from the provider's EDCD Waiver services;

4. Any other events (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 consecutive calendar days; or

5. The initial selection by the waiver individual or ~~family/caregiver~~ family or caregiver of a provider to provide services, or a change by the waiver individual or ~~family/caregiver~~ family or caregiver of a provider, if it affects the individual's patient pay amount.

H. Changes or termination of services.

1. The provider may decrease the amount of authorized care if the revised POC is appropriate and based on the medical needs of the waiver individual. The participating provider shall collaborate with the waiver individual or the ~~family/caregiver/EOR~~ family, caregiver, or EOR, or both as appropriate, to develop the new POC and calculate the new hours of service delivery. The provider shall discuss the decrease in care with the waiver individual or ~~family/caregiver/EOR~~ family, caregiver, or EOR, document the conversation in the waiver individual's record, and notify the designated Srv Auth contractor. The Srv Auth contractor shall process the decrease request and the waiver individual shall be notified of the change by letter. This letter shall clearly state the waiver individual's right to appeal this change.

2. If a change in the waiver individual's condition necessitates an increase in care, the participating provider shall assess the need for the increase and, collaborate with the waiver individual and ~~family/caregiver/EOR~~ family, caregiver, or EOR, as appropriate, to develop a POC for services to meet the changed needs. The provider may implement the increase in ~~personal/respite~~ personal care or respite care hours without approval from DMAS, or the designated Srv Auth contractor, if the amount of services does not exceed the total amount established by DMAS as the maximum for the level of care designated for that individual on the plan of care.

3. Any increase to a waiver individual's POC that exceeds the number of hours allowed for that individual's level of care or any change in the waiver individual's level of care

shall be authorized by DMAS or the designated Srv Auth contractor prior to the increase and be accompanied by adequate documentation justifying the increase.

4. In an emergency situation when either the health, safety, or welfare of the waiver individual or provider personnel is endangered, or both, DMAS, or the designated Srv Auth contractor, shall be notified prior to discontinuing services. The written notification period set out below shall not be required. If appropriate, local department of social services adult or child protective services, as may be appropriate, shall be notified immediately. Appeal rights shall be afforded to the waiver individual.

5. In a nonemergency situation, when neither the health, safety, nor welfare of the waiver individual or provider personnel is endangered, the participating provider shall give the waiver individual at least 10 calendar days' written notification (plus three days for mail transit for a total of 13 calendar days from the letter's date) of the intent to discontinue services. The notification letter shall provide the reasons for and the effective date the provider will be discontinuing services. Appeal rights shall be afforded to the waiver individual.

I. Staff education and training requirements.

1. RNs shall (i) be currently licensed to practice in the Commonwealth as an RN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia; (ii) have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or NF, or as an LPN who worked for at least one year in one of these settings; and (iii) submit to a criminal records check and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The RN shall not be compensated for services provided to the waiver individual if this record check verifies that the RN has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia or if the RN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

2. LPNs shall work under supervision as set out in 18VAC90-20-37. LPNs shall (i) be currently licensed to practice in the Commonwealth as an LPN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia; (ii) shall have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or NF. The LPN shall meet the qualifications and skills, prior to being assigned to care for the waiver individual, that are required by the individual's POC; and (iii) submit to a criminal records check and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The LPN shall not be compensated for services provided to the waiver individual if this record check verifies that the LPN has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia or if the LPN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

3. Personal care aides who are employed by personal care agencies that are licensed by VDH shall meet the requirements of 12VAC5-381. In addition, personal care aides shall also receive annually a minimum of 12 documented hours of agency-provided training in the performance of these services.

4. Personal care aides who are employed by personal care agencies that are not licensed by the VDH shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who are either elderly or who have disabilities, as ensured by the provider prior to being assigned to the care of an individual, and shall have the required skills and training to perform the services as specified in the waiver individual's POC and related supporting documentation.

a. Personal care aides' required initial (that is, at the onset of employment) training, as further detailed in the applicable provider manual, shall be met in one of the following ways: (i) registration with the Board of Nursing as a certified nurse aide; (ii) graduation from an approved educational curriculum as listed by the Board of Nursing; or (iii) completion of the provider's educational curriculum, which must be a minimum of 40 hours in duration, as taught by an RN who meets the same requirements as the RN listed in subdivision 1 of this subsection.

b. In addition, personal care aides shall also be required to receive annually a minimum of 12 documented hours of agency-provided training in the performance of these services.

5. Personal care aides shall:

a. Be at least 18 years of age or older;

b. Be able to read and write English to the degree necessary to perform the expected tasks and create and maintain the required documentation;

c. Be physically able to perform the required tasks and have the required skills to perform services as specified in the waiver individual's supporting documentation;

d. Have a valid social security number that has been issued to the personal care aide by the Social Security Administration;

e. Submit to a criminal records check and, if the waiver individual is a minor, consent to a search of the VDSS

Child Protective Services Central Registry. The aide shall not be compensated for services provided to the waiver individual effective the date in which the record check verifies that the aide has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the aide has a founded complaint confirmed by the VDSS Child Protective Services Central Registry;

f. Understand and agree to comply with the DMAS EDCD Waiver requirements; and

g. Receive tuberculosis (TB) screening as specified in the criteria used by the VDH.

6. Consumer-directed personal care attendants shall:

a. Be 18 years of age or older;

b. Be able to read and write in English to the degree necessary to perform the tasks expected and create and maintain the required documentation;

c. Be physically able to perform the required tasks and have the required skills to perform consumer-directed services as specified in the waiver individual's supporting documentation;

d. Have a valid social security number that has been issued to the personal care attendant by the Social Security Administration;

e. Submit to a criminal records check and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry. The attendant shall not be compensated for services provided to the waiver individual effective the date in which the record check verifies that the attendant has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the attendant has a founded complaint confirmed by the VDSS Child Protective Services Central Registry;

f. Understand and agree to comply with the DMAS EDCD Waiver requirements;

g. Receive tuberculosis (TB) screening as specified in the criteria used by the VDH; and

h. Be willing to attend training at the individual's or ~~family/caregiver's~~ family or caregiver's request.

12VAC30-122-125. Electronic visit verification.

A. Except as specified in subsection B of this section, the requirements of 12VAC30-60-65 shall apply for personal care services, respite care services, and companion services.

B. EVV requirements shall not apply to respite care services provided by a DBHDS-licensed provider in a DBHDS-licensed program site, such as a group home or sponsored residential home or a supervised living, supported living, or similar facility or location licensed to provide respite care services as permitted by the Centers for Medicare and Medicaid Services.

VA.R. Doc. No. R19-5467; Filed December 18, 2019, 10:31 a.m.

Fast-Track Regulation

Titles of Regulations: **12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-181, 12VAC30-60-185).**

12VAC30-70. Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (adding 12VAC30-70-418).

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

12VAC30-130. Amount, Duration and Scope of Selected Services (amending 12VAC30-130-5010 through 12VAC30-130-5150).

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: February 19, 2020.

Effective Date: March 5, 2020.

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 authorizes the Board of Medical Assistance Services to administer and amend the State Plan for Medical Assistance and to promulgate regulations. Section 32.1-324 of the Code of Virginia grants the Director of the Department of Medical Assistance Services (DMAS) the authority of the board when it is not in session. The Medicaid authority established by § 1902(a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

Purpose: These changes are essential to protect the health, safety, and welfare of citizens because they clarify existing rules for the addiction and recovery treatment services (ARTS) program to make it easier for providers to understand program rules and to make these services more accessible to Medicaid members.

Rationale for Using Fast-Track Rulemaking Process: These regulations are expected to be noncontroversial. The initial ARTS regulations were noncontroversial, and they implemented new substance use programs. These updates do not restrict services or negatively impact providers or Medicaid members. Instead, these updates provide

clarification to answer questions raised by providers since the initial ARTS implementation.

Substance: The changes in this regulatory package streamline, simplify, and clarify existing requirements for ARTS services and ARTS providers. The changes include:

1. Changing references from "the BHSA," which means the behavioral health services administrator, to "DMAS or its contractor" because the BHSA contract will be ending.

2. Correcting outdated citations.

3. Clarifying the roles and responsibilities of credentialed addiction treatment professionals (CATPs), certified substance abuse counselors (CSACs), certified substance abuse counselor-assistants (CSAC-As), and certified substance abuse counselor-supervisees (CSAC-supervisees). CATPs are licensed or registered with various boards through the Department of Health Professions, while CSACs, CSAC-As, and CSAC-supervisees are lower-level staff who are certified through the Board of Counseling. Defining these roles allows lower-level staff to perform tasks appropriate to their skill level, which frees up CATPs to perform higher-level skills. The Board of Counseling recently posted a guidance document that reflects this change, and DMAS seeks to match its requirements to the requirements of the Board of Counseling.

4. Providing additional clarity on substance use disorder counseling, psychotherapy, and counseling. Substance use disorder counseling can be provided by a CSAC as part of a CSAC's scope of practice as defined by the Board of Counseling, while psychotherapy and counseling may only be provided by licensed staff.

5. Providing additional clarity about medication assisted treatment (MAT). The Centers for Medicare and Medicaid Services (CMS) requires Medicaid agencies to assess members to determine if they need MAT, and requires MAT to be provided onsite or through referral in intensive outpatient, partial hospitalization, and residential levels of care. "States Shall Demonstrate Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD," a CMS guidance document explaining this requirement, can be accessed at https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

6. Clarifying the telemedicine definition to include the requirements of a 2014 Medicaid memo to providers. The definition of "face-to-face" was broadened to include the use of telemedicine so that telemedicine can be used to provide ARTS services. The 2014 memo can be accessed at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/MedicaidMemostoProviders and searching for the memo dated May 13, 2014.

7. Removing the hard limits on intensive outpatient treatment in compliance with the Mental Health Parity and Addiction Equity Act (Public Law 110-343).

8. In response to a public comment received during the original implementation of the ARTS program, clarifying that drug screening may be conducted using urine or blood serums.

Issues: The primary advantage of these regulatory changes to the public and the agency is that they streamline and simplify existing requirements for ARTS services and provide additional clarity to ARTS providers. There are no disadvantages to the public, the agency, or the Commonwealth as a result of these changes.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Director of the Department of Medical Assistance Services (DMAS) proposes to update this regulation to reflect the changes that have already occurred in the provision of Addiction and Recovery Treatment Services (ARTS).

Background. The ARTS program provides a comprehensive continuum of addiction and recovery treatment services, including inpatient withdrawal management services, residential treatment services, partial hospitalization, intensive outpatient treatment, outpatient treatment, and peer recovery supports.

According to DMAS, in the last several years there have been changes in a number of laws, regulations, and guidance from other entities that have affected how the ARTS program operates. For example, the Board of Counseling and the Board of Medicine have amended the scope of practice for the professions they regulate who provide services to ARTS recipients. Similarly, the federal Centers for Medicare and Medicaid Services has issued a Parity Rule that affected the service limits in this program and guidance on certain terms used in this regulation.

Estimated Benefits and Costs. The proposed amendments update the regulation to reflect the changes that have occurred in this program due to external laws, regulations, and guidance.[2] The proposed amendments also make clarifying changes to language that has prompted questions from providers of addiction and recovery treatment services.

Since the proposed amendments simply reflect the changes on how the ARTS program currently operates, no significant economic effect is expected other than improving the clarity of the rules this program currently operates under.

Businesses and Other Entities Affected. This regulation primarily applies to 3,465 ARTS providers and the Medicaid clients they serve.

Localities[3] Affected.[4] The proposed amendments should not affect any locality more than others. The proposed amendments do not appear to introduce costs for local governments.

Projected Impact on Employment. The proposed amendments would not affect employment.

Effects on the Use and Value of Private Property. The proposed amendments would not affect the use and value of private property.

Adverse Effect on Small Businesses.[5] The proposed amendments do not adversely affect small businesses.

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[2]The references to external laws, regulations, and guidance can be found at https://townhall.virginia.gov/L/GetFile.cfm?File=64\5229\8540\AgencyStatement_DMAS_8540_vA.pdf

[3]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[4]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[5]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."

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

Summary:

The amendments clarify and update the requirements for providers of Addiction and Recovery Treatment Services (ARTS) Program services to Medicaid members, including (i) updating citations and terminology; (ii) clarifying roles for professionals who provide various addiction treatments; (iii) specifying that medical assisted treatment must be provided onsite or through referral in intensive outpatient, partial hospitalization, and residential levels of care pursuant to the Centers for Medicare and Medicaid Services requirements; (iv) including telemedicine in the definition of "face-to-face" for purposes of providing ARTS services; (v) removing hard limits on intensive outpatient treatment; and (vi) clarifying that drug screening can be done by testing urine or blood serums.

12VAC30-60-181. Utilization review of addiction~~,~~ and recovery~~, and~~ treatment services.

A. Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider's care. Such documentation shall fully disclose the extent of services provided in order to support provider's claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

B. Utilization reviews shall be conducted by the Department of Medical Assistance Services or its designated contractor.

C. Service authorizations shall be required for American Society of Addiction Medicine (ASAM) Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0.

D. A multidimensional assessment by a credentialed addiction treatment professional (CATP), as defined in 12VAC30-130-5020, shall be required for ASAM Levels 1.0 through 4.0. Certified substance abuse counselors (CSACs) are able to complete a multidimensional assessment to make recommendations for an ASAM level of care, which shall be signed and dated by a CATP within one business day. The multidimensional assessment shall be maintained in the individual's record by the provider. Medical necessity for all ASAM levels of care shall be based on the outcome of the individual's multidimensional assessment.

E. Individual service plans (ISPs) and treatment plans shall be developed upon admission to medically managed intensive inpatient services (ASAM Level 4.0), substance use residential and inpatient services (ASAM Levels 3.1, 3.3, 3.5, and ~~3,7)~~ 3.7), and substance use intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5). ISPs or treatment plans shall be developed upon initiation of opioid treatment services (OTP) ~~and~~, office-based opioid treatment (OBOT)~~;~~, and substance use outpatient services (ASAM Level 1.0).

1. The provider shall include the individual and the family or caregiver, as may be appropriate, in the development of the ISP or treatment plan. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated at least annually and as the individual's needs and progress change. An ISP that is not updated either annually or as the individual's needs and progress change shall be considered outdated.

2. All ISPs shall be completed and contemporaneously signed and dated by the ~~credentialed addiction treatment professional~~ CATP preparing the ISP. For ASAM Levels 3.1, 3.3, and 3.5, the ISP may be completed by a CSAC if the CATP signs and dates the ISP within one business day.

3. The child's or adolescent's ISP shall also be signed by the parent or legal guardian, and the adult individual shall sign his own ISP. If the individual, whether a child, adolescent, or adult, is unwilling or unable to sign the ISP, then the service provider shall document the reasons why the individual was not able or willing to sign the ISP.

F. A comprehensive ISP, as defined in ~~12VAC30-50-226~~ 12VAC30-130-5020, shall be fully developed within 30 calendar days of the initiation of services. The comprehensive ISP shall be developed with the individual, in consultation with the individual's family, as appropriate, and shall address (i) a summary or reference to the individual's identified needs; (ii) short-term and long-term goals and measurable objectives for addressing each identified individually specific need; (iii) services and supports and frequency of services to accomplish the goals and objectives; (iv) target dates for accomplishment of goals and objectives; (v) estimated duration of service; (vi) medication assisted treatment assessment, which shall be provided onsite or through referral; and ~~(vi)~~ (vii) the role ~~or roles~~ of other agencies if the plan is a shared responsibility and the staff designated as responsible for the coordination and integration of services. The ISP shall be reviewed at least every 90 calendar days and shall be modified as the needs and progress of the individual ~~changes~~ change. Documentation of the ISP review shall include the dated signatures of the ~~credentialed addiction treatment professional~~ CATP and the individual. CSACs may perform the ISP reviews in ASAM Levels 3.1, 3.3, and 3.5 if a CATP signs and dates the ISP review within one business day.

G. Progress notes, as defined in ~~12VAC30-50-130~~ 12VAC30-60-185, shall disclose the extent of services provided and corroborate the units billed. ~~Claims not supported by corroborating progress notes may be subject to recovery of expenditures.~~ Each progress note shall be individualized to the member to demonstrate the individual member's particular circumstances, treatment, and progress. Claim payments shall be retracted for services that are not supported by documentation that is individualized to the member.

H. Documentation shall include assessment and referral for medication assisted treatment as medically indicated.

12VAC30-60-185. Utilization review of substance use case management.

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

"Face-to-face" means the same as that term is defined in 12VAC30-130-5020.

"Individual service plan" or "ISP" means the same as the term is defined in ~~12VAC30-50-226~~ 12VAC30-130-5020.

"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 and are part of the minimum documentation requirements that convey the individual's status, staff intervention, 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~~ units or hours required to deliver the service. The content of each progress note shall corroborate the ~~time/units~~ time or units billed for each rendered service. Progress notes shall be documented for each service that is billed.

"Register" or "registration" means notifying the Department of Medical Assistance Services or its contractor that an individual will be receiving services that do not require service authorization, such as outpatient services for substance use disorders or substance use case management.

B. Utilization review: substance use case management services.

1. The Medicaid enrolled individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for a substance use disorder. Tobacco-related disorders or caffeine-related disorders and ~~nonsubstance-related~~ non-substance-related disorders shall not be covered.

2. Reimbursement shall be provided only for "active" case management. An active client for substance use case management shall mean an individual for whom there is a current substance use individual service plan (ISP) in effect that requires a minimum of two distinct substance use case management activities being performed each calendar month and at a minimum one face-to-face client contact at least every 90-calendar-day period.

3. Billing can be submitted for an active recipient only for months in which a minimum of two distinct substance use case management activities are performed.

4. An ISP shall be completed within 30 calendar days of initiation of this service with the individual in a person-centered manner and shall document the need for active substance use case management before such case management services can be billed. The ISP shall require a minimum of two distinct substance use case management activities being performed each calendar month and a minimum of one face-to-face client contact at least every 90 calendar days. The substance use case manager shall review the ISP with the individual at least every 90 calendar days for the purpose of evaluating and updating the individual's progress toward meeting the individualized service plan objectives.

5. The ISP shall be reviewed with the individual present, and the outcome of the review shall be documented in the individual's medical record.

C. Utilization review: substance use case management services.

1. Utilization review general requirements. Utilization reviews shall be conducted by DMAS or its designated contractor. Reimbursement shall be provided only when there is an active ISP ~~and~~, a minimum of two distinct substance use case management activities are performed each calendar month, and there is a minimum of one face-to-face client contact at least every 90-calendar-day period. Billing can be submitted only for months in which a minimum of two distinct substance use case management activities are performed within the calendar month.

2. In order to receive reimbursement, providers shall register this service with the managed care organization or the ~~behavioral health services administration~~ DMAS contractor, as required, within one business day of service initiation to avoid duplication of services and to ensure informed and seamless care coordination between substance use treatment and substance use case management providers.

3. The Medicaid eligible individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for a substance use disorder with the exception of tobacco-related disorders or caffeine-related disorders and ~~nonsubstance-related~~ non-substance-related disorders.

4. Substance use case management shall not be billed for individuals in institutions for mental disease, except during the month prior to discharge to allow for discharge planning, limited to two months within a 12-month period. Substance use case management shall not be billed concurrently with any other type of Medicaid reimbursed case management and care coordination.

5. The ISP, as defined in ~~12VAC30-50-226~~ 12VAC30-130-5020, shall document the need for substance use case management and be fully completed within 30 calendar days of initiation of the service, and the substance use case manager shall review the ISP at least every 90 calendar days. Such reviews shall be documented in the individual's medical record. If needed, a grace period will be granted following the date of the last review. When the review is completed in a grace period, the next subsequent review shall be scheduled 90 calendar days from the date the review was initially due and not the date of actual review.

6. The ISP shall be updated and documented in the individual's medical record at least annually and as an individual's needs change.

7. The provider of substance use case management services shall be licensed by the Department of Behavioral Health and Developmental Services as a provider of substance use case management and credentialed by the ~~behavioral health services administration~~ DMAS contractor or the managed care organization as a provider of substance use case management services.

8. Progress notes, as defined in subsection A of this section, shall be required to disclose the extent of services provided and corroborate the units billed.

12VAC30-70-418. Reimbursement for residential and inpatient substance use treatment services.

A. The following substance use disorder treatment services for adults and adolescents are provided in a residential or inpatient setting: (i) clinically managed population-specific high intensity residential service (ASAM Level 3.3); (ii) clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5); (iii) medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7); and (iv) medically managed intensive inpatient services (ASAM Level 4.0).

B. If one of the services in subsection A of this section is furnished to an individual in a freestanding psychiatric hospital or inpatient psychiatric unit of an acute care hospital, reimbursement shall be based on the hospital reimbursement described in 12VAC30-70-241 and the reimbursement of services provided under the arrangement described in 12VAC30-80.

C. If one of the services in subsection A of this section is furnished to an individual in an appropriately licensed residential setting, reimbursement shall be based on the psychiatric residential treatment facility (Level C) reimbursement described in 12VAC30-70-417.

12VAC30-80-32. Reimbursement for substance 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.

1. Psychotherapy and substance use disorder counseling services of licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

2. Psychotherapy and substance use disorder counseling 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~~ registered 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~~ http://www.dmas.virginia.gov.

B. Rates for the following ~~addiction and recovery treatment services (ARTS) physician and clinic services~~ preferred office-based opioid treatment (OBOT) services and opioid treatment programs shall be based on the agency fee schedule: (i) initiation of medication assisted treatment ~~induction~~ with a visit unit of service; (ii) individual and group ~~opioid treatment service~~ substance use disorder counseling and psychotherapy with a 15-minute unit of service; and (iii) 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~~ http://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 services (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~~ http://www.dmas.virginia.gov.

D. Reimbursement for all clinically managed low intensity residential (ASAM Level 3.1) services shall be based on the therapeutic group home (Level B) reimbursement described in 12VAC30-80-30.

E. 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.~~ F. 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~~ http://www.dmas.virginia.gov.

~~F.~~ G. 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~~ http://www.dmas.virginia.gov.

12VAC30-130-5010. Addiction and recovery treatment services; purpose.

The purpose of this part shall be to establish coverage of treatment for substance use disorders as defined in the American Society of Addiction Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, Third Edition, as published by the American Society of Addiction Medicine including outpatient physician, nurse practitioner, and clinic services~~,~~ that include evidence-based medication assisted treatment, intensive outpatient services, partial hospitalization services, residential treatment services, and inpatient withdrawal management services as defined in 12VAC30-130-5040 through 12VAC30-130-5150.

12VAC30-130-5020. Definitions.

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

"Abstinence" means the intentional and consistent restraint from the pathological pursuit of reward or relief, or both, that involves the use of substances.

"Addiction" means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

"Addiction-credentialed physician" means a physician who holds a board certification in addiction medicine from the American Board of Addiction Medicine, a subspecialty board certification in addition to certification in psychiatry from the American Board of Psychiatry and Neurology, or subspecialty board certification in addiction medicine from the American Osteopathic Association. DMAS also recognizes physicians with the DATA 2000 buprenorphine waiver and physicians treating addiction who have specialty training or experience in addiction medicine or addiction psychiatry. If treating adolescents, "addiction-credentialed physician" means an addiction-credentialed physician who also has experience and specialty training with adolescent medicine.

"Adherence" means the individual receiving treatment has demonstrated his ability to cooperate with, follow, and take personal responsibility for the implementation of his treatment plans.

"Adolescent" means an individual from 12 years of age to 20 years of age.

"Allied health professional" means counselor aides or group living workers who meet the DBHDS licensing requirements for unlicensed staff in residential settings.

"ARTS" means addiction and recovery treatment services.

"ARTS care coordinator" means an employee of DMAS, its contractor, or an MCO who is a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist, nurse practitioner, or registered nurse with two years of clinical experience in the treatment of substance use disorders. The ARTS care coordinator performs independent assessments of requests for all ARTS intensive outpatient programs (ASAM Level 2.1); partial hospitalization programs (ASAM Level 2.5); residential treatment services (ASAM Levels 3.1, 3.3, 3.5, and 3.7); and inpatient services (ASAM Level 3.7 and 4.0).

"ASAM" means the American Society of Addiction Medicine.

"ASAM criteria" means the six different life areas used by the ASAM Patient Placement Criteria to develop a holistic biopsychosocial assessment of an individual that is used for service planning, level of care, and length of stay treatment decisions.

~~"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS. The 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. DMAS shall retain authority for and oversight of the BHSA entity or entities.~~

"BHA" means behavioral health authority.

"Biomedical" means biological or physical aspects of a member's condition that require assessment and services that are delivered by appropriately credentialed medical staff, who are available to assess and treat co-occurring biomedical disorders that may be the result of, or independent of, a substance use disorder.

"Buprenorphine-waivered ~~practitioners"~~ practitioner" means a health care ~~providers~~ provider licensed under Virginia law and registered with the Drug Enforcement Administration (DEA) to prescribe Schedule III, IV, or V medications for treatment of pain. ~~Physicians shall have completed the buprenorphine waiver training course and obtained the waiver to prescribe or dispense buprenorphine for opioid use disorder required under~~ More specifically, a buprenorphine-waivered physician has obtained the buprenorphine waiver through the Drug Addiction Treatment Act of 2000 (DATA 2000)~~. They shall have been issued a DEA X number by the DEA to prescribe buprenorphine for the treatment of opioid use disorder. Practitioners who are not physicians must meet,~~ while a buprenorphine-waivered nurse practitioner or physician assistant has obtained the buprenorphine waiver through DATA 2000. A buprenorphine-waivered practitioner meets all federal and state requirements and ~~be~~ is supervised by or ~~work~~ works in collaboration with a qualifying physician ~~who is buprenorphine waivered.~~ in accordance with the applicable regulatory board. In accordance with § 54.1-2957 of the Code of Virginia, a nurse practitioner may practice without a written or electronic practice agreement with a qualifying physician. All buprenorphine-waivered practitioners have a DEA-X number to prescribe buprenorphine for the treatment of opioid use disorder.

"Care coordination" means collaboration and sharing of information among health care providers who are involved with an individual's health care to ~~improve~~ assist in improving the care of the individual. This includes e-consultations from primary care providers to specialists.

"Certified substance abuse counselor" or "CSAC" means the same as that term is defined in § 54.1-3507.1 of the Code of Virginia.

"Certified substance abuse counseling assistant" or "CSAC-A" means the same as that term is defined in § 54.1-3507.2 of the Code of Virginia.

"Certified substance abuse counselor-supervisee" means an individual who has completed the educational requirements

described in clause (i) of § 54.1-3507.1 C of the Code of Virginia, but who has not completed the practice hours described in clause (ii) of § 54.1-3507.1 C of the Code of Virginia.

"Child" means an individual from birth up to 12 years of age.

"Clinical experience" means, for the purpose of these ARTS requirements, practical experience in providing direct services to individuals with diagnoses of substance use disorder. Clinical experience shall include supervised internships, supervised practicums, or supervised field experience. Clinical experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience.

~~"Co-occurring disorders" means the presence of concurrent substance use disorder and mental illness without implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other. Other terms used to describe co-occurring disorders include "dual diagnosis," "dual disorders," "mentally ill chemically addicted (MICA)," "chemically addicted mentally ill (CAMI)," "mentally ill substance abusers (MISA)," "mentally ill chemically dependent (MICD)," "concurrent disorders," "coexisting disorders," "comorbid disorders," and "individuals with co-occurring psychiatric and substance symptomatology (ICOPSS)."~~

"Counseling" means the same as that term is defined in § 54.1-3500 of the Code of Virginia.

"Credentialed addiction treatment ~~professionals"~~ professional" or "CATP" means an individual licensed or registered with the appropriate board in the following roles: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) physician extenders with experience or training in addiction medicine; (iii) a licensed psychiatrist; ~~(iii)~~ (iv) a licensed clinical psychologist; ~~(iv)~~ (v) a licensed clinical social worker; ~~(v)~~ (vi) a licensed professional counselor; ~~(vi)~~ (vii) a ~~licensed~~ certified psychiatric clinical nurse specialist; ~~(vii)~~ (viii) a licensed psychiatric nurse practitioner; ~~(viii)~~ (ix) a licensed marriage and family therapist; ~~(ix)~~ (x) a licensed substance abuse treatment practitioner; ~~(x) residents~~ (xi) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and ~~in a residency approved by~~ is registered with the Virginia Board of Counseling; ~~(xi) residents~~ (xii) a resident in psychology who is under supervision of a licensed clinical psychologist and ~~in a residency approved by~~ is registered with the Virginia Board of Psychology (18VAC125-20-10); ~~(xii) supervisees~~ or (xiii) a supervisee in social work who is under the supervision of a licensed clinical social worker ~~approved by~~ and is registered with the Virginia Board of Social Work (18VAC140-20-10)~~;~~ ~~or (xiii) an individual with certification as a substance abuse counselor (CSAC) (18VAC115-30-10) or certification as a substance abuse counseling assistant (CSAC-A) (18VAC115-30-10) under supervision of licensed provider and within his scope of practice, as described in §§ 54.1-3507.1 and 54.1-3507.2 of the Code of Virginia~~.

"CSB" means community services board.

"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.

~~"DHP" means the Department of Health Professions.~~

"DMAS" ~~or "the department"~~ 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.

"Evidence-based" means an empirically-supported clinical practice or intervention with a proven ability to produce positive outcomes.

"Face-to-face" means encounters that occur in person or through telemedicine.

~~"FAMIS" means the Family Access to Medical Insurance Security Plan as set out in 12VAC30-141.~~

"FQHC" means federally qualified health center.

"Individual" means the patient, client, beneficiary, or member who receives services set out in 12VAC30-130-5000 et seq. These terms are used interchangeably.

"Individual service plan" or "ISP" means ~~the same as the term is defined in 12VAC30-50-226.~~ an initial and comprehensive treatment plan that is regularly updated and specific to an individual's unique treatment needs as identified in the assessment. An ISP contains an individual's treatment or training needs, the individual's goals and measureable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. An individual is included in the development of the ISP, and the ISP is signed by the individual. If the individual is a minor, the ISP is also signed by the individual's parent or legal guardian. An ISP includes documentation if the individual is a minor child or an adult who lacks legal capacity and is unable or unwilling to sign the ISP.

"Induction phase" means the medically monitored initiation of buprenorphine, buprenorphine and naloxone, naltrexone, or methadone treatment performed in a qualified practitioner's office or licensed OTP. The goal of the induction phase is to

find the individual's ideal dose of buprenorphine, buprenorphine and naloxone, naltrexone, or methadone. The ideal dose minimizes both side effects and drug craving.

"Licensed practical nurse" means a professional who is licensed by the Commonwealth as a practical nurse or holds a multistate licensure privilege to practice practical nursing according to 18VAC90-19-80.

"Managed care organization" or "MCO" meansan organization that offers managed care health insurance plans (MCHIP), as defined by § 38.2-5800 of the Code of Virginia, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis that (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with, or employed by the health carrier.

"Medication assisted treatment" or "MAT" means the same as that term is defined in 42 CFR 8.2.

"Multidimensional assessment" or "assessment" means the individualized, person-centered biopsychosocial assessment performed face-to-face, in which the provider obtains comprehensive information from the individual ~~(including,~~ and family members and significant others as ~~needed)~~ needed, including history of the present illness; family history; developmental history; alcohol, tobacco, and other drug use or addictive behavior history; ~~personal/social~~ personal or social history; legal history; psychiatric history; medical history; spiritual history as appropriate; review of systems; mental status exam; physical examination; formulation and diagnoses; survey of assets, vulnerabilities and supports; and treatment recommendations. The ASAM multidimensional assessment is a theoretical framework for this individualized, person-centered assessment that includes the following ~~six~~ dimensions: (i) acute intoxication or likelihood of withdrawal ~~potential~~, or both; (ii) ~~biomedical~~ medical conditions and complications, both historical and current; (iii) emotional, behavioral, or cognitive ~~conditions~~ status and ~~complications~~ any identified issues; (iv) an individual's readiness to change; (v) risks for relapse~~,~~ or continued use~~, or continued problem potential~~; and (vi) ~~recovery or living~~ home environment. The level of care determination, ISP, and recovery strategies development may be based upon this multidimensional assessment.

~~"Office-based opioid treatment" or "OBOT" means addiction treatment services for individuals with moderate to severe opioid use disorder provided by buprenorphine-waivered practitioners working in collaboration with credentialed addiction treatment practitioners providing psychosocial counseling in public and private practice settings.~~

~~"Opiate" means one of a group of alkaloids derived from the opium poppy (Papaver somniferum) that has the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression but excludes synthetic opioids.~~

"Opioid" means any psychoactive chemical that resembles morphine in pharmacological effects, including opiates and ~~synthetic/semisynthetic~~ synthetic or semisynthetic agents that exert their effects by binding to highly selective receptors in the brain where morphine and endogenous opioids affect their actions.

"Opioid treatment program" or "OTP" means ~~a program certified by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) that engages in supervised assessment and treatment, using methadone, buprenorphine, L-alpha-acetyl methadol, or naltrexone, of individuals who are addicted to opioids~~ the same as that term is defined in 42 CFR 8.2.

"Opioid treatment services" or "OTS" means preferred office-based opioid treatment (OBOT) and ~~opioid treatment programs~~ OTPs that encompass a variety of pharmacological and nonpharmacological treatment modalities, including substance use disorder counseling and psychotherapy.

"Overdose" means the inadvertent or deliberate consumption of a dose of a chemical substance much larger than either habitually used by the individual or ordinarily used for treatment of an illness that is likely to result in a serious toxic reaction or death.

"Physician extenders" means licensed nurse practitioners as defined in ~~18VAC90-30-10~~ § 54.1-3000 of the Code of Virginia and licensed physician assistants as defined in § 54.1-2900 of the Code of Virginia.

~~"Practitioner" means a provider who is permitted to prescribe buprenorphine by the scope of his licenses under federal and state law.~~

"Preferred office-based opioid treatment" or "preferred OBOT" means addiction treatment services for individuals with a primary opioid use disorder provided by buprenorphine-waivered practitioners working in collaboration with CATPs providing psychotherapy and substance use disorder counseling in public and private practice settings.

"Program of assertive community treatment" or "PACT" means the same as that term is defined in 12VAC35-105-20.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have a substance use disorder or mental illness and their family members or

caregivers to access clear and concise information about substance use disorders or mental illness and (ii) a way of accessing and learning strategies to deal with substance use disorders or mental illness and its effects in order to design effective treatment plans and strategies.

"Psychotherapy" or "therapy" means the use of psychological methods in a professional relationship to assist a person to acquire great human effectiveness or to modify feelings, conditions, attitudes, and behaviors that are emotionally, intellectually, or socially ineffectual or maladaptive.

"Recovery" means a process of sustained effort that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction and consistently pursues abstinence, behavior control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and more effective coping with emotional responses leading to reversal of negative, self-defeating internal processes and behaviors and allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process.

"Registered nurse" or "RN" means ~~a professional who is either licensed by the Commonwealth or who holds a multi-state licensure privilege to practice nursing~~ the same as "professional nurse" is defined in § 54.1-3000 of the Code of Virginia.

"Relapse" means a process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward or relief through the use of substances and other behaviors often leading to disengagement from recovery activities. Relapse can be triggered by exposure to (i) rewarding substances and behaviors, (ii) environmental cues to use, and (iii) emotional stressors that trigger heightened activity in brain stress circuits. The event of using or acting out is the latter part of the process, which can be prevented by early intervention.

"RHC" means rural health clinic.

"SBIRT" means screening, brief intervention, and referral to treatment. SBIRT services are an evidence-based and community-based practice designed to identify, reduce, and prevent problematic substance use disorders.

"Service authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by ~~a~~ DMAS ~~service authorization~~ or its contractor, ~~BHSA,~~ or an MCO 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.

"Substance use care coordinator" means staff in an OTP or preferred OBOT setting who have:

1. At least a bachelor's degree in one of the following fields: social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, or human services counseling, and at least either (i) one year of substance use disorder related direct experience or training or a combination of experience or training in providing services to individuals with a diagnosis of substance use disorder or (ii) a minimum of one year of clinical experience or training in working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or

2. Licensure by the Commonwealth as a registered nurse with at least either (i) one year of direct experience or training or a combination of experience and training in providing services to individuals with a diagnosis of substance use disorder or (ii) a minimum of one year of clinical experience or training or a combination of experience and training in working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or

3. Certification as a CSAC or a CSAC-A.

"Substance use case management" means the same as set out in 12VAC30-50-491.

"Substance use disorder" or "SUD" means a substance-related addictive disorder, as defined in the DSM-5 with the exception of tobacco-related disorders and non-substance-related disorders, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from the use of alcohol~~, tobacco,~~ or other drugs despite significant related problems.

"Substance use disorder counseling" means the same as "substance abuse counseling" is defined in 18VAC115-30-10.

"Telemedicine" means ~~the practice of the medical arts via electronic means rather than face to face~~ the real-time, two-way transfer of medical data and information using an interactive audio-video connection for the purposes of medical diagnosis and treatment. The member is located at the originating site, while the provider renders services from a remote location via the audio-video connection. Equipment utilized for telemedicine shall be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter for professional medical services.

"Tolerance" or "tolerate" means a state of adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time.

"Withdrawal management" means services to assist an individual's withdrawal from the use of substances.

12VAC30-130-5030. Eligible individuals.

Children and adults who participate in Medicaid managed care plans and Medicaid fee for service and meet ASAM medical necessity criteria shall be eligible for ARTS. ~~Notwithstanding the coverage limitations set forth in the Governor's Access Plan for the Seriously Mental Ill (GAP SMI), GAP SMI enrollees who meet ASAM medical necessity criteria shall be eligible for ARTS with the exception of inpatient detoxification services (ASAM Level 4.0) and substance use case management.~~

12VAC30-130-5040. Covered services: requirements; limits; standards.

A. Addiction and recovery ~~and~~ treatment services.

1. In order to be covered, ARTS shall (i) meet medical necessity criteria based upon the multidimensional assessment completed by a ~~credentialed addiction treatment professional within the scope of their practice~~ CATP or a CSAC under the supervision of a CATP and (ii) be accurately reflected in provider medical record documentation and on ~~providers'~~ provider claims for services by recognized diagnosis codes that support and are consistent with the requested professional services. ARTS services require a primary substance use diagnosis, and the purpose for treatment shall be related to the substance use disorder. Individuals may have a secondary, co-occurring diagnosis. A CATP or a CSAC under the supervision of a CATP shall complete the multidimensional assessments. A CATP must sign and date assessments performed by a CSAC within one business day.

2. These ARTS services, with their service definitions, shall be covered in all levels of care: (i) medically managed intensive inpatient services (ASAM Level 4); (ii) substance use ~~residential/inpatient~~ residential or inpatient services (ASAM Levels 3.1, 3.3, 3.5, and 3.7); (iii) substance use intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5); (iv) opioid treatment services~~,~~ (opioid treatment programs and preferred office-based opioid treatment); (v) substance use outpatient services (ASAM Level 1.0); (vi) early intervention services (ASAM Level 0.5); (vii) substance use care coordination, (viii) substance use case management services; and (ix) withdrawal management services, which shall be provided when medically necessary~~, as a component of the medically managed inpatient services (ASAM Level 4.0), substance use residential/inpatient services (ASAM Levels 3.3, 3.5, and 3.7), substance use intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5), opioid treatment services, opioid treatment programs and office-based opioid treatment, and substance use outpatient services (ASAM Level 1.0)~~.

B. ARTS services shall be fully integrated with all physical health and behavioral health services for a complete continuum of care for all Medicaid individuals meeting the medical necessity criteria. In order to receive reimbursement for ARTS services, the individual shall be enrolled in Virginia Medicaid and shall meet the following medical necessity criteria:

1. The individual shall demonstrate at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for ~~Substance Related~~ substance-related and ~~Addictive Disorders~~ addictive disorders, with the exception of tobacco-related disorders ~~or caffeine-related disorders or dependence and nonsubstance-related~~ and non-substance-related addictive disorders ~~or be~~, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from the use of alcohol or other drugs despite significant related problems. Individuals younger than 21 years of age may also qualify if they are assessed to be at risk for developing a substance use disorder~~, for youth younger than 21 years of age using the ASAM multidimensional assessment~~.

2. The individual shall be assessed by a ~~certified addiction treatment professional~~ CATP or a CSAC under the supervision of a CATP who will determine if ~~he~~ the individual meets the severity and intensity of treatment requirements for each service level defined by the most current version of the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (Third Edition, 2013). Medical necessity for ASAM levels of care shall be based on the outcome of the individual's documented multidimensional assessment. ~~The following outpatient ASAM levels of care do not require a complete multidimensional assessment using the ASAM theoretical framework to determine medical necessity but do require an assessment by a certified addiction treatment professional: opioid treatment programs, office-based opioid treatment, and substance use outpatient services (ASAM Level 1.0).~~

3. For individuals younger than 21 years of age who do not meet the ASAM medical necessity criteria upon initial review, a second individualized review shall be conducted to determine if the individual needs medically necessary treatment under the early periodic screening diagnosis and treatment (EPSDT) benefit described in § 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening.

C. Determination of medical necessity based on ASAM criteria for addiction and recovery treatment services.

1. DMAS ~~contracted managed care organizations and the BHSA~~ or its contractor shall employ or contract with licensed treatment professionals to apply the ASAM criteria to review and coordinate service needs when administering ARTS benefits.

2. The ARTS care coordinator or a licensed physician or medical director employed by ~~the~~ DMAS or its contractor or an MCO ~~or BHSA~~ shall perform an independent assessment of requests for all ARTS intensive outpatient services (ASAM Level 2.1), partial hospitalization services (ASAM Level 2.5), residential treatment services (ASAM Levels 3.1, 3.3, 3.5, and 3.7), and ARTS inpatient treatment services (ASAM ~~Level~~ Levels 3.7 and 4.0).

3. Length of treatment and service limits shall be determined by the ARTS care coordinator or a licensed physician or medical director employed by ~~the BHSA~~ DMAS or its contractor or an MCO who is applying the ASAM criteria.

~~4. "ARTS care coordinator" means a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, or nurse practitioner or registered nurse with clinical experience in substance use disorders, who is employed by the BHSA or MCO to perform an independent assessment of requests for all ARTS residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7, and 4.0).~~

12VAC30-130-5050. Covered services: clinic services - opioid treatment program services.

A. Settings for opioid treatment program (OTP) services. The agency-based OTP provider shall be licensed by DBHDS and contracted by ~~the BHSA~~ DMAS or its contractor or an MCO. ~~Opioid treatment services~~ The staffing requirements for OTP providers shall follow the DBHDS licensing requirements set forth in 12VAC35-105-925 and in the DBHDS guidance document entitled "Opioid Medication Assisted Treatment License and Oversight" (March, 2017). The interdisciplinary team shall include CATPs acting within the scope of practice in accordance to their professional regulatory board and state and federal requirements, including an addiction-credentialed physician as defined in 12VAC30-130-5020. OTP services are ~~allowable in~~ allowed simultaneously for members in other ASAM Levels, including 1.0 through 3.7 (excluding inpatient services). ~~OTP's~~ OTPs shall meet the service components, staff requirements, and risk management requirements.

B. OTP service components.

1. Linking the individual to psychological, medical, and psychiatric consultation as necessary to meet the individual's needs.

2. Access to emergency medical and psychiatric care through connections with more intensive levels of care.

3. Access to evaluation and ongoing primary care.

4. Ability to conduct or arrange for appropriate laboratory and toxicology tests including ~~urine~~ drug screenings, using either urine or blood serums.

5. ~~Licensed physicians~~ Physicians who are available to evaluate and monitor (i) use of methadone, buprenorphine products, or naltrexone products and (ii) pharmacists and nurses to dispense and administer these medications and who follow the Board of Medicine guidance for treatment of individuals with buprenorphine for addiction.

6. Individualized, patient-centered assessment and treatment.

7. Ability to assess, order, administer, reassess, and regulate medication and dose levels appropriate to the individual; supervise withdrawal management from opioid analgesics, including methadone, buprenorphine products, or naltrexone products; and oversee and facilitate access to appropriate treatment for opioid use disorder.

8. Medication for other physical and mental health illness is provided as needed either ~~on-site~~ onsite or through collaboration with other providers.

9. Cognitive, behavioral, and other substance use disorder-focused ~~therapies,~~ psychotherapies and substance use disorder counseling by a CATP reflecting a variety of treatment approaches, provided to the individual on an individual, group, or family basis. CSACs and CSAC-supervisees are recognized to provide substance use disorder counseling in these settings as allowed within scopes of practice as defined in § 54.1-3507.1 of the Code of Virginia.

10. Optional substance use care coordination that includes integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring individual progress and tracking individual outcomes; supporting conversations between buprenorphine-waivered practitioners and behavioral health professionals to develop and monitor individualized treatment plans; linking individuals with community resources to facilitate referrals and respond to social service needs; and tracking and supporting individuals when they obtain medical, behavioral health, or social services outside the practice.

11. ~~Ability~~ Provision of onsite screening or the ability to refer for screening for infectious diseases such as human immunodeficiency virus, hepatitis B and C, and

tuberculosis at treatment initiation and then at least annually or more often based on risk factors and the ability to provide or refer for treatment of infectious diseases as necessary.

12. Onsite medication administration treatment during the induction phase, which must be provided by a physician, nurse practitioner, physician assistant, or registered nurse. Medication administration during the maintenance phase may be provided either by a registered nurse or licensed practical nurse.

13. Prescription of naloxone for each member receiving methadone, buprenorphine products, or naltrexone products.

14. Ability to provide pregnancy testing for women of childbearing age.

15. For individuals of childbearing age, the ability to provide family planning services or to refer the individual for family planning services.

C. OTP staff requirements.

1. Staff requirements shall meet the licensing requirements of 12VAC35-105-925. The interdisciplinary team shall include ~~credentialed addiction professionals~~ CATPs trained in the treatment of opioid use disorder, including an addiction credentialed physician or physician extender and ~~credentialed addiction treatment professionals~~ CATPs as defined in 12VAC30-130-5020. ~~"Addiction credentialed physician" means a physician who holds a board certification in addiction medicine from the American Board of Addiction Medicine, a subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology, or subspecialty board certification in addiction medicine from the American Osteopathic Association. In situations where a certified addiction physician is not available, physicians treating addiction should have some specialty training or experience in addiction medicine or addiction psychiatry. If treating adolescents, they should have experience with adolescent medicine.~~ OTPs may utilize CSACs and CSAC-supervisees to provide substance use disorder counseling and psychoeducational services within their scopes of practice as defined in § 54.1-3507.1 of the Code of Virginia. OTPs may also utilize CSAC-As pursuant to § 54.1-3507.2 of the Code of Virginia as well as registered peer recovery specialists within their scopes of practice. A registered peer recovery specialist shall meet the definition in § 54.1-3500 of the Code of Virginia.

2. Staff shall be knowledgeable in the assessment, interpretation, and treatment of the biopsychosocial dimensions of alcohol or other substance use disorders.

3. A physician or physician extender as defined in 12VAC30-130-5020~~,~~ shall be available during medication dispensing and clinical operating hours~~,~~ in person or by telephone.

D. OTP risk management shall be clearly and adequately documented in each individual's record and shall include:

1. Random ~~urine~~ drug screening, using either urine or blood serums, for all individuals, conducted at least eight times during a 12-month period as described in 12VAC35-105-980. Definitive screenings shall only be utilized when clinically indicated. Outcomes of the drug screening shall be used to support positive patient outcomes and recovery.

2. A check of the Virginia Prescription Monitoring Program prior to initiation of buprenorphine products or naltrexone products and at least quarterly for all individuals.

3. Prescription of naloxone.

4. Opioid overdose prevention education, including the ~~prescribing~~ purpose of and the administration of naloxone and the impact of polysubstance use. Education shall include discussion of the role of medication assisted treatment and the opportunity to reduce harm associated with polysubstance use. The goal is to help individuals remain in treatment to reduce the risk for harm.

5. Clinically indicated infectious disease testing for diseases such as HIV; hepatitis A, B, and C; syphilis; and tuberculosis at treatment initiation and then annually or more frequently, depending on the clinical scenario and the patient's risk. Those who test positive shall be treated either onsite or through referral.

6. For individuals without immunity to the hepatitis B virus, vaccination, either onsite or through referral, shall be offered.

7. For individuals without HIV infection, pre-exposure prophylaxis to prevent HIV infection, either onsite or through referral, shall be offered.

8. Pregnancy testing for women of childbearing age, and contraceptive services, either onsite or through referral, shall be offered.

12VAC30-130-5060. Covered services: clinic services - preferred office-based opioid treatment.

A. ~~Office-based~~ Preferred office-based opioid treatment (OBOT) shall be provided by a buprenorphine-waivered practitioner and may be provided in a variety of practice settings, including primary care clinics, outpatient health system clinics, psychiatry clinics, ~~federally qualified health centers~~ FQHCs, ~~CSBs/BHAs~~ CSBs, BHAs, local health department clinics, and physician offices. The practitioner shall be contracted by ~~the BHSA~~ DMAS or its contractor or an MCO to perform OBOT services. OBOT services shall meet the ~~following~~ criteria~~:~~ established in this section.

~~1.~~ B. OBOT service components.

~~a.~~ 1. Access to emergency medical and psychiatric care.

~~b.~~ 2. Affiliations with more intensive levels of care such as intensive outpatient programs and partial hospitalization programs ~~that unstable~~ to which individuals can be referred ~~to~~ when clinically indicated.

~~c.~~ 3. Individualized, patient-centered multidimensional assessment and treatment.

~~d.~~ 4. Assessing, ordering, administering, reassessing, and regulating medication and dose levels appropriate to the individual; supervising withdrawal management from opioid analgesics; and overseeing and facilitating access to appropriate treatment for opioid use disorder and alcohol use disorder.

~~e.~~ 5. Medication for other physical and mental ~~illnesses~~ health disorders shall be provided as needed either ~~on-site~~ onsite or through collaboration with other providers.

~~f.~~ 6. Assurance that buprenorphine products are only dispensed onsite during the induction phase. After the induction phase, buprenorphine products shall be prescribed to the member.

7. Assurance that buprenorphine monoproduct is only prescribed in accordance with Board of Medicine rules related to the prescribing of buprenorphine for addiction.

8. Cognitive, behavioral, and other substance use disorder-focused ~~therapies~~ counseling and psychotherapies, reflecting a variety of treatment approaches, shall be provided to the individual on an individual, group, or family basis and shall be provided by ~~credentialed addiction treatment professionals~~ CATPs working in collaboration with the buprenorphine-waivered practitioner who is prescribing buprenorphine products or naltrexone products to individuals with ~~moderate to severe~~ a primary opioid use disorder. These therapies can be provided via telemedicine as long as they meet ~~the department's~~ DMAS requirements for an OBOT and for the use of telemedicine. (See the Medicaid Memo entitled "Updates to Telemedicine Coverage" dated May 13, 2014.) Preferred OBOTs may utilize CSACs and CSAC-supervisees to provide substance use disorder counseling and psychoeducational services within their scope of practice as defined in § 54.1-3507.1 of the Code of Virginia.

~~g.~~ 9. Substance use care coordination provided, including interdisciplinary care planning between the buprenorphine-waivered ~~physician~~ practitioner and the ~~licensed behavioral health provider~~ treatment team to develop and monitor individualized and personalized treatment plans focused on the best outcomes for the individual. This care coordination includes monitoring individual progress, tracking individual outcomes, linking the individual with community resources to facilitate referrals and respond to social service needs, and tracking and supporting the individual's medical, behavioral health, or social services received outside the practice.

~~h. Referral~~ 10. Provision of onsite screening or referral for screening for clinically indicated infectious ~~diseases such as human immunodeficiency virus, hepatitis B and C, and tuberculosis~~ disease testing for diseases such as HIV; hepatitis A, B, and C; syphilis; and tuberculosis at treatment initiation and then at least annually or more often based on risk factors and the ability to provide or refer for treatment of infectious diseases as necessary.

11. Onsite medication administration treatment during the induction phase, which shall be provided by a physician, nurse practitioner, physician assistant, or registered nurse.

12. Ability to provide pregnancy testing for women of childbearing age.

13. For individuals of childbearing age, the ability to provide family planning services or to refer the individual for family planning services.

~~B.~~ C. OBOT staff requirements.

1. Buprenorphine-waivered ~~practitioner licensed under Virginia law who has completed one of the continuing medical education courses approved by the federal Center for Substance Abuse Treatment and obtained the waiver to prescribe or dispense buprenorphine for opioid use disorder required under the Drug Addiction Treatment Act of 2000 (21 USC § 800 et seq.). The practitioner must have a DEA X number issued by the U.S. Drug Enforcement Agency that is included on all buprenorphine prescriptions for treatment of opioid use disorder~~ practitioners are required.

2. ~~Credentialed addiction treatment professionals~~ CATPs are required and shall work in collaboration with the buprenorphine-waivered practitioner who is prescribing buprenorphine products or naltrexone products to individuals with ~~moderate to severe~~ a primary opioid use disorder. This collaboration can be in person or via telemedicine as long as it meets the department's requirements for the OBOT setting and for telemedicine. CSACs, CSAC-supervisees, and CSAC-As are also recognized in the preferred OBOT setting as well as registered peer recovery specialists. A registered peer recovery specialist shall meet the definition in § 54.1-3500 of the Code of Virginia.

~~C.~~ D. OBOT risk management shall be documented in each individual's record and shall include:

1. Random ~~urine~~ drug screening, using either urine or blood serums, for all individuals, conducted at a minimum of eight times per year. Drug screenings include presumptive and definitive screenings and shall be accurately interpreted. Definitive screenings shall only be

utilized when clinically indicated. Outcomes of the drug screening shall be used to support positive patient outcomes and recovery.

2. A check of the Virginia Prescription Monitoring Program prior to initiation of buprenorphine products or naltrexone products and at least quarterly for all individuals thereafter.

3. Prescription of naloxone.

4. Opioid overdose prevention education, including the ~~prescribing~~ purpose of and the administration of naloxone and the impact of polysubstance use. Education shall include discussion of the role of medication assisted treatment and the opportunity to reduce harm associated with polysubstance use. The goal is to help individuals remain in treatment to reduce the risk for harm.

5. Periodic monitoring of unused medication and opened medication wrapper counts when clinically indicated.

6. Clinically indicated infectious disease testing for diseases such as HIV; hepatitis A, B, and C; syphilis; and tuberculosis at treatment initiation and then annually or more frequently, depending on the clinical scenario and the patient's risk. Those individuals who test positive shall be treated either onsite or through referral.

7. For individuals without immunity to the hepatitis B virus, vaccination either onsite or through referral.

8. For patients without HIV infection, pre-exposure prophylaxis to prevent HIV infection shall be offered either onsite or through referral.

9. Women of child-bearing age shall be tested for pregnancy and shall be offered contraceptive services either onsite or through referral.

12VAC30-130-5070. Covered services: practitioner services - early intervention/screening brief intervention and referral to treatment (ASAM Level 0.5).

A. Early intervention (ASAM Level 0.5) settings for screening, brief intervention, and referral to treatment (SBIRT) services shall include health care settings, including local health departments, ~~federally qualified health centers~~ FQHCs, ~~rural health clinics~~ RHCs, ~~CSBs/BHAs~~ CSBs, BHAs, health systems, emergency departments, pharmacies, physician offices, and outpatient clinics. ~~These providers~~ Providers shall be licensed by ~~DHP~~ the Department of Health Professions and either directly contracted by ~~the BHSA~~ DMAS or its contractor or an MCO to perform the interpretation and intervention for this level of care~~,~~ or shall be employed by organizations that are contracted by ~~the BHSA~~ DMAS or its contractor or an MCO.

B. Early ~~intervention/SBIRT~~ intervention or SBIRT (ASAM Level 0.5) service components shall include:

1. Identifying individuals who may have alcohol or other substance use problems using an evidence-based screening tool.

2. Following administration of the evidence-based screening tool, a brief intervention by a ~~licensed clinician~~ CATP acting within the scope of the CATP's practice shall be provided to educate individuals about substance use, alert these individuals to possible consequences, and~~,~~ if needed, begin to motivate individuals to take steps to change their behaviors. Billing shall occur through the licensed provider or agency.

C. Early ~~intervention/SBIRT~~ intervention or SBIRT (ASAM Level 0.5) staff requirements. Physicians, pharmacists, and other ~~credentialed addiction treatment professionals~~ CATPs shall administer the evidence-based screening tool with the individual and provide the counseling and intervention. Licensed providers may delegate administration of the evidence-based screening tool to other clinical staff as allowed by their scope of practice, such as ~~physicians delegating administration of the tool to~~ a CSAC, a CSAC-supervisee, a licensed registered nurse, or a licensed practical nurse~~, but the licensed provider shall review the tool with the individual and provide the counseling and intervention~~. The physician may delegate the counseling and intervention but shall be available for review as needed. Billing for SBIRT shall occur through the licensed provider or agency.

12VAC30-130-5080. Covered services: outpatient services - physician services (ASAM Level 1.0).

A. Outpatient services (ASAM Level 1.0) shall be provided by a ~~credentialed addiction treatment professional, psychiatrist, or physician~~ CATP contracted by ~~the BHSA~~ DMAS or its contractor or an MCO to perform the services in the following community based settings: primary care clinics, outpatient health system clinics, psychiatry clinics, ~~federally qualified health centers (FQHCs)~~ FQHCs, ~~community service boards/BHAs~~ RHCs, CSBs, BHAs, local health departments, and physician and provider offices. Reimbursement for substance use outpatient services shall be made for medically necessary services provided in accordance with an ISP or the treatment plan and include withdrawal management as necessary. Services can be provided ~~face-to-face~~ in person or by telemedicine. Outpatient services shall meet the ASAM Level 1.0 service components and staff requirements as follows:

1. Outpatient services (ASAM Level 1.0) service components.

a. Substance use outpatient services shall be provided fewer than nine hours per week and may be delivered in the following health care settings: local health departments, FQHCs, rural health clinics, ~~CSBs/BHAs~~

CSBs, BHAs, health systems, emergency departments, physician and provider offices, and outpatient clinics. Provision of services in a setting other than the office or a clinic, as defined in this subsection shall be documented. Services shall include professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.

b. A multidimensional assessment shall (i) be used, (ii) be documented to determine that an individual meets the medical necessity criteria, and (iii) include the evaluation or analysis of substance use disorders, the diagnosis of substance use disorder, and the assessment of treatment needs to provide medically necessary services. The multidimensional assessment shall include a physical examination and laboratory testing necessary for substance use disorder treatment as necessary.

c. Individual psychotherapy or substance use disorder counseling ~~between the individual and~~ shall be provided by a ~~credentialed addiction treatment professional shall be provided~~ CATP. Services shall be provided ~~face to face~~ in person or by telemedicine ~~shall qualify as reimbursable~~.

d. Group psychotherapy or substance use disorder counseling shall be provided by a ~~credentialed addiction treatment professional,~~ CATP with a maximum of 10 individuals in the group ~~shall be provided. Such counseling~~ and shall focus on the needs of the individuals served.

e. Family ~~therapy~~ psychotherapy or substance use disorder counseling shall be provided by a CATP to facilitate the individual's recovery and support for the family's recovery.

f. Evidenced-based patient education on addiction, treatment, recovery, and associated health risks shall be provided.

g. Medication services shall be provided, including the prescription of or administration of medication related to substance use treatment~~,~~ or the assessment of the side effects or results of that medication. Medication services shall be provided by staff lawfully authorized to provide such services who shall order laboratory testing within their scope of practice or licensure.

h. Collateral services shall be provided. ~~"Collateral services" means services provided by therapists or counselors for the purpose of engaging persons who are significant to the individual receiving SUD services. The services are focused on the individual's treatment needs and support achievement of his recovery goals.~~

2. Outpatient services (ASAM Level 1.0) staff requirements shall include:

a. ~~Credentialed addiction treatment professional~~ A CATP; or

b. A registered nurse or a practical nurse who is licensed by the Commonwealth with at least one year of clinical experience involving medication management.

B. Outpatient services (ASAM Level 1.0) co-occurring enhanced programs shall include:

1. Ongoing substance use case management for highly crisis prone individuals with co-occurring disorders.

2. ~~Credentialed addiction treatment professionals~~ CATPs who are trained in severe and chronic mental health and psychiatric disorders and are able to assess, monitor, and manage individuals who have a co-occurring mental health disorder. "Co-occurring disorders" means the presence of concurrent substance use disorder and mental illness without implication as to which disorder is primary and which is secondary, which disorder occurred first, or whether one disorder caused the other.

12VAC30-130-5090. Covered services: community based services - intensive outpatient services (ASAM Level 2.1).

A. Intensive outpatient services (ASAM Level 2.1) shall be a structured program of skilled treatment services for adults, children, and adolescents delivering a minimum of three service hours per service day for adults to achieve an average of nine to 19 hours of services per week ~~for adults~~ and a minimum of two service hours per service day for children and adolescents to achieve an average of six to 19 hours of services per week ~~for children and adolescents~~. Withdrawal management services may be provided as necessary. The following service components shall be provided weekly as directed by the ISP for reimbursement:

1. Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral.

2. Psychiatric and other individualized treatment planning.

3. Individual, family, and group psychotherapy, substance use disorder counseling, medication management, ~~family therapy,~~ and psychoeducation. ~~"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have a substance use disorder or mental illness and their family members or caregivers to access clear and concise information about substance use disorders or mental illness and (ii) a way of accessing and learning strategies to deal with substance use disorders or mental illness and its effects in order to design effective treatment plans and strategies.~~

4. Medication assisted treatment that is provided onsite or through referral.

5. Occupational and recreational therapies, motivational interviewing, enhancement, and engagement strategies to inspire an individual's motivation to change behaviors.

~~5.~~ 6. Psychiatric and medical consultation, which shall be available within 24 hours of the requested consult by telephone and preferably within 72 hours of the requested consult in person or via telemedicine.

~~6.~~ 7. Psychopharmacological consultation.

~~7.~~ 8. Addiction medication management and 24-hour crisis services.

~~8.~~ 9. Medical, psychological, psychiatric, laboratory, and toxicology services.

B. Intensive outpatient services (ASAM Level 2.1) shall be provided by agency-based providers that shall be licensed by DBHDS as a substance abuse intensive outpatient service for adults, children, and adolescents and contracted with ~~the BHSA~~ DMAS or its contractor or an MCO to provide this service. Intensive outpatient service providers shall meet the ASAM Level 2.1 service components and staff requirements as follows:

1. Interdisciplinary team of ~~credentialed addiction treatment professionals~~ CATPs shall be required. ASAM Level 2.1 may utilize CSACs or CSAC-supervisees to provide substance use disorder counseling and psychoeducational services within their scopes of practice as defined in § 54.1-3507.1 of the Code of Virginia.

2. Generalist physicians or physicians with experience in addiction medicine are permitted to provide general medical evaluations and ~~concurrent/integrated~~ concurrent or integrated general medical care.

3. Physicians and physician extenders who are either employed by or contracted with the agency or through referral arrangements with the agency and who shall have a DEA-X number to prescribe buprenorphine.

4. Staff who shall be cross-trained to understand signs and symptoms of psychiatric disorders and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.

~~4.~~ 5. Emergency services, which shall be available, when necessary, by telephone 24 hours per day and seven days per week when the treatment program is not in session.

~~5.~~ 6. Direct affiliation with, or close coordination through referrals to, higher and lower levels of care and supportive housing services.

C. Intensive outpatient services (ASAM Level 2.1) co-occurring enhanced programs.

1. Co-occurring capable programs offer these therapies and support systems in intensive outpatient services described in this section to individuals with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a planned program of therapies.

2. Individuals who are not able to benefit from a full program of therapies will be offered enhanced program services to match the intensity of hours in ASAM Level 2.1, including substance use case management, program of assertive community treatment (PACT), medication management, and psychotherapy. ~~"Program of assertive community treatment" or "PACT" means the same as defined in 12VAC30-105-20.~~

12VAC30-130-5100. Covered services: community based care - partial hospitalization services (ASAM Level 2.5).

A. Partial hospitalization services (ASAM Level 2.5) components. Partial hospitalization services components shall include the following, as defined in the ISP and provided on a weekly basis:

1. Individualized treatment planning.

2. A minimum of 20 hours per week and at least five service hours per service day of skilled treatment services with a planned format, including individual and group psychotherapy, substance use disorder counseling, medication management, ~~family therapy,~~ education groups, occupational and recreational therapy, and other therapies. Withdrawal management services may be provided as necessary. Time not spent in skilled, clinically intensive treatment is not billable.

3. Family ~~therapies~~ psychotherapy and substance use disorder counseling involving family members, guardians, or significant ~~other~~ others in the assessment, treatment, and continuing care of the individual.

~~4. A planned format of therapies, delivered in individual or group settings.~~

~~5.~~ 4. Motivational interviewing, enhancement, and engagement strategies.

5. Medication assisted treatment that is provided onsite or through referral.

B. Partial hospitalization services (ASAM Level 2.5). The substance use partial hospitalization service provider shall be licensed by DBHDS as a substance abuse partial hospitalization program or substance ~~abuse/mental~~ abuse or mental health partial hospitalization program and contracted with ~~the BHSA~~ DMAS or its contractor or an MCO. Partial hospitalization service providers shall meet the ASAM Level 2.5 support systems and staff requirements as follows:

1. Interdisciplinary team comprised of ~~credentialed addiction treatment professionals and~~ CATPs, which shall include an addiction-credentialed physician~~,~~ or physician with experience in addiction medicine, or physician extenders as defined in 12VAC30-130-5020~~, shall be~~

~~required~~. ASAM Level 2.5 may utilize CSACs or CSAC-supervisees to provide substance use disorder counseling and psychoeducational services within their scopes of practice as defined in § 54.1-3507.1 of the Code of Virginia.

2. Physicians shall have specialty training or experience, or both, in addiction medicine or addiction psychiatry. Physicians who treat adolescents shall have experience with adolescent medicine.

3. Physicians and physician extenders who are either employed by or contracted with the agency and who shall have a DEA-X number to prescribe buprenorphine.

4. Program staff shall be cross-trained to understand signs and symptoms of mental illness and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.

~~4.~~ 5. Medical, psychological, psychiatric, laboratory, and toxicology services that are available by consult or referral.

~~5.~~ 6. Psychiatric and medical formal agreements to provide medical consult within eight hours of the requested consult by telephone or within 48 hours in person or via telemedicine.

~~6.~~ 7. Emergency services are available 24-hours a day and seven days a week.

~~7.~~ 8. Direct affiliation with or close coordination through referrals to higher and lower levels of care and supportive housing services.

C. Partial hospitalization services (ASAM Level 2.5) co-occurring enhanced programs shall offer:

1. Therapies and support systems as described in this section to individuals with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a full program of therapies. Other individuals who are not able to benefit from a full program of therapies (who are severely or chronically mentally ill) will be offered enhanced program services to constitute intensity of hours in ASAM Level 2.5, including substance use case management, ~~assertive community treatment~~ PACT, medication management, and psychotherapy.

2. Psychiatric services as appropriate to meet the individual's mental health condition. Services may be available by telephone and ~~on site~~ onsite, or closely coordinated ~~off site~~ offsite, or via telemedicine within a shorter time than in a co-occurring capable program.

3. Clinical leadership and oversight and, at a minimum, capacity to consult with an addiction psychiatrist via telephone, via telemedicine, or in person.

4. ~~Credentialed addiction treatment professionals~~ CATPs with experience assessing and treating co-occurring mental illness.

12VAC30-130-5110. Covered services: clinically managed low intensity residential services (ASAM Level 3.1).

A. Clinically managed low intensity residential services (ASAM Level 3.1). The agency-based residential group home services (ASAM Level 3.1) shall be licensed by DBHDS as a mental health and substance abuse group home service for adults or children or licensed by DBHDS as a ~~substance abuse halfway house~~ supervised living residence for adults and contracted by ~~the BHSA~~ DMAS or its contractor or an MCO. Clinically directed program activities constituting at least five hours per week of professionally directed treatment shall be designed to stabilize and maintain substance use disorder symptoms and to develop and apply recovery skills. Activities shall include relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery. This service shall not include settings where clinical treatment services are not provided. ASAM Level 3.1 clinically managed low intensity residential service providers shall meet the service components and staff requirements of this section.

B. Clinically managed low intensity residential services (ASAM Level 3.1) service components.

1. Physician consultation and emergency services, which shall be available 24 hours a day and seven days per week.

2. Arrangements for medically necessary procedures including laboratory and toxicology tests that are appropriate to the severity and urgency of an individual's condition.

3. Arrangements for pharmacotherapy for psychiatric ~~or anti-addiction medications~~ needs.

4. Medication assisted treatment that is provided onsite or through referral.

5. Arrangements for higher and lower levels of care and other services.

C. The following services shall be provided as directed by the ISP:

1. Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life;

2. Addiction pharmacotherapy and drug screening;

3. Motivational enhancement and engagement strategies;

4. ~~Counseling~~ Substance use disorder counseling and clinical monitoring;

5. Regular monitoring of the individual's medication adherence;

6. Recovery support services;

7. Services for the individual's family and significant others, as appropriate to advance the individual's treatment goals and objectives identified in the ISP; and

8. Education on benefits of medication assisted treatment and referral to treatment as necessary.

D. Clinically managed low intensity residential services (ASAM Level 3.1) staff requirements.

1. Staff shall provide awake 24-hour onsite supervision. The provider's staffing plan must be in compliance with DBHDS licensing regulations for staffing plans set forth in 12VAC35-46-870 and 12VAC35-105-590.

2. Clinical staff who are experienced and knowledgeable about the biopsychosocial and psychosocial dimensions and treatment of substance use disorders. Clinical staff shall be able to identify the signs and symptoms of acute psychiatric conditions and decompensation.

3. An addiction-credentialed physician or physician with experience in addiction medicine or a physician extender acting within his scope of practice shall review the residential group home admission if the multidimensional assessment indicates medical concerns or systems in ASAM Dimensions 1 or 2, to confirm medical necessity for services~~,~~ and a team of ~~credentialed addiction treatment professionals~~ CATPs who shall develop and shall ensure delivery of the ISP. For ASAM Level 3.1, the ISP may be completed by a CSAC or CSAC-supervisee if the CATP signs and dates the ISP within one business day.

4. Coordination with community physicians to review treatment as needed.

5. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and to monitor the individual's administration of prescribed medications.

E. Clinically managed low intensity residential services (ASAM Level 3.1) co-occurring enhanced programs as required by ASAM.

1. In addition to the ASAM Level 3.1 service components listed in this section, programs for individuals with both unstable substance use and psychiatric disorders shall offer appropriate psychiatric services, including medication evaluation and laboratory services. Such services are provided either ~~on-site~~ onsite, via telemedicine, or closely coordinated with an ~~off-site~~ offsite provider, as appropriate to the severity and urgency of the individual's mental health condition.

2. Certified addiction treatment professionals shall be cross-trained in addiction and mental health to (i) understand the signs and symptoms of mental illness and (ii) understand and be able to explain to the individual the purpose of psychotropic medications and interactions with substance use.

3. The therapies described in this section shall be offered as well as planned clinical activities (either ~~on-site~~ onsite or with an ~~off-site~~ offsite provider) that are designed to stabilize and maintain the individual's mental health program and psychiatric symptoms.

4. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental illness.

5. Medication education and management shall be provided.

12VAC30-130-5120. Covered services: clinically managed population - specific high intensity residential service (ASAM Level 3.3).

A. Clinically managed population-specific high intensity residential service (ASAM Level 3.3). The facility-based provider shall be licensed by DBHDS ~~to provide~~ as (i) a supervised residential treatment ~~services~~ service for adults ~~or licensed by DBHDS to provide~~; (ii) a substance abuse residential treatment service for adults~~, supervised residential treatment services for adults, or~~; (iii) a substance abuse residential treatment service for women with children; (iv) a substance abuse and mental health residential treatment ~~services~~ service for adults~~, and~~ that has substance abuse listed on its license or within the "licensed as" statement or be a Level C (psychiatric residential treatment facility) service provider; or (v) a "mental health residential-children" provider that has substance abuse listed on its license or within the "licensed as" statements. All providers shall be contracted by ~~the BHSA~~ DMAS or its contractor or an MCO. ASAM Level 3.3 settings do not include sober houses, boarding houses, or group homes where treatment services are not provided. Residential treatment service providers for clinically managed population-specific high intensity residential service (ASAM Level 3.3) shall meet the service components and staff requirements in this section.

B. Clinically managed population-specific high intensity residential service (ASAM Level 3.3) service components.

1. Clinically managed population-specific high intensity residential service components shall include:

a. Access to a consulting physician or physician extender who is either employed by or contracted with the agency or through referral arrangements with the agency and who has a DEA-X number to prescribe buprenorphine and emergency services 24 hours a day and seven days a week;

b. Arrangements for higher and lower levels of care;

c. Arrangements for laboratory and toxicology services appropriate to the severity of need; and

d. Arrangements for addiction pharmacotherapy, including medication assisted treatment that is provided onsite or through referral.

2. The following therapies shall be provided as directed by the ISP for reimbursement:

a. Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life;

b. Addiction pharmacotherapy ~~and drug screening,~~ including medication assisted treatment that is provided onsite or through referral;

c. ~~Range~~ Drug screening, using either urine or blood serums;

d. A range of cognitive and behavioral ~~therapies~~ psychotherapies administered individually and in family and group settings as appropriate to the individual's needs to assist the individual in initial involvement or re-engagement in regular productive daily activity;

e. Substance use disorder counseling and psychoeducation activities provided individually or in family and group settings to promote recovery;

~~d.~~ f. Recreational therapy, art, music, physical therapy, and vocational rehabilitation;

~~e.~~ g. Motivational enhancement and engagement strategies;

~~f.~~ h. Regular monitoring of the individual's medication adherence;

~~g.~~ i. Recovery support services;

~~h.~~ j. Services for the individual's family and significant others, as appropriate to advance the individual's treatment goals and objectives identified in the ISP;

~~i.~~ k. Education on benefits of medication assisted treatment and referral to treatment as necessary; and

~~j.~~ l. Withdrawal management services may be provided as necessary.

C. Clinically managed population-specific high intensity residential service (ASAM Level 3.3) staff requirements.

1. The interdisciplinary team shall include ~~credentialed addiction treatment professionals, physicians, or physician extenders~~ CATPs and allied health professionals in an interdisciplinary team. ASAM Level 3.3 may utilize CSACs or CSAC-supervisees to provide substance use disorder counseling and psychoeducational services within their scopes of practice as defined in § 54.1-3507.1 of the Code of Virginia.

2. Staff shall provide awake 24-hour onsite supervision. The provider's staffing plan must be in compliance with DBHDS licensing regulations for staffing plans set forth in 12VAC35-46-870 and 12VAC35-105-590.

3. Clinical or credentialed staff ~~who are~~ shall be experienced and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders and who are available ~~on site~~ onsite or by telephone 24 hours per day. ~~Clinical~~ Licensed clinical staff shall be able to identify acute psychiatric conditions and decompensation.

4. Substance use case management is included in this level of care.

5. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and to monitor the individual's administration of prescribed medications.

D. Clinically managed population-specific high intensity residential service co-occurring enhanced programs, as required by ASAM.

1. Appropriate psychiatric services, including medication evaluation and laboratory services, shall be provided ~~on site~~ onsite or through a closely coordinated ~~off-site~~ offsite provider, as appropriate to the severity and urgency of the individual's mental condition.

2. ~~Psychiatrists and credentialed addiction treatment professionals~~ CATPs shall be available to assess and treat co-occurring substance use and mental illness using specialized training in behavior management techniques.

3. Credentialed addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental illness and be able to provide education to the individual on the interactions with substance use and psychotropic medications.

12VAC30-130-5130. Covered services: clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5).

A. Clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5) settings for services. The facility based residential treatment service provider (ASAM Level 3.5) shall be licensed ~~by DBHDS~~ as (i) a substance abuse residential treatment ~~services~~ service for adults or children, (ii) a psychiatric unit that has substance abuse listed on its license or within the "licensed as" statements, (iii) a substance abuse residential treatment service for women with children, ~~or~~ (iv) a substance abuse and mental health residential treatment ~~services~~ service for

adults and children that has substance abuse listed on its license or within the "licensed as" statements, (v) a Level C (psychiatric residential treatment facility) provider, or (vi) a "mental health residential-children" provider that has substance abuse on its license or within the "licensed as" statements and shall be contracted by ~~the BHSA~~ DMAS or its contractor or an MCO. Residential treatment providers (ASAM Level 3.5) shall meet the service components and staff requirements in this section.

B. Clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5) service components.

1. These residential treatment services, as required by ASAM, include:

a. Telephone or in-person consultation with a physician or physician extender who shall be available to perform required physician services. Emergency services shall be available 24 hours per day and seven days per week;

b. Arrangements for more and less intensive levels of care and other services such as sheltered workshops, literacy training, and adult education;

c. Arrangements for needed procedures, including medical, psychiatric, psychological, laboratory, and toxicology services appropriate to the severity of need; and

d. Arrangements for addiction pharmacotherapy, including medication assisted treatment that is provided onsite or through referral.

2. The following therapies shall be provided as directed by the ISP for reimbursement:

a. Clinically directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life. Activities shall be designed to stabilize and maintain substance use disorder symptoms and apply recovery skills and may include relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery.

b. Range of cognitive ~~and~~, behavioral ~~therapies~~ psychotherapies, and substance use disorder counseling administered individually and in family and group settings to assist the individual in initial involvement or re-engagement in regular productive daily activities, including education on medication management, addiction pharmacotherapy, and education skill building groups to enhance the individual's understanding of substance use and mental illness.

c. Psychoeducational activities.

d. Addiction pharmacotherapy and drug screening.

~~d.~~ e. Recreational therapy, art, music, physical therapy, and vocational rehabilitation.

~~e.~~ f. Motivational enhancements and engagement strategies.

~~f.~~ g. Monitoring of the adherence to prescribed medications and over-the-counter medications and supplements.

~~g.~~ h. Daily scheduled professional services and interdisciplinary assessments and treatment designed to develop and apply recovery skills.

~~h.~~ i. Services for family and significant others, as appropriate, to advance the individual's treatment goals and objectives identified in the ISP.

~~i. Education on benefits of medication assisted treatment and referral to treatment as necessary.~~

j. Withdrawal management services may be provided as necessary.

C. Clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5) staff requirements.

1. The interdisciplinary team shall include ~~credentialed addiction treatment professionals~~ CATPs, physicians, or physician extenders and allied health professionals. Physicians and physician extenders who are either employed by or contracted with the agency or through referral arrangements with the agency and who shall have a DEA-X number to prescribe buprenorphine. ASAM Level 3.5 may utilize CSACs or CSAC-supervisees to provide substance use disorder counseling and psychoeducational services within their scopes of practice as defined in § 54.1-3507.1 of the Code of Virginia.

2. Staff shall provide awake 24-hour onsite supervision. The provider's staffing plan must be in compliance with DBHDS licensing regulations for staffing plans set forth in 12VAC35-46-870 and 12VAC35-105-590.

3. Clinical staff who are experienced in and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders. Clinical staff shall be able to identify acute psychiatric conditions and decompensations.

4. Substance use case management shall be provided in this level of care.

5. Appropriately credentialed medical staff shall be available ~~on site~~ onsite or by telephone 24 hours per day, seven days per week to assess and treat co-occurring biological and physiological disorders and to monitor the individual's administration of medications in accordance with a physician's prescription.

D. Clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5) co-occurring enhanced programs as required by ASAM.

1. Psychiatric services, medication evaluation, and laboratory services shall be provided. Such services shall be available by telephone within eight hours of requested service and ~~on site~~ onsite or via telemedicine, or closely coordinated with an ~~off site~~ offsite provider within 24 hours of requested service, as appropriate to the severity and urgency of the individual's mental and physical condition.

2. Staff shall be ~~credentialed addiction treatment professionals~~ CATPs who are able to assess and treat co-occurring substance use and psychiatric disorders.

3. Planned clinical activities shall be required and shall be designed to stabilize and maintain the individual's mental health problems and psychiatric symptoms.

4. Medication education and management shall be provided.

12VAC30-130-5140. Covered services: medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7).

A. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) settings for services. The facility-based ~~providers~~ provider of ASAM Level 3.7 services shall be licensed by DBHDS as ~~an inpatient psychiatric unit with a DBHDS medical detoxification license,~~ (i) a freestanding psychiatric hospital or inpatient psychiatric unit with a DBHDS medical detoxification license or managed withdrawal license; (ii) a residential crisis stabilization unit with a DBHDS medical detoxification license or managed withdrawal license; (iii) a substance abuse residential treatment ~~services (RTS) for adults/children~~ service for women with children with a DBHDS ~~medical detoxification~~ managed withdrawal license ~~or a residential crisis stabilization unit with DBHDS medical detoxification license~~; (iv) a Level C (psychiatric residential treatment facility) provider; (v) a "mental health residential-children" provider with a substance abuse residential license and a DBHDS managed withdrawal license; (vi) a "managed withdrawal-medical detox adult residential treatment" provider; or (vii) a "medical detox-chemical dependency unit" for adults and shall be contracted by ~~the BHSA~~ DMAS or its contractor or the MCO. ASAM Level 3.7 providers shall meet the service components and staff requirements in this section.

B. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) service components. The following therapies shall be provided as directed by the ISP for reimbursement:

1. Daily clinical services provided by an interdisciplinary team to involve appropriate medical and nursing services, as well as individual, group, and family activity services. Activities may include pharmacological, including medication assisted treatment that is provided onsite or through referral; withdrawal management~~,~~; cognitive-behavioral~~,~~; and other ~~therapies~~ psychotherapies and substance use disorder counseling administered on an individual or group basis and modified to meet the individual's level of understanding and assist in the individual's recovery.

2. Counseling and clinical monitoring to facilitate re-involvement in regular productive daily activities and successful re-integration into family living if applicable.

3. Psychoeducational activities.

4. Random drug screens to monitor use and strengthen recovery and treatment gains.

~~4.~~ 5. Regular medication monitoring.

~~5.~~ 6. Planned clinical activities to enhance understanding of substance use disorders.

~~6.~~ 7. Health education associated with the course of addiction and other potential health related risk factors, including tuberculosis, human immunodeficiency virus, hepatitis B and C, and other sexually transmitted infections.

~~7.~~ 8. Evidence based practices, such as motivational interviewing to address ~~the individuals~~ an individual's readiness to change, designed to facilitate understanding of the relationship of the substance use disorder and life impacts.

~~8.~~ 9. Daily treatments to manage acute symptoms of biomedical substance use or mental illness.

~~9.~~ 10. Services to family and significant others as appropriate to advance the individual's treatment goals and objectives identified in the ISP.

~~10.~~ 11. Physician monitoring, nursing care, and observation shall be available. A physician shall be available to assess the individual in person or via telemedicine within 24 hours of admission and thereafter as medically necessary.

~~11.~~ 12. A licensed and registered nurse who shall conduct an alcohol or other drug-focused nursing assessment upon admission. A licensed registered nurse or licensed practical nurse shall be responsible for monitoring the individual's progress and for medication administration duties.

~~12.~~ 13. Additional medical specialty consultation~~,~~; psychological, laboratory, and toxicology services shall be

available ~~on-site~~ onsite, either through consultation or referral.

~~13.~~ 14. Coordination of necessary services shall be available ~~on-site~~ onsite or through referral to a closely coordinated ~~off-site~~ offsite provider to transition the individual to lower levels of care.

~~14.~~ 15. Psychiatric services shall be available ~~on-site~~ onsite or through consultation or referral to a closely coordinated ~~off-site~~ offsite provider when a presenting problem could be attended to at a later time. Such services shall be available within eight hours of requested service by telephone or within 24 hours of requested service in person or via telemedicine.

C. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) staff requirements.

1. The interdisciplinary team shall include ~~credentialed addiction treatment professionals~~ CATPs and addiction-credentialed physicians or physicians with experience in addiction medicine to assess, treat, and obtain and interpret information regarding the individual's psychiatric and substance use disorders. Physicians and physician extenders who are either employed by or contracted with the agency or through referral arrangements with the agency and who shall have a DEA-X number for prescribing buprenorphine. ASAM Level 3.7 may utilize CSACs or CSAC-supervisees to provide substance use disorder counseling and psychoeducational services within their scopes of practice as defined in § 54.1-3507.1 of the Code of Virginia.

2. Clinical staff shall be knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental illnesses and their treatment. Clinical staff shall be able to identify acute psychiatric conditions, symptom increase or escalation, and decompensation.

3. Clinical staff shall be able to provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment, including the administration of prescribed medications.

4. ~~Addiction-credentialed~~ An addiction-credentialed physician or physician with experience in addiction medicine shall oversee the treatment process and assure quality of care. Licensed physicians shall perform physical examinations for all individuals who are admitted. Staff shall supervise addiction pharmacotherapy integrated with psychosocial therapies. The professional may be a physician or a psychiatrist, or a physician extender as defined in 12VAC30-130-5020 if knowledgeable about addiction treatment.

D. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) co-occurring enhanced programs as required by ASAM.

1. Appropriate psychiatric services, medication evaluation, and laboratory services shall be available.

2. A psychiatrist assessment of the individual shall occur within four hours of admission by telephone and within 24 hours following admission in person or via telemedicine, or sooner, as appropriate to the individual's behavioral health condition, and thereafter as medically necessary.

3. A behavioral health-focused assessment at the time of admission shall be performed by a registered nurse or licensed mental health clinician. A licensed registered nurse or licensed practical nurse supervised by a registered nurse shall be responsible for monitoring the individual's progress and administering or monitoring the individual's self-administration of medications.

4. Psychiatrists and ~~credentialed addiction treatment professionals~~ CATPs who are able to assess and treat co-occurring psychiatric disorders and who have specialized training in the behavior management techniques and evidenced-based practices shall be available.

5. Access to an addiction-credentialed physician shall be available along with access to either a psychiatrist, a certified addiction psychiatrist, or a psychiatrist with experience in addiction medicine.

6. ~~Credentialed addiction treatment professionals~~ CATPs shall have experience and training in addiction and mental health to understand the signs and symptoms of mental illness and be able to provide education to the individual on the interaction of substance use and psychotropic medications.

7. Planned clinical activities shall be offered and designed to promote stabilization and maintenance of the individual's behavioral health needs, recovery, and psychiatric symptoms.

8. Medication education and management shall be offered.

12VAC30-130-5150. Covered services: medically managed intensive inpatient services (ASAM Level 4.0).

A. Medically managed intensive inpatient services (ASAM Level 4.0) settings for services. Acute care hospitals licensed by the Virginia Department of Health shall be the designated setting for medically managed intensive inpatient treatment and shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs. Such service settings shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress, or all of these, resulting

from, or co-occurring with, an individual's use of alcohol or other drugs, with the exception of tobacco-related disorders, caffeine-related disorders or dependence or ~~nonsubstance-related~~ non-substance-related disorders.

B. Medically managed intensive inpatient services (ASAM Level 4.0) service components.

1. The service components of medically managed intensive inpatient services shall be:

a. An evaluation or analysis of substance use disorders shall be provided, including the diagnosis of substance use disorders and the assessment of treatment needs for medically necessary services.

b. Observation and monitoring the individual's course of withdrawal shall be provided. This shall be conducted as frequently as deemed appropriate for the individual and the level of care the individual is receiving. This may include, for example, observation of the individual's health status.

c. Medication services, including the prescription or administration related to substance use disorder treatment services or the assessment of the side effects or results of that medication, conducted by appropriate licensed staff who provide such services within their scope of practice or license.

2. The following therapies shall be provided for reimbursement:

a. Daily clinical services provided by an interdisciplinary team to stabilize acute addictive or psychiatric symptoms. Activities shall include pharmacological, cognitive-behavioral, and other ~~therapies~~ psychotherapies or substance use disorder counseling administered on an individual or group basis and modified to meet the individual's level of understanding. For individuals with a severe biomedical disorder, physical health interventions are available to supplement addiction treatment. For the individual who has less stable psychiatric symptoms, ASAM Level 4.0 co-occurring capable programs offer individualized treatment activities designed to monitor the individual's mental health and to address the interaction of the mental health programs and substance use disorders.

b. Health education services.

c. Planned clinical interventions that are designed to enhance the individual's understanding and acceptance of illness of addiction and the recovery process.

d. Services for the individual's family, guardian, or significant other, as appropriate, to advance the individual's treatment and recovery goals and objectives identified in the ISP.

e. This level of care offers 24-hour nursing care and daily physician care for severe, unstable problems in any of the following ASAM dimensions: (i) acute intoxication or withdrawal potential; (ii) biomedical conditions and complications; and (iii) emotional, behavioral, or cognitive conditions and complications.

f. Discharge services shall be the process to prepare the individual for referral into another level of care, post treatment return or reentry into the community, or the linkage of the individual to essential community treatment, housing, recovery, and human services.

C. Medically managed intensive inpatient services (ASAM Level 4.0) staff requirements.

1. An interdisciplinary staff of appropriately credentialed clinical staff including, for example, addiction-credentialed physicians or physicians with experience in addiction medicine, licensed nurse practitioners, licensed physician assistants, registered nurses, licensed professional counselors, licensed clinical psychologists, or licensed clinical social workers who assess and treat individuals with severe substance use disorders or addicted individuals with concomitant acute biomedical, emotional, or behavioral disorders. Physicians and physician extenders who are either employed by or contracted through the agency or through referral arrangements with the agency and who shall have a DEA-X number to prescribe buprenorphine.

2. Medical management by physicians and primary nursing care shall be available 24 hours per day and counseling services shall be available 16 hours per day.

D. Medically managed intensive inpatient services (ASAM Level 4.0) co-occurring enhanced programs. These programs shall be provided by appropriately licensed or registered credentialed mental health professionals who assess and treat the individual's co-occurring mental illness and are knowledgeable about the biological and psychosocial dimensions of psychiatric disorders and his treatment.

NOTICE: Forms used in administering the regulation have been filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (12VAC30-130)

Forms accompanying Part II of this chapter:

Virginia Uniform Assessment Instrument (eff. 1994)

Forms accompanying Part III of this chapter:

MI/IDD Supplement, DMAS-95, Level I PASRR Form and Instructions (rev 4/2019)

MI/IDD/Related Conditions Supplement Level II, DMAS-95 MI/IDD/RC Supplement (rev. 12/2015)

Forms accompanying Part VII of this chapter:

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

Request for Hospice Benefits, DMAS-420 (rev. 9/2019)

~~Forms accompanying Part VIII of this chapter:~~

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

Forms accompanying Part IX of this chapter:

Patient Information Form Medicaid LTC Communication Form, DMAS-122, 225 (eff. 10/2011)

~~Instructions for Completion DMAS-122 form~~

~~Forms accompanying Part XII of this chapter:~~

~~Health Insurance Premium Payment (HIPP) Program Insurance Information Request Form~~

~~Health Insurance Premium Payment (HIPP) Program Medical History Form (HIPP Form 7, Rev. 11/92).~~

~~Health Insurance Premium Payment (HIPP) Program Employers Insurance Verification Form (HIPP Form 2, Rev. 11/92)~~

~~Health Insurance Premium Payment (HIPP) Program Employer Agreement (HIPP Form 3, Rev. 11/92)~~

~~Health Insurance Premium Payment (HIPP) Program Notice of HIPP Determination (HIPP Form 4, Rev. 11/92)~~

~~Health Insurance Premium Payment (HIPP) Program Notice of HIPP Approval~~

~~Health Insurance Premium Payment (HIPP) Program Notice of HIPP Status (HIPP Form 6, Rev. 11/92)~~

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

~~Forms accompanying Part XIV of this chapter:~~

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

~~Forms accompanying Part XV of this chapter:~~

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

~~Forms accompanying Part XVIII of this chapter:~~

~~Virginia Independent Clinical Assessment Program (VICAP) (eff. 6/11)~~

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-130)

Virginia Medicaid Nursing Home Manual, Department of Medical Assistance Services.

Virginia Medicaid Rehabilitation Manual, Department of Medical Assistance Services.

Virginia Medicaid Hospice Manual, Department of Medical Assistance Services.

Virginia Medicaid School Division Manual, Department of Medical Assistance Services.

Policy Manual: Definitions of Priority Mental Health Populations, POLICY 1029(SYS)90 - 2

The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, American Society of Addiction Medicine, Inc., 4601 North Park Avenue, Upper Arcade, Suite 101 Chevy Chase, Maryland 20815, www.asam.org

Diagnostic and Statistical Manual of Mental Disorders: DSM-5, Fifth Edition, 2013, American Psychiatric Association, 1000 Wilson Boulevard, Arlington, Virginia 22209, www.psych.org

Medicaid Memo: Updates to Telemedicine Coverage, May 13, 2014, Department of Medical Assistance Services

Department of Behavioral Health and Developmental Services Opioid Medication Assisted Treatment License and Oversight (eff. 3/2017)

VA.R. Doc. No. R20-5749; Filed December 18, 2019, 12:24 p.m.

Fast-Track Regulation

Titles of Regulations: **12VAC30-70. Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (amending 12VAC30-70-291, 12VAC30-70-301, 12VAC30-70-425).**

12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-20).

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: February 19, 2020.

Effective Date: March 5, 2020.

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 authorizes the Board of Medical Assistance Services to administer and amend the State Plan for Medical Assistance and to promulgate regulations. 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 State Plan for Medical Assistance and to promulgate regulations 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.

Purpose: The amendments are required to conform regulation to items of the 2018 state budget. This action is necessary for the public health, safety, and welfare in that it ensures appropriate funding for Medicaid services provided by hospitals and thereby ensures that hospitals can continue to provide services to Medicaid members.

Rationale for Using Fast-Track Rulemaking Process: The proposed amendments at 12VAC30-70-291 and 12VAC30-70-301 are required by Item 303 SSS of Chapter 2 of the 2018 Acts of Assembly, Special Session I. The proposed amendment at 12VAC30-70-425 and 12VAC30-80-20 are required by Item 303 XX 7 of Chapter 2 of the 2018 Acts of Assembly, Special Session I. DMAS attained the approval from the Centers for Medicare and Medicaid Services that was required prior to implementation of the new reimbursement rates as of October 25, 2018.

Substance: The proposed amendment to 12VAC30-70-291 updates the section to indicate an additional indirect medical education (IME) payment for freestanding children's hospitals in the District of Columbia. The proposed amendment to 12VAC30-70-301 eliminates disproportionate share hospital (DSH) payments to out-of-state children's hospitals, to include freestanding children's hospitals in the District of Columbia. The proposed amendments to 12VAC30-70-425 and 12VAC30-80-20 update existing regulations to allow additional supplemental payments to be issued to each non-state-government-owned acute care hospital for inpatient services provided to Medicaid patients.

Currently, DSH payments are being made to out-of-state children's hospitals to include freestanding children's hospitals located in the District of Columbia. The proposed regulations eliminate these DSH payments in 12VAC30-70-301 and increase the IME payments to freestanding children's hospitals in the District of Columbia by the amount of DSH payments that the hospital was eligible for in state fiscal year (SFY) 2018 in 12VAC30-70-291. The total Type Two hospital DSH allocation is reduced by the total amount paid to freestanding children's hospitals in the District of Columbia in SFY 2018. All changes to these two sections are effective as of July 1, 2018.

Unreimbursed Medicaid cost payments are currently made to non-state-government-owned hospitals as certified through provider cost reports and meeting other criteria as outlined in regulation. Beginning July 1, 2018, additional supplemental payments shall be made to non-state-government-owned acute care hospitals for inpatient and outpatient services. The supplemental payments will be made quarterly for inpatient and outpatient services that were provided in the prior quarter. The quarterly payments shall begin with the first quarter in SFY 2019 and will be calculated by multiplying the Medicaid inpatient and outpatient hospital payments paid in that quarter by the inpatient and outpatient upper payment level (UPL) gap percentages for each hospital. UPL gap percentages are calculated annually for hospitals using the most recent year in which the data is available and inflated to the SFY in which the payments are being made. These updates are being made in 12VAC30-70-425 and 12VAC30-80-20.

Issues: The primary advantages to the Commonwealth and the public from these regulatory changes are the provision of additional reimbursement for certain hospitals. There are no disadvantages to the Commonwealth or the public as a result of this regulatory action.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Medical Assistance Services (Board) proposes to revise the current regulations to (1) reclassify certain payments made to a freestanding children's hospital in the District of Columbia and (2) allow additional supplemental payments to be issued to non-state-government-owned[2] acute care hospitals in order to increase the reimbursement for inpatient services provided to Medicaid patients; the supplemental payments are related to another regulatory action currently underway.

The 2018 Appropriation Act contained budget language in two items that directed DMAS to amend the State Plan for Medical Assistance (state plan). The first Item, 303 SSS, authorized the Department of Medical Assistance Services (DMAS) to amend the state plan such that Disproportionate Share Hospital (DSH) payments for the Children's National Medical Center (CNMC) are discontinued and replaced with an indirect medical education (IME) payment. DSH payments take into account the financial situation of hospitals that serve a disproportionate number of low income patients with special needs. IME payments recognize the higher operating costs at hospitals with teaching programs (the increased diagnostic and treatment costs related to their educational mission).[3]

Specifically, the proposed amendment would: (i) make CNMC no longer eligible to receive DSH payments, (ii) increase the annual IME payments made to CNMC by the amount of DSH the hospital was eligible for in state fiscal year 2018 (12VAC30-70-291), and (iii) reduce the Type 2 DSH allocation by the same amount (12VAC30-70-301). The

Act authorized DMAS to implement these changes effective July 1, 2018, prior to the completion of any regulatory action to effect this change. The rationale provided for this budget amendment states that the hospital was at their federal cap, thereby preventing the hospital from being able to accept DSH funding from the Commonwealth. Because the hospital recently met the state threshold to receive IME payments from the Commonwealth, the budget was amended to allow the continuation of such payments in lieu of any future DSH payments.[4]

The second Item, 303.XX.7, directs DMAS to make supplemental payments to Chesapeake Regional Hospital, which is operated by the Chesapeake Hospital Authority.[5] DMAS is implementing this by amending 12VAC30-70-425, which involves non-state-government-owned hospitals such as Chesapeake Regional. This item is related to two separate items in the same Act (3-5.15 and 3-5.16) that affect private acute care hospitals and instruct DMAS to levy a provider coverage assessment and a provider payment rate assessment, in addition to implementing a statewide supplemental payment. These items are being addressed through a different regulatory action that is currently in place as an emergency regulation (Action number 5100).[6] The proposed amendment in this Action regarding the calculation of this supplemental payment is identical to the language pertaining to supplemental payments in the emergency regulation. Item 303.XX.7 required that DMAS secure approval from the Centers for Medicare and Medicaid Services prior to implementation; this approval was obtained as of October 25, 2018.

Estimated Benefits and Costs. CNMC would benefit by qualifying to receive IME payments from the state, thereby allowing them to continue receiving funds amount despite having met the federal cap for DSH payments. Because the amount being paid to CNMC would be staying the same, it is unlikely that any other benefits or costs would accrue.

Chesapeake Regional would benefit from receiving any supplemental payments, which should be substantially less than the cost incurred by the hospital to receive them. As described by the budget amendment for this Item, the hospital will make an intergovernmental transfer to DMAS to be used as the state share for the supplemental Medicaid payments to the hospital. In exchange, the hospital will receive a substantially larger amount of federal funds, and the general fund will not be impacted.

Businesses and Other Entities Affected. No other entities are likely to be affected, besides CNMC and Chesapeake Regional as described above.

Localities[7] Affected.[8] The proposed amendment does not introduce new costs for local governments. Chesapeake Regional is located in Chesapeake; hence the locality may be affected depending on the overall impact of the supplemental payments on the hospital and the number of Medicaid-insured individuals it serves.

Projected Impact on Employment. The proposed amendments do not appear to affect total employment.

Effects on the Use and Value of Private Property. The proposed amendment has no effect on the use and value of private property, nor does it affect real estate development costs.

Adverse Effect on Small Businesses.[9] The proposed amendment does not adversely affect small businesses.

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[2]A non-state-government-owned hospital is owned or operated by a unit of government other than a state.

[3]http://sfc.virginia.gov/pdf/health/2010%20Session/062110%20DMAS%20-%20Crawford.pdf

[4]https://budget.lis.virginia.gov/amendment/2018/2/HB5002/Introduced/SE/303/3s/

[5]https://law.lis.virginia.gov/authorities/chesapeake-hospital-authority/

[6]http://townhall.virginia.gov/L/ViewAction.cfm?actionid=5100 The proposed stage of this action is currently at the Office of the Attorney General.

[7]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[8]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[9]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. "

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

Summary:

The amendments contain three provider reimbursement updates as required by Chapter 2 of the 2018 Acts of Assembly, Special Session I. The amendments (i) add an indirect medical education payment for freestanding children's hospitals in the District of Columbia; (ii) eliminate disproportionate share hospital payments to out-of-state children's hospitals, to include freestanding children's hospitals in the District of Columbia; and (iii) allow additional supplemental payments to be issued to each non-state-government-owned acute care hospital for inpatient services provided to Medicaid patients.

12VAC30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education (IME). Out-of-state cost reporting hospitals are eligible for this payment only if they have

Virginia Medicaid utilization in the base year of at least 12% of total Medicaid days. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

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

1. Type One hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows (this formula also applies to Children's Hospital of the King's Daughters effective July 1, 2013):

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

An IME factor shall be calculated for each Type One hospital and shall equal a factor that, when used in the calculation of the IME percentage, shall cause the resulting IME payments to equal what the IME payments would be with an IME factor of one, plus an amount equal to the difference between operating payments using the adjustment factor specified in subdivision B 1 of 12VAC30-70-331 and operating payments using an adjustment factor of one in place of the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows (excluding Children's Hospital of the King's Daughters):

IME Percentage for Type Two Hospitals = [1.89 X ((1 + r)$^{0.405}$-1)] X 0.5695

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

C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers.

1. For Type Two hospitals, this payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12VAC30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

2. For Type One hospitals, this payment shall be equal to the hospital's hospital-specific operating rate per case, as determined in 12VAC30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section. Effective April 1, 2012, the operating rate per case used in the formula shall be revised to reflect an adjustment factor of one and case-mix adjusted by multiplying the operating rate per case in this subsection by the weight per case for FFS discharges that is determined during rebasing. This formula applies to Children's Hospital of the King's Daughters effective July 1, 2017.

D. An additional IME payment not to exceed $200,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU utilization in excess of 50% as reported to the Department of Medical Assistance Services as of March 1, 2004. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

E. An additional IME payment not to exceed $500,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU days in excess of 4,500 as reported to the Department of Medical Assistance Services as of March 1, 2005, that do not otherwise receive an additional IME payment under subsection D of this section. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2003.

F. Effective July 1, 2013, total payments for IME in combination with other payments for freestanding children's hospitals with greater than 50% Medicaid utilization in 2009 shall not exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject. Effective July 1, 2017, IME payments cannot exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject, excluding third-party reimbursement for Medicaid eligible patients.

G. Effective July 1, 2018, an additional $362,360 IME payment shall be added to the IME payment calculated in subdivision B 2 of this section for freestanding children's hospitals located in the District of Columbia.

12VAC30-70-301. Payment to disproportionate share hospitals.

A. Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis and shall be final subject to subsections E and K of this section.

B. Effective July 1, 2014, in order to qualify for DSH payments, DSH eligible hospitals shall have a total Medicaid inpatient utilization rate equal to 14% or higher in the base year using Medicaid days eligible for Medicare DSH defined in 42 USC § 1396r-4(b)(2) or a low income utilization rate

defined in 42 USC § 1396r-4(b)(3) in excess of 25%. Eligibility for out-of-state cost reporting hospitals shall be based on total Medicaid utilization or on total Medicaid neonatal intensive care unit (NICU) utilization equal to 14% or higher. Effective July 1, 2018, freestanding children's hospitals located in the District of Columbia shall not be eligible for DSH payments.

C. Effective July 1, 2014, the DSH reimbursement methodology for all hospitals except Type One hospitals is the following:

1. Each hospital's DSH payment shall be equal to the DSH per diem multiplied by each hospital's eligible DSH days in a base year. Days reported in provider fiscal years in state fiscal year (FY) 2011 (available from the Medicaid cost report through the Hospital Cost Report Information System (HCRIS) as of July 30, 2013) will be the base year for FY 2015 prospective DSH payments. DSH shall be recalculated annually with an updated base year. Future base year data shall be extracted from Medicare cost report summary statistics available through HCRIS as of October 1 prior to next year's effective date.

2. Eligible DSH days are the sum of all Medicaid inpatient acute, psychiatric, and rehabilitation days above 14% for each DSH hospital subject to special rules for out-of-state cost reporting hospitals. Eligible DSH days for out-of-state cost reporting hospitals shall be the higher of the number of eligible days based on the calculation in the first sentence of this subdivision times Virginia Medicaid utilization (Virginia Medicaid days as a percent of total Medicaid days) or the Medicaid NICU days above 14% times Virginia NICU Medicaid utilization (Virginia NICU Medicaid days as a percent of total NICU Medicaid days). Eligible DSH days for out-of-state cost reporting hospitals that qualify for DSH but that have less than 12% Virginia Medicaid utilization shall be 50% of the days that would have otherwise been eligible DSH days.

3. Additional eligible DSH days are days that exceed 28% Medicaid utilization for Virginia Type Two hospitals, excluding Children's Hospital of the Kings Daughters (CHKD).

4. The DSH per diem shall be calculated in the following manner:

a. The DSH per diem for Type Two hospitals is calculated by dividing the total Type Two DSH allocation by the sum of eligible DSH days for all Type Two DSH hospitals. For purposes of DSH, Type Two hospitals do not include CHKD or any hospital whose reimbursement exceeds its federal uncompensated care cost limit. The Type Two hospital DSH allocation shall equal the amount of DSH paid to Type Two hospitals in state FY 2014 increased annually by the percent change in the federal allotment, including any reductions as a result of the Patient Protection and Affordable Care Act (Affordable Care Act), ~~P.L.~~ Public Law 111-148, adjusted for the state fiscal year. Effective July 1, 2018, the Type Two hospital DSH allocation shall be reduced by the amount of DSH allocated to freestanding children's hospitals located in the District of Columbia.

b. The DSH per diem for state inpatient psychiatric hospitals is calculated by dividing the total state inpatient psychiatric hospital DSH allocation by the sum of eligible DSH days. The state inpatient psychiatric hospital DSH allocation shall equal the amount of DSH paid in state FY 2013 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act, adjusted for the state fiscal year.

c. Effective July 1, 2017, the annual DSH payment shall be calculated separately for each eligible hospital by multiplying each year's state inpatient psychiatric hospital DSH allocation described in subdivision C 4 b of this section by the ratio of each hospital's uncompensated care cost for the most recent DSH audited year completed prior to the DSH payment year to the uncompensated care cost of all state inpatient psychiatric hospitals for the same audited year.

d. The DSH per diem for CHKD shall be three times the DSH per diem for Type Two hospitals.

5. Each year, the department shall determine how much Type Two DSH has been reduced as a result of the Affordable Care Act and adjust the percent of cost reimbursed for outpatient hospital reimbursement.

D. Effective July 1, 2014, the DSH reimbursement methodology for Type One hospitals shall be to pay its uncompensated care costs up to the available allotment. Interim payments shall be made based on estimates of the uncompensated care costs and allotment. Payments shall be settled at cost report settlement and at the conclusion of the DSH audit.

E. Prior to July 1, 2014, hospitals qualifying under the 14% inpatient Medicaid utilization percentage shall receive a DSH payment based on the hospital's type and the hospital's Medicaid utilization percentage.

1. Type One hospitals shall receive a DSH payment equal to:

a. The sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433.

b. Multiplied by the Type One hospital DSH ~~Factor~~ factor. The Type One hospital DSH factor shall equal a percentage that when applied to the DSH payment calculation yields a DSH payment equal to the total calculated using the methodology outlined in subdivision 1 a of this subsection using an adjustment factor of one in the calculation of operating payments rather than the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times the hospital's Medicaid operating reimbursement, times 1.2074 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times the hospital's Medicaid operating reimbursement, times 1.2074. Out-of-state cost reporting hospitals with Virginia utilization in the base year of less than 12% of total Medicaid days shall receive 50% of the payment described in this subsection.

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

1. Type One hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times 17, times the hospital's Medicaid operating reimbursement.

2. Type Two hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.

3. Calculation of a hospital's low-income patient utilization percentage is defined in 42 USC § 1396r-4(b)(3).

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

For freestanding psychiatric facilities licensed as hospitals, DSH payment shall be based on the most recently settled Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.

H. Effective July 1, 2010, DSH payments shall be rebased for all hospitals with the final calculation reduced by a uniform percentage such that the expenditures in FY 2011 do not exceed expenditures in FY 2010 separately for Type One and Type Two hospitals. The reduction shall be calculated after determination of eligibility. Payments determined in FY 2011 shall not be adjusted for inflation in FY 2012.

I. Effective July 1, 2013, DSH payments shall not be rebased for all hospitals in FY 2014 and shall be frozen at the payment levels for FY 2013 eligible providers.

J. To be eligible for DSH, a hospital shall also meet the requirements in 42 USC § 1396r-4(d). No DSH payment shall exceed any applicable limitations upon such payment established by 42 USC § 1396r-4(g).

K. If making the DSH payments prescribed in this chapter would exceed the DSH allotment, DMAS shall adjust DSH payments to Type One hospitals. Any DSH payment not made as prescribed in the State Plan as a result of the DSH allotment shall be made upon a determination that an available allotment exists.

12VAC30-70-425. ~~Certified public expenditures~~ Supplemental payments for ~~nonstate~~ non-state-government-owned hospitals for inpatient services.

A. In addition to payments made elsewhere, effective July 1, 2005, DMAS shall draw down federal funds to cover unreimbursed Medicaid costs for inpatient services provided by ~~nonstate~~ non-state-government-owned hospitals as certified by the provider through cost reports.

B. A ~~nonstate~~ non-state-government-owned hospital is owned or operated by a unit of government other than a state.

C. Effective July 1, 2018, additional supplemental payments will be issued to each non-state-government-owned acute care hospital for inpatient services provided to Medicaid patients.

1. The supplemental payment shall equal inpatient hospital clam payments times the upper payment limit (UPL) gap percentage.

a. The annual UPL gap percentage is the percentage calculated where the numerator is the difference for each non-state-government-owned acute care hospital between a reasonable estimate of the amount that would be paid under Medicare payment principles for inpatient hospital services provided to Medicaid patients, as calculated in accordance with 42 CFR 447.272, and what Medicaid paid for such services, and the denominator is Medicaid claim payments to each hospital for inpatient hospital services provided to Medicaid patients in the same years used in the numerator.

b. The UPL gap percentage will be calculated annually for each hospital using data for the most recent year for which comprehensive annual data are available and inflated to the state fiscal year for which payments are to be made.

c. Maximum aggregate payments to all qualifying hospitals shall not exceed the available upper payment limit. If inpatient payments for non-state-government-

owned hospitals would exceed the upper payment limit, the numerator in the calculation of the UPL gap percentage shall be reduced proportionately.

2. After the close of each quarter, beginning with the July 1, 2018, to September 30, 2018, quarter, each qualifying hospital shall receive supplemental payments for the inpatient services paid during the prior quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated by multiplying the Medicaid inpatient hospital payments paid in that quarter by the annual UPL gap percentage for each hospital.

12VAC30-80-20. Services that are reimbursed on a cost basis.

A. Payments for services listed in this section shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision D 1 e of this section. The upper limit for reimbursement shall be no higher than payments for Medicare patients in accordance with 42 CFR 447.321. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform Centers for Medicare and Medicaid Services-approved cost report by participating providers. The cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, DMAS or its designee shall take action in accordance with its policies to assure that an overpayment is not being made. All cost reports shall be reviewed and reconciled to final costs within 180 days of the receipt of a completed cost report. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form provided by DMAS, with signed certification;

2. The provider's trial balance showing adjusted journal entries;

3. The provider's financial statements including a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

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

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

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

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

D. The services that are cost reimbursed are:

1. For dates of service prior to January 1, 2014, outpatient hospital services, including rehabilitation hospital outpatient services and excluding laboratory services.

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

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room 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 hospital 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 for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services rendered in emergency departments that DMAS determines were 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 performed 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 for subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 1 b (1) of this subsection. Such criteria shall include:

(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, 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.

c. Limitation of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at various percentages as noted in subdivisions 1 c (1) and 1 c (2) of this subsection of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date.

(1) Type One hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

(2) Type Two hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be 77% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be 76% of allowable cost.

d. The last cost report with a fiscal year end on or after December 31, 2013, shall be used for reimbursement for dates of service through December 31, 2013, based on this section. Reimbursement shall be based on charges reported for dates of service prior to January 1, 2014. Settlement will be based on four months of runout from the end of the provider's fiscal year. Claims for services paid after the cost report runout period will not be settled.

e. Payment for direct medical education costs of nursing schools, paramedical programs, and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

2. Rehabilitation agencies or comprehensive outpatient rehabilitation.

a. Effective July 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities that are operated by community services boards or state agencies shall be reimbursed their costs. For reimbursement

methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

b. Effective October 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities operated by state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

3. Supplement payments to Type One hospitals for outpatient services.

a. In addition to payments for services set forth elsewhere in the State Plan, DMAS makes supplemental payments to qualifying state government owned or operated hospitals for outpatient services furnished to Medicare members on or after July 1, 2010. To qualify for a supplement payment, the hospital must be part of the state academic health system or part of an academic health system that operates under a state authority.

b. The amount of the supplemental payment made to each qualifying hospital shall be equal to the difference between the total allowable cost and the amount otherwise actually paid for the services by the Medicaid program based on cost settlement.

c. Payment for furnished services under this section shall be paid at settlement of the cost report.

4. Supplemental payments for private hospital partners of Type One hospitals. Effective for dates of service on or after October 25, 2011, quarterly supplemental payments shall be issued to qualifying private hospitals for outpatient services rendered during the quarter. These quarterly supplemental payments will cease for dates of service on or after the effective date of State Plan amendments authorizing increased payments to qualifying hospitals from the Health Care Provider Rate Assessment Fund established pursuant to § 32.1-331.02 of the Code of Virginia and approved by the Centers for Medicare and Medicaid Services.

a. In order to qualify for the supplemental payment, the hospital shall be enrolled currently as a Virginia Medicaid provider and shall be owned or operated by a private entity in which a Type One hospital has a nonmajority interest.

b. Reimbursement methodology.

(1) Hospitals notparticipating in the Medicaid disproportionate share hospital (DSH) program shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than two years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in a fiscal year shall be the lesser of:

(a) The difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid individuals during the fiscal year; or

(b) $1,894 per Medicaid outpatient visit for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor) under contract with the department.

(2) Hospitals participating in the DSH program shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than two years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in a fiscal year shall be the lesser of:

(a) The difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid individuals during the fiscal year;

(b) $1,894 per Medicaid outpatient visit for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor) under contract with the department; or

(c) The difference between the limit calculated under § 1923(g) of the Social Security Act and the hospital's DSH payments for the applicable payment period.

c. Limit. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

5. Supplemental outpatient payments for non-state-government-owned hospitals. Effective July 1, 2018, supplemental payments will be issued to qualifying non-state-government-owned hospitals for outpatient services provided to Medicaid patients.

a. Qualifying hospitals are all non-state-government-owned acute care hospitals.

b. The supplemental payment shall equal outpatient hospital claim payments times the upper payment limit (UPL) gap percentage.

(1) The annual UPL gap percentage is the percentage calculated where the numerator is the difference for each qualifying hospital between a reasonable estimate of the amount that would be paid under Medicare payment principles for outpatient hospital services provided to

Medicaid patients, as calculated in accordance with 42 CFR 447.321, and what Medicaid paid for such services, and the denominator is Medicaid claim payments to all qualifying hospitals for outpatient hospital services provided to Medicaid patients in the same year used in the numerator.

(2) The annual UPL gap percentage will be calculated annually for each hospital using the most recent year for which comprehensive annual data are available and inflated to the state fiscal year for which payments are to be made.

6. Quarterly payments. After the close of each quarter, beginning with the July 1, 2018, to September 30, 2018, quarter, each qualifying hospital shall receive supplemental payments for the outpatient services paid during the prior quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated by multiplying the Medicaid outpatient hospital payments paid in that quarter by the annual UPL gap percentage for each hospital.

VA.R. Doc. No. R20-6018; Filed December 18, 2019, 8:33 a.m.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Proposed Regulation

Title of Regulation: **12VAC35-105. Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (amending 12VAC35-105-675).**

Statutory Authority: § 37.2-203 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: March 20, 2020.

Agency Contact: Emily Bowles, Legal Coordinator, Office of Licensing, Department of Behavioral Health and Developmental Services, 1220 Bank Street, P.O. Box 1797, Richmond, VA 23218, telephone (804) 225-3281, FAX (804) 692-0066, TTY (804) 371-8977, or email emily.bowles@dbhds.virginia.gov.

Basis: Section 37.2-203 of the Code of Virginia authorizes the State Board of Behavioral Health and Developmental Services to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner and the Department of Behavioral Health and Developmental Services (DBHDS).

Purpose: DBHDS and the Department of Medical Assistance Services (DMAS) regulations concerning reviews of individual service plans are not aligned, which creates an unnecessary situation in which service providers must adhere to two separate requirements for the same practice. The proposed changes align DBHDS and DMAS regulations as to when a quarterly review or a revised assessment of an individualized services plan (ISP) must be documented. The amendments allow practitioners to follow the same process rather than two different processes, which decreases administrative burdens and allows more time to provide services. By decreasing administrative burden through the adjusted timeframe, providers are allowed more time to thoroughly prepare and document the ISP review and changes to the ISP, which potentially benefit the health and safety of an individual receiving services by ensuring all information is in place to inform a treatment team of an individual's specific needs.

Substance: Providers licensed by DBHDS are currently required to review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. No allowance exists for additional administrative time to document the review, as is allowed in DMAS regulations. Such administrative "grace periods" are not uncommon.

The proposed amendments allow providers to document each quarterly review or a revised assessment in the individual's record "no later than 15 calendar days from the date the review was due to be completed." The proposed amendments do not change the current quarterly deadline for the review. Also, clarification is made to exclude case management from this 15-day change, and specific language is added regarding 30 days related to case management in response to comments received during the public comment period.

Issues: The advantage for the public and the agency will be that providers have more efficient use of time because the regulation will no longer be duplicative in conflicting ways. There are no identified disadvantages to the public or the Commonwealth in making these amendments.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Board of Behavioral Health and Developmental Services (Board) proposes to allow case management providers a 30-day grace period and other mental health providers a 15-day grace period for documentation of Individualized Services Plans (ISPs).

Background. This action was originally started as a fast-track action.[2] After receiving public comments, the Board now proposes additional language through the standard regulatory process.

Estimated Benefits and Costs. Currently, mental health providers serving Medicaid patients are allowed under Medicaid regulations[3] a 15-day grace period to document ISPs. In addition, as indicated by the public comments and

agreed by the Board, Medicaid case managers are allowed a 30-day grace period,[4] allowing them an additional 15-day period to document ISPs. Case management providers need additional time to document ISPs because they evaluate input from other mental health providers. Having the same grace period as other providers would not allow them time to incorporate input from other mental health providers. The Board now proposes to align its regulations with Medicaid regulations by providing identical grace periods: a 30-day grace period for case managers and a 15-day grace period for other mental health providers.

The proposed change is expected to allow more flexibility to the mental health providers who are licensed through the Board and serve the Medicaid population because they will have more time to document their reviews. The flexibility provided by this regulation could reduce compliance costs (e.g., possibly reducing the need for overtime pay for staff reviewing ISPs). Also, according to the Department of Behavioral Health and Developmental Services (DBHDS), noncompliance with this documentation requirement has resulted in citations during regular inspections. Therefore, a reduction in citations regarding timeliness of documentation of ISPs is expected.

The proposed amendment would not affect services received by those individuals with an ISP. Given the increased flexibility and reduction in citations for providers, and no adverse elements associated with the proposed grace periods, this action would likely produce a net benefit.

Businesses and Other Entities Affected. According to DBHDS, there are more than 100,000 individuals whose ISPs are reviewed on a regular basis by 1,100 licensed service providers most of which are likely small businesses.

Localities[5] Affected.[6] The proposed amendments do not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendments should not have any effect on total employment.

Effects on the Use and Value of Private Property. The proposed amendments are unlikely to affect the use and value of private property.

Adverse Effect on Small Businesses:[7] The proposed amendments do not adversely affect small businesses.

[2]See https://townhall.virginia.gov/l/ViewStage.cfm?stageid=8341

[3]12VAC30-50-226

[4]12VAC30-60-143

[5]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[6]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[7]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."

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

Summary:

The proposed amendments allow case management providers a 30-day grace period and other mental health providers a 15-day grace period for documentation of an individualized services plan, aligning the regulation with Medicaid timeframe requirements.

12VAC35-105-675. Reassessments and ISP reviews.

A. Reassessments shall be completed at least annually and when there is a need based on the medical, psychiatric, or behavioral status of the individual.

B. The provider shall (i) update the ISP at least annually~~. The provider shall review~~ and (ii) complete quarterly reviews of the ISP. The provider shall review the ISP at least every three months from the date of the implementation of the comprehensive ISP ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~. These reviews shall evaluate the individual's progress toward meeting the ~~plan's~~ ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.

VA.R. Doc. No. R19-5541; Filed December 20, 2019, 1:25 p.m.

Fast-Track Regulation

Title of Regulation: **12VAC35-180. Regulations to Assure the Protection of Subjects in Human Research (amending 12VAC35-180-10, 12VAC35-180-30, 12VAC35-180-60 through 12VAC35-180-150).**

Statutory Authority: §§ 37.2-203 and 37.2-402 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 15, 2020.

Agency Contact: Ruth Anne Walker, Director of Regulatory Affairs, Department of Behavioral Health and Developmental Services, Jefferson Building, 1220 Bank Street, 11th Floor, Richmond, VA 23219, telephone (804) 225-2252, FAX (804) 786-8623, TTY (804) 371-8977, or email ruthanne.walker@dbhds.virginia.gov.

Basis: Section 37.2-203 of the Code of Virginia authorizes the state board to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner and the department.

Purpose: This action is the result of a periodic review initiated on October 5, 2017. No comments were received during the public comment period held from October 30, 2017, through November 21, 2017. The periodic review found the regulations reasonable and consistent with the statutory requirements but in need of some minor revisions to align them with state and federal requirements.

This regulation ensures the health, safety, and welfare of the individuals involved in human research. 12VAC35-180 applies to the department and any person, entity, or organization offering services that are licensed, funded, or operated by the department; some of those service providers are small businesses. It also applies to any research review committee, as defined in 12VAC35-180, at one of these entities or organizations. Updates and clarifications in the regulation will help those using system services, providing services, and conducting human research.

Rationale for Using the Fast-Track Rulemaking Process: This rulemaking is expected to be noncontroversial and appropriate for the fast-track rulemaking process because no comments were received during the review. None of these changes are controversial or establish any additional regulatory burdens. The action updates the regulations, which will be helpful to those in the system using services, those providing services, and entities conducting human research.

Substance: Clarifications, corrections of typos, and nonsubstantive edits are made throughout the regulation. Specifically, some of the amendments are as follows:

1. Updates to definitions include:

• "Board" to conform to the definition of that word in § 37.2-100 of the Code of Virginia.

• "Community services board" to conform to the definition of that term in § 37.2-100 and includes deleting "mental retardation."

• "Individual" to conform to the federal research regulations at 45 CFR 46.102(e)(1) and 45 CFR 46.102(e)(5).

• "Informed consent" to remove substantive language and place it properly in 12VAC35-180-100.

• "Research review committee" to add "human research review committee and institutional review board."

2. Amendments in 12VAC35-180-70 include:

• In subdivision A 6, deleting an unnecessary list of types of vulnerable people.

• Deleting subsection B.

• Conforming subsection F to 45 CFR 46.113.

• Adding a new subsection I to comply with requirements of the Human Rights Regulations (12VAC35-115) regarding notification to the local human rights committee.

3. Amendments in 12VAC35-180-80 move text from subdivision 2 into subdivision 1 c to make clear that such research must occur in an educational setting.

4. Amendments in 12VAC35-180-100 include:

• Adding language from the definition of "Informed consent" to create a new subsection B that complies with 45 CFR 46.116.

• Adding cross-references to the Human Rights Regulations in subsection D.

5. Amendments in 12VAC35-180-120 add a cross reference to § 37.2-402 of the Code of Virginia.

Issues: The amendments are the result of a periodic review, which included a public comment period. The advantage of the proposed amendments to the public and the agency is better protection of individuals involved in research, interested stakeholders, and the system overall because of clarification and updated language so that the regulation mirrors federal regulations. There are no disadvantages to the public or the agency or Commonwealth to the regulatory action.

Small Business Impact Review Report of Findings: This fast-track regulatory action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to a periodic review,[1] the State Board of Behavioral Health and Developmental Services (Board) proposes to allow a research subject to withdraw his participation without a loss of benefits to him and to require the research review committee to report termination or suspension of research to the principal investigator, appropriate institutional officers, head of the department or agency, and the commissioner.

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

Estimated Economic Impact. The Board proposes to allow a research subject to withdraw his participation without a loss of benefits to him. According to the Department of Behavioral Health and Developmental Services (DBHDS), this is a federal rule, and researchers are subject to this requirement if they are receiving federal funding.[2] The intent of this requirement is to make sure the participant is not

coerced into being a part of research in which he no longer wishes to participate. This change may elevate the chances of a researcher losing a subject in a study, but would ensure that participation is voluntary.

The Board also proposes to require the research review committee to report termination or suspension of research to the principal investigator, appropriate institutional officers, the department or agency head, and the commissioner with a statement of the reasons of the committee's action. According to DBHDS, the report would be rather short without creating any significant cost. The report would ensure transparency and help eliminate asymmetric information among the relevant parties.

The remaining proposed amendments are wording changes to improve the clarity of the regulation and are not expected to create any significant economic impact.

Businesses and Entities Affected. The proposed change pertains to 13 DBHDS operated facilities and 1,300 licensed service providers. However, according to DBHDS, research involving human subjects is rare. There have been few applications in the recent past to conduct any such research.

Localities Particularly Affected. The proposed amendment would not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendment would not affect employment.

Effects on the Use and Value of Private Property. The proposed amendment would not affect the use and value of private property.

Real Estate Development Costs. The proposed amendment would 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 amendment would not have costs or other effects on small businesses.

Alternative Method that Minimizes Adverse Impact. The proposed amendment would not impose adverse impacts on small businesses.

Adverse Impacts:

Businesses. The proposed amendment would not impose adverse impacts on businesses.

Localities. The proposed amendment would not adversely affect localities.

Other Entities. One of the proposed amendments may elevate the chances of a researcher losing a subject in a study to ensure that participation is voluntary.

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[1]http://townhall.virginia.gov/l/ViewPReview.cfm?PRid=1612

[2]See 45 CFR 46.103(a).

Agency's Response to Economic Impact Analysis: The agency concurs with Department of Planning and Budget's economic impact analysis.

Summary:

The amendments (i) better align the regulation with state and federal requirements, (ii) modify definitions, (iii) add appropriate cross references, (iv) update and clarify the regulation, and (v) reorganize some requirements. The amendments are the result of a periodic review initiated on October 5, 2017.

CHAPTER 180
REGULATIONS TO ~~ASSURE~~ ENSURE THE PROTECTION OF SUBJECTS IN HUMAN RESEARCH

12VAC35-180-10. Definitions.

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

"Affiliated with the institution" means employed by the institution or a member of a household containing an employee of the institution.

"Board" means the State Board of Behavioral Health and Developmental Services.

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

"Community services board" or "CSB" means ~~a~~ the public body established pursuant to § 37.2-501 of the Code of Virginia that provides mental health, ~~mental retardation~~ developmental, and substance abuse services to individuals within each city or county that established it. For the purpose of these regulations, community services board also includes a behavioral health authority established pursuant to § 37.2-602 of the Code of Virginia.

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

"Health information" means "health information" pursuant to 45 CFR 160.103 or any information, whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

"Human research" means any systematic investigation, including research development, testing, and evaluation, utilizing human subjects, that is designed to develop or contribute to generalized knowledge. Human research shall not ~~be deemed to~~ include research exempt from federal research regulation pursuant to 45 CFR 46.101(b).

"Individual" means a human subject pursuant to ~~45 CFR 46.102 (f)~~ 45 CFR 46.102(e)(1) about whom an investigator (whether professional or student) conducting research obtains (i) data through interaction with the individual; or (ii) ~~protected health~~ identifiable private information pursuant to 45 CFR 46.102(e)(5).

"Individually identifiable health information" means information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

a. That identifies the individual; or

b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

"Informed consent" means the knowing and voluntary agreement, without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion, of an individual who is capable of exercising free power of choice. ~~For the purposes of human research, the basic elements of information necessary for such consent shall include:~~

~~1. A reasonable and comprehensible explanation to the individual of the proposed procedures or protocols to be followed, and their purposes, including descriptions of any attendant discomforts, risks and benefits reasonably to be expected, how the results of the human research will be disseminated, and how the identity of the individual will be protected;~~

~~2. A disclosure of any appropriate alternative procedures or therapies that might be advantageous for the individual together with their side effects, risks, and benefits;~~

~~3. A description of any adverse consequences and risks to be expected and an indication whether there may be other significant risks not yet identified;~~

~~4. An instruction that the individual may withdraw his consent and discontinue participation in the human research at any time without prejudice to him or fear of reprisal;~~

~~5. An explanation of any costs or compensation that may accrue to the individual and, if applicable, the availability of third party reimbursement for the proposed procedures or protocols or any medical care that may be available if an injury occurs; and;~~

~~6. An offer to answer and answers to any inquiries by the individual or, if applicable, his legally authorized representative concerning the procedures and protocols and a description of the ways in which concerns may be raised or questions asked;~~

"Institution" or "agency" means the department, any community services board, or any facility or program operated, funded, or licensed by the department.

"Interaction" includes communication or interpersonal contact between the investigator and the individual who is the subject of the human research.

"Intervention" includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the individual or individual's environment that are performed for human research purposes.

"Legally authorized representative" means in the following specified order of priority, (i) the parent or parents having custody of an individual who is a prospective subject of human research who is a minor, (ii) the agent appointed under an advance directive as defined in § 54.1-2982 of the Code of Virginia, executed by the individual who is the prospective subject of human research, provided the advance directive authorizes the agent to make decisions regarding the individual's participation in human research, (iii) the legal guardian of an individual who is a prospective subject of human research, (iv) the spouse of an individual who is a prospective subject of human research, except where a suit for divorce has been filed and the divorce decree is not yet final, (v) an adult child of the an individual who is a prospective subject of human research, (vi) a parent of the individual who is a prospective subject of human research when the individual is an adult, (vii) an adult brother or sister of the individual who is a prospective subject of human research, or (viii) any person or judicial or other body authorized by law or regulation to consent on behalf of an individual who is a prospective subject of human research to such individual's participation in the particular human research. For the purposes of this definition, any person authorized by law or regulation to consent on behalf of an individual who is a prospective subject of human research to his participation in the particular human research shall include an attorney-in-fact appointed under a durable power of attorney, to the extent the power grants the authority to make such a decision. The attorney-in-fact shall not be employed by the person, institution, or agency conducting the human research. No official or employee of the institution or agency conducting or authorizing the human research shall be qualified to act as a legally authorized representative.

"Minimal risk" means that the risks of harm anticipated in the proposed human research are not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations, tests, or treatments.

"Nontherapeutic research" means human research in which there is no reasonable expectation of direct benefit to the physical or mental condition of the individual.

"Protected health information (PHI)" means individually identifiable health information that is created or received by or on behalf of the institution or agency that is maintained or transmitted in any medium, including electronic media. PHI excludes individually identifiable health information in:

1. Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USC § 1232g;

2. Records described at 20 USC § 1232g(a)(4)(B)(iv) (educational records not otherwise covered under the Family Educational Rights Privacy Act in subdivision 1 of this definition); or

3. Employment records held by a covered entity in its role as an employer.

"Research review committee," ~~or~~ "committee," "human research review committee," or "institutional review board" means a committee of professionals ~~to~~ who provide complete and adequate review of human research activities pursuant to § 32.1-162.19 of the Code of Virginia.

12VAC35-180-30. Applicability.

This chapter shall apply to the Department of Behavioral Health and Developmental Services, any community services board, and any facility operated, funded, or licensed by the department ~~which~~ that conducts or ~~which~~ that proposes to conduct or authorize human research in which individuals participate as human subjects.

12VAC35-180-60. Composition of research review committees.

A. Each research review committee shall have at least five members, appointed by the head of the institution or agency, with varying backgrounds to ensure the competent, complete, and professional review of human research activities commonly conducted by the institution or agency. The committee shall be sufficiently qualified through the maturity, experience, and diversity of its members, including consideration of race, gender, and cultural background, to promote respect for its advice and counsel in safeguarding the rights and welfare of individuals who are the subjects of human research. In addition to possessing the professional competence necessary to review specific human research activities, the committee must be able to ascertain the acceptability of applications and proposals in terms of institutional commitments and regulations, applicable law, standards of professional conduct and practice, and community attitudes. If a committee regularly reviews human research that has an impact on individuals who are institutionalized or are otherwise vulnerable, including individuals who reside in ~~mental health~~ state facilities ~~or state training centers~~, the committee shall have in its membership one or more persons who are primarily concerned with the welfare of these individuals and who have appropriate experience to serve in that capacity.

B. No committee shall consist entirely of members of one profession, and at least one member shall be a person whose primary concerns are in nonscientific areas (e.g., lawyers, ethicists, members of the clergy).

C. Each committee shall include at least one member who is not otherwise affiliated with the institution or agency and who is not part of the immediate family of a person who is affiliated with the institution or agency.

D. No member of a committee shall participate in the committee's initial or continuing review of any project in which the member is directly involved or for which he has administrative approval authority, except to provide information requested by the committee. The committee shall be responsible for determining whether a member has a conflicting interest. The committee member shall be replaced ~~in~~ if the ~~case of~~ conflicting ~~interests resulting~~ interest results in a decrease of the committee below five persons.

E. A committee may, at its discretion, invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the committee. These individuals may not vote with the committee.

F. A quorum of the committee shall consist of a majority of its members including at least one member whose primary concerns are in nonscientific areas.

G. The committee and the institution or agency shall establish procedures and rules of operation necessary to fulfill the requirements of this chapter.

12VAC35-180-70. Elements of each committee's review process.

A. No human research shall be conducted or authorized by an institution or agency unless a research review committee has reviewed and approved the proposed human research project giving consideration to:

1. The adequacy of the description of the potential benefits and risks involved and the adequacy of the methodology of the human research;

2. The degree of the risk, and, if the human research is nontherapeutic, whether it presents greater than minimal risk;

3. Whether the rights and welfare of the individuals who are the subjects of the human research are adequately protected;

4. Whether the risks to the individuals who are the subjects of human research are outweighed by the potential benefits to them;

5. Whether the risks to individuals are minimized by using procedures that are consistent with sound human research design and that do not unnecessarily expose individuals to risk and, whenever appropriate, by using procedures already being performed on individuals for diagnostic or treatment purposes;

6. When some or all of the individuals are likely to be incapable of providing informed consent or are otherwise vulnerable to coercion or undue influence, ~~such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons,~~ whether additional safeguards have been included in the study to protect the rights and welfare of these individuals;

7. Whether the informed consent is to be obtained by methods that are adequate and appropriate and whether the written consent form is adequate and appropriate in both content and language for the particular human research and for the individuals who are the particular subjects of the human research;

8. Whether the persons proposing to supervise or conduct the particular human research are appropriately competent and qualified;

9. Whether criteria for selection of individuals to participate as human research subjects are equitable; and

10. Whether the human research conforms with such other requirements of the department, where applicable.

~~B. Each committee shall review approved projects to ensure conformity with the approved proposal at least annually.~~

~~C.~~ B. When cooperating institutions conduct some or all of the human research involving some or all of the individuals, each cooperating institution is responsible for safeguarding the rights and welfare of the individuals and for complying with this chapter, except that in complying with this chapter institutions may enter into joint review, rely upon the review of another qualified committee, or come to similar agreements aimed at avoiding duplication of effort. These agreements must be in writing and designate a lead institution, which shall be the institution responsible for reporting and dealing with possible misconduct in human research. Such agreements may be made by the committee chair with the approval of a majority of the members present at a meeting of the committee. If a given institution or agency does not have a research review committee, this arrangement shall be approved by the chief executive officer of the institution, or his designee.

~~D.~~ C. The committee shall consider human research proposals within 45 days after submission to the committee's chair. In order for the human research to be approved, it shall receive the approval of a majority of those members present, including one nonscientific person, at a meeting in which a quorum exists. A committee shall notify investigators and the institution in writing of its decision to approve or disapprove the proposed human research ~~activity~~ project, or of modifications required to secure committee approval.

~~E.~~ D. The committee shall develop a written description of the procedure to be followed by an individual who has a complaint about a human research project in which he is participating or has participated.

~~F.~~ E. Any individual who has a complaint about a human research project in which he is participating or has participated shall be referred to the chairperson of the committee who shall refer it to the committee to determine if there has been a violation of the protocol.

F. The committee shall have the authority to suspend or terminate approval of research that is not being conducted in accordance with the committee requirements or that has been associated with unexpected serious harm to any individuals. Any suspension or termination of approval shall include a statement of the reasons for the committee's action and shall be reported promptly to the investigator, appropriate institutional officials, the department or agency head, and the commissioner.

G. The chair of the committee shall provide a written report as soon as possible to the head of the institution of any violation of the human research protocol that led the committee to either suspend or terminate the human research.

H. The committee shall require periodic written reports to ensure that the project is being carried out in conformity with the proposal. The frequency of such reports should reflect the nature and degree of risk of each human research project, but shall be at least annually.

I. Prior to participation by individuals in any human research project, the institution or agency shall inform and provide a copy of the research review committee approval to the local human rights committee established pursuant to 12VAC35-115. Once the research has been initiated, the institution or agency shall update the local human rights committee periodically on the status of an individual's participation.

J. The committee shall ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and federal and state regulations regarding the use and disclosure of PHI created for human research. In particular, authorization shall be obtained for the use and

disclosure of PHI created for the purpose of human research, except as otherwise permitted by 45 CFR 164.512(i).

12VAC35-180-80. Kinds of human research exempt from committee review.

Human research activities in which the involvement of individuals as subjects is limited to one or more of the following categories are exempt from this chapter unless the human research is covered by other sections of this chapter:

1. Human research conducted in established or commonly accepted educational settings, involving commonly used educational practices, such as:

a. Research on regular and special education instructional strategies; ~~or~~

b. Research on the effectiveness of or the comparison among instructional techniques, curriculum or classroom management methods~~.~~; or

~~2. Human research~~ c. Research involving solely the use and analysis of the results of educational tests, whether cognitive, diagnostic, aptitude, or achievement, if the data from such tests are recorded in such a manner so that individuals cannot be identified, directly or through identifiers linked to the individuals.

~~3.~~ 2. Human research involving survey or interview procedures, unless responses are recorded in such a manner that the individuals can be identified, directly or through identifiers linked to the individuals~~;~~, and either:

a. The individual's responses, if they became known outside the human research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the individual's financial standing, employability, or reputation; or

b. The human research deals with sensitive aspects of the individual's own behavior, such as sexual behavior, drug or alcohol use, or illegal conduct.

~~4.~~ 3. Human research involving solely the observation (including observation by individuals who are the subjects of human research) of public behavior, unless observations are recorded in such a manner that individuals can be identified, directly or through identifiers linked to the individuals, and either:

a. The observations recorded about the individual, if they became known outside the human research, could reasonably place the individual at risk of criminal or civil liability or be damaging to the individual's financial standing, employability, or reputation; or

b. The human research deals with sensitive aspects of the individual's own behavior such as sexual behavior, drug or alcohol use, or illegal conduct.

~~5.~~ 4. Human research involving solely the collection or study of existing data, documents, records, or pathological or diagnostic specimens, if these sources are publicly available or if the information taken from these sources is recorded in such a manner that individuals cannot be identified, directly or through identifiers linked to the individuals.

~~6.~~ 5. Human research involving solely a combination of any of the activities described in this section.

12VAC35-180-90. Expedited review procedures for certain kinds of human research involving no more than minimal risk.

A. A research review committee may conduct an expedited review of a human research project that involves no more than minimal risk to the individuals who are the subjects of the human research if (i) another institution's or agency's human research review committee has reviewed and approved the project, or (ii) the review involves only minor changes in previously approved human research and the changes occur during the approved project period. Under an expedited review procedure, the review may be carried out by the committee chair and two or more experienced reviewers designated by the chair from among members of the committee. In reviewing the human research, the reviewers may exercise all of the authority of the committee except that the reviewers may not disapprove the human research. A human research ~~activity~~ project may be disapproved only after review in accordance with the nonexpedited ~~procedure~~ review elements set forth in 12VAC35-180-70.

B. Each committee ~~which~~ that uses an expedited review procedure shall adopt a method for keeping all members advised of human research proposals ~~which~~ that have been approved under the procedure.

12VAC35-180-100. Informed consent.

A. No human research shall be conducted in the absence of informed consent subscribed to in writing by the individual or by the individual's legally authorized representative except as provided for in subsection F of this section. If the individual is capable of providing informed consent, written consent must be provided by the individual and witnessed. If the individual is incapable of making an informed decision, as defined in § 54.1-2982 of the Code of Virginia, at the time consent is required, written consent must be provided by the individual's legally authorized representative and witnessed. If the individual is a minor otherwise capable of rendering informed consent, the consent shall be provided by both the minor and his legally authorized representative. An investigator shall seek such consent only under circumstances that provide the individual who is the prospective subject or the representative sufficient opportunity to consider whether to participate and that minimize the possibility of coercion or undue influence. The information that is given to the

individual or, if applicable, the individual's legally authorized representative shall be in language understandable to the individual or the representative.

If two or more persons who qualify as legally authorized representatives have equal decision-making priority under this chapter inform the principal investigator or attending physician that they disagree as to participation of the individual in human research, the individual shall not be enrolled in the human research that is the subject of the consent.

B. For the purposes of human research, the basic elements of information necessary for such consent shall include:

1. A statement that the study involves research and a reasonable and comprehensible explanation to the individual of the proposed procedures or protocols to be followed and the purposes, including descriptions of any reasonably foreseeable discomforts, risks, and benefits and how the results of the human research will be disseminated;

2. A statement describing the extent, if any, to which confidentiality of records identifying the individual will be maintained;

3. A disclosure of any appropriate alternative procedures or treatments that might be advantageous for the individual together with side effects, risks, and benefits of those alternative procedures or treatments;

4. A description of any adverse consequence and risk to be expected and an indication whether there may be other significant risks not yet identified;

5. A statement that participation is voluntary and instruction that the individual may refuse to participate or withdraw his consent and discontinue participation in the human research at any time without prejudice to him, fear of reprisal, penalty, or loss of any benefit to which he is otherwise entitled;

6. An explanation of costs or compensation that may accrue to the individual and, if applicable, the availability of third-party reimbursement for the proposed procedures or protocols or any medical care that may be available if an injury occurs; and

7. A statement of whom to contact for answers to inquiries by the individual or, if applicable, the individual's legally authorized representative concerning the research and a description of the ways in which concerns may be raised or questions asked and notification of whom to contact in the event of any research-related injury to the individual.

C. No individual shall participate in human research unless this requirement is met. No informed consent shall include any language through which the individual waives or appears to waive any of his legal rights, including any release of any person, institution, or agency or any agents thereof from liability for negligence. Notwithstanding the informed consent by ~~alegally~~ a legally authorized representative, no individual shall be forced to participate in any human research if the investigator conducting the human research knows that participation in the human research is protested by the individual. In the case of individuals suffering from organic brain disease causing progressive deterioration of cognition for which there is no known cure or medically accepted treatment, the implementation of experimental courses of therapeutic treatment to which the legally authorized representative has given informed consent shall not constitute the use of force. Each individual shall be given a copy of the signed consent form required by 12VAC35-180-40 A except as provided for in subsection ~~F~~ H of this section.

~~C.~~ D. Prior to participation by an individual in any human research project, the institution or agency shall meet the requirements of 12VAC35-115-130.

E. No legally authorized representative may consent to nontherapeutic human research unless it is determined by the research review committee that such nontherapeutic human research will present no more than a minor increase over minimal risk to the individual. A legally authorized representative may not consent to participation in human research on behalf of an individual if the legally authorized representative knows, or upon reasonable inquiry ought to know, that any aspect of the human research protocol is contrary to the religious beliefs or basic values of the individual, whether expressed orally or in writing. A legally authorized representative may not consent to participation in human research involving nontherapeutic sterilization, abortion, psychosurgery, or admission for human research purposes to a facility or hospital as defined in § 37.2-100 of the Code of Virginia. No nontherapeutic human research shall be performed without the consent of the individual or, if applicable, ~~his~~ the individual's legally authorized representative.

~~D.~~ F. The research review committee may approve a consent procedure that does not include or that alters some or all of the elements of informed consent set forth in 12VAC35-180-10, or that waives the requirements to obtain informed consent provided the committee finds and documents that:

1. The human research involves no more than minimal risk to the individuals;

2. The omission, waiver, or alteration will not adversely affect the rights and welfare of the individuals;

3. The human research could not practicably be carried out without the omission, waiver, or alteration; and

4. Whenever appropriate, the individuals shall be provided with additional pertinent information after participation.

~~E.~~ G. A written consent document that embodies the elements of informed consent ~~required by~~ as defined in 12VAC35-180-10 may be read to the individual or, if applicable, the individual's legally authorized representative, but in any event, the investigator shall give either the individual or the legally authorized representative adequate opportunity to read it before it is signed.

~~F.~~ H. The committee may waive the requirement in subsection ~~E~~ A of this section for the investigator to obtain a written informed consent form for some or all individuals if it finds that the only record linking the individual and the human research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each individual shall be asked whether the individual wants documentation linking the individual with the human research, and the individual's wishes shall govern. In cases where the documentation requirement is waived, the committee may require the investigator to provide individuals with a written statement explaining the human research.

12VAC35-180-110. Committee records.

A. An institution or agency, or when appropriate a committee, shall prepare and maintain adequate documentation of committee activities, including the following:

1. Copies of all human research proposals reviewed, scientific evaluations, if any, that accompany the proposals, approved sample consent documents, progress reports submitted by investigators, and reports of injuries to individuals who are subjects of the human research.

2. Minutes of committee meetings which shall be in sufficient detail to show attendance at the meetings; actions taken by the committee; the vote on these actions including the number of members voting for, against, and abstaining; the basis for requiring changes in or disapproving human research; and a written summary of the discussion of issues about which opposition has been voiced and their resolution.

3. Records of continuing review activities.

4. Copies of all correspondence between the committee and the investigators.

5. A list of committee members.

6. Written procedures for the committee.

7. Statements of significant new findings provided to individuals.

B. The records required by this chapter shall be retained for at least three years, and records relating to human research ~~which~~ that is conducted shall be retained for six years after completion of the human research. All records shall be accessible for inspection and copying by authorized employees or agents of the department at reasonable times and in a reasonable manner. An overview of approved human research projects and the results of such projects shall be made public on the website of the institution or agency conducting the human research unless otherwise exempt from disclosure under the Virginia Freedom of Information Act~~,~~ (§ 2.2-3700 et seq. of the Code of Virginia).

12VAC35-180-120. Mandatory reporting.

Each research review committee shall submit to the governor, the General Assembly, and the commissioner or his designee at least annually a report on the human research projects reviewed and approved by the committee, including any significant deviations from the proposals as approved, in accordance with § 37.2-402 of the Code of Virginia and this chapter.

12VAC35-180-130. Role of the department and commissioner.

The commissioner shall ~~assure~~ ensure that the department's human rights program, through procedures described in ~~12VAC35-115~~ 12VAC35-115-130, protects the rights of individuals who are admitted to a state ~~hospital, training center~~ facility, or other facility operated, funded, or licensed by the department to refuse to participate as a subject of human research and ~~assure~~ ensure that written and informed consent is received from individuals or their legally authorized representative prior to their participation as a subject of human research.

12VAC35-180-140. Applicability of state policies.

Nothing in this chapter shall be construed as limiting in any way the rights under regulations promulgated by the State Board of Behavioral Health and Developmental Services pursuant to § 37.2-400 of the Code of Virginia of individuals participating in human research ~~under regulations promulgated by the State Board of Behavioral Health and Developmental Services pursuant to § 37.2-400 of the Code of Virginia~~.

12VAC35-180-150. Applicability of federal policies.

Human research at institutions or agencies ~~which~~ that are subject to policies and regulations for the protection of individuals promulgated by any agency of the federal government shall be exempt from this chapter.

VA.R. Doc. No. R20-5244; Filed December 18, 2019, 10:51 a.m.

Fast-Track Regulation

Title of Regulation: **12VAC35-270. Certified Recovery Residences (adding 12VAC35-270-10 through 12VAC35-270-40).**

Statutory Authority: §§ 37.2-203 and 37.2-431.1 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 7, 2020.

Agency Contact: Ruth Anne Walker, Director of Regulatory Affairs, Department of Behavioral Health and Developmental Services, Jefferson Building, 1220 Bank Street, 11th Floor, Richmond, VA 23219, telephone (804) 225-2252, FAX (804) 786-8623, TTY (804) 371-8977, or email ruthanne.walker@dbhds.virginia.gov.

Basis: Chapter 220 of the 2019 Acts of Assembly added § 37.2-431.1 of the Code of Virginia, creating an avenue for the certification of recovery residences through regulations adopted by the State Board of Behavioral Health and Developmental Services. Section 37.2-203 of the Code of Virginia authorizes the state board to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner and the Department of Behavioral Health and Developmental Services (DBHDS).

Purpose: As reported in a May 2017 brief of The National Council for Behavioral Health titled Recovery Housing Issue Brief: Information for State Policymakers:

> "Recovery housing" refers to safe, healthy, and substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery and recovery services and supports.

The brief also reports, as excerpted from the U.S. Department of Health and Human Services, Office of the Surgeon General (2016) report "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health:"

> Many residents live in recovery housing during or after outpatient addiction treatment. Length of stay is self-determined and can last for several months to years. Residents often share resources, give experiential advice about how to access health care and social services, find employment, budget and manage finances, handle legal problems, and build life skills. Many recovery homes are organized under the leadership of a house manager and require residents to participate in a recovery program, such as 12-step and other mutual aid groups.

While many recovery residences are well-run, a national effort has been growing to bring standards to how recovery residences are operated due to "unscrupulous actors running sober living homes who profit off the misery of their occupants." Governing Magazine, May 14, 2018. Sober Living Homes and the Regulation They Need.

A stakeholder workgroup was convened over the last year in Virginia to receive input from subject matter experts across the state. The legislation was developed through the workgroup with broad community feedback that called for greater accountability for recovery housing to ensure the health, safety, and welfare of individuals staying in recovery residences. A compromise was developed with stakeholders to provide departmental oversight to recovery housing without being overly burdensome to these "organic" community-based organizations. Certified recovery residences will be held to nationally recognized standards to ensure safety and recovery through effective peer support, mutual accountability, and clear social structures. Voluntary certification of recovery housing is intended to make it easier to locate recovery housing for individuals needing such housing and thus create a list of available houses to be utilized by courts, community services boards, individuals, and families.

Rationale for Using Fast-Track Rulemaking Process: These amendments are noncontroversial as the certification is voluntary. A stakeholder workgroup was convened over the last year in Virginia to receive input from subject matter experts across the state regarding recovery residences. The legislation mandating the voluntary certification was developed through the workgroup with broad community feedback that called for greater accountability for recovery housing to ensure the health, safety, and welfare of individuals staying in recovery residences. The draft regulation text closely tracks the legislative language.

Substance: The new regulation establishes a process for the maintenance of a list by DBHDS of certified recovery houses. As allowed in the legislation, DBHDS identifies through the regulation specific credentialing entities and requires the submission of an application with proof of good standing from one of the specific credentialing entities in order to have a recovery residence added to the list on the DBHDS website.

Issues: Certified recovery residences will be held to nationally recognized standards to ensure safety and recovery through effective peer support, mutual accountability, and clear social structures. Voluntary certification of recovery housing is intended to make it easier to locate recovery housing for individuals needing such housing and thus create a list of available houses to be utilized by courts, community services boards, individuals, and families.

The advantage of this regulation to the public is that it allows for individuals and families to find safe recovery housing easier and faster within their affordability and that clearly serves their population. There are no identified disadvantages to the public or the Commonwealth in making this change.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Board of Behavioral Health and Developmental Services (Board) seeks to add a new chapter (12VAC35-270) titled Certified Recovery Residences. The Board proposes in this regulation to certify recovery residences (or sober houses) in order to provide accurate and useful information for individuals in recovery from substance use disorders (SUDs).[2] Certification would be optional.

The Board reports that individuals in recovery from SUDs benefit from mutual peer support and accountability in a recovery oriented environment. With recent increases in the demand for sober housing, the Board finds it necessary to increase effective recovery supports and reduce instances of unscrupulous management of recovery homes. Voluntary certification would provide a low-cost mechanism for bona fide recovery residences to signal their compliance with best practice standards. Houses that are certified would be added to a list of certified recovery residences that would be maintained by the Department of Behavioral Health and Development Services (DBHDS) on its website. This list would be used as a resource by social workers, parole officers, and others working with individuals who are most likely to look for sober housing.

Background. The 2019 Acts of Assembly (Chapter 220) adds a section to the Code of Virginia (§ 37.2-431.1 Certified recovery residences), which (i) prohibits anyone from representing that a recovery residence has been certified, unless it has actually been certified by DBHDS in accordance with regulations adopted by the Board, (ii) directs DBHDS to maintain a list of certified recovery residences on its website, and (iii) allows DBHDS to institute civil proceedings against anyone violating the provisions of this section. The law specifically allows the Board to promulgate regulations that may require accreditation or membership in a credentialing agency as a condition of certification.[3]

The proposed regulation mirrors the law almost verbatim, except to specify that any person, nonprofit organization, or business entity seeking to operate a certified recovery residence must be credentialed by the Virginia Association of Recovery Residences (VARR) or Oxford House.[4] DBHDS chose these two accrediting bodies because they were recognized by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) and explained other credentialing entities seeking to become active in Virginia could be eligible if they were to be recognized by SAMHSA as an effective recovery housing model.

Estimated Benefits and Costs. DBHDS' cost of maintaining a list of certified recovery residences on its website is likely to be nominal. Individuals, nonprofits or businesses that operate recovery residences and seek credentialing with VARR must pay a $500 annual membership fee for the first house and an additional $50 per year for each additional house. Oxford House does not appear to charge a membership fee.

The benefits of access to sober housing for individuals in recovery have been studied extensively and are well documented.[5] The Oxford House model in particular has been evaluated rigorously and found to be cost-effective because they lower the likelihood of relapse and incarceration.[6] Due to the opioid crisis, recovery housing has received renewed attention in a Surgeon General's report,[7] and SAMHSA has developed a set of best practices for individuals or organizations wishing to start a recovery residence.[8]

However, increased mainstream interest in recovery housing has also allowed unethical practices to proliferate, such as coercive treatment of residents and Medicaid fraud, increasing calls for oversight by state and local governments[9] and prompting the U.S. Government Accountability Office (GAO) to examine recovery housing.[10] Because sober houses are financially self-sustaining by design, they generally fall outside the regulatory purview of state and local authorities. Individuals who end up in an abusive shared-housing situation face the same costs as any tenant faced with an abusive landlord or roommates but with the additional risk of jeopardizing their sobriety and losing their job or parole or other resources that were conditioned on their sobriety.

Further, the central problem is lack of information: individuals looking for sober housing (and the caseworkers who might be helping them) need a reliable source of information indicating which houses are likely to be safe and legitimate recovery residences. This proposed regulation provides a solution to the lack of information by creating a voluntary certification that is sufficiently accessible to recovery residences and creates a network of houses meeting nationally recognized standards. Further, this certification and the information maintained by DBHDS would provide caseworkers and caregivers in outpatient settings who are working with individuals in recovery with an additional resource to offer their clients. To the extent that these efforts increase the availability of reliable information works as intended, these professionals, the clients they serve, and legitimate sober homes all stand to benefit. Houses that choose not to be certified can continue to provide sober housing, but their pool of clients and referrals may decrease as people seek to choose houses that are less likely to be run in an unscrupulous manner.

Lastly, the proposed regulation does not explicitly state that certification would be voluntary and leaves a number of operational details to these credentialing entities. Once the regulation takes effect, any lack of clarity about the voluntary nature of the certification, the choice of credentialing entities, or actions taken by those credentialing entities could diminish the informational value of the certification, which would in turn limit the benefits described above.

Businesses and Other Entities Affected. The proposed regulation potentially affects recovery housing owners and operators, their residents, recovery organizations, law-enforcement officials, parole or probation officers, courts, and community services boards.

Localities[11] Affected.[12] The proposed regulation does not appear to introduce new costs for local governments.

Localities that currently have higher rates of SUD prevalence may be more likely to have recovery residences, but the proposed introduction of voluntary certification is likely to benefit them.

Projected Impact on Employment. The proposed regulation is unlikely to affect total employment, except to the extent that individuals in recovery are able to maintain their sobriety and find employment.

Effects on the Use and Value of Private Property. The proposed regulation does not appear to directly affect real estate development costs. It is unclear what effect certification may have on the value of private property in neighborhoods that contain recovery houses. Some homeowners may not want homes in their neighborhood to be used as recovery residences because it may be perceived as "undesirable" and could drive down the value of their home. However, obtaining certification could allay such concerns and reduce the risk of the neighborhood actually experiencing any decline in house prices.

Adverse Effect on Small Businesses:[13] The proposed regulation is unlikely to adversely impact small businesses, other than perhaps recovery residences that either chose to not obtain a certification or are unable to do so.

[2]"Recovery residence" is defined in the proposed regulation as "a housing facility that provides alcohol-free and illicit-drug-free housing to individuals with substance abuse disorders and individuals with co-occurring mental illnesses and substance abuse disorders that does not include clinical treatment services." Since they are private, self-sustaining and do not provide any SUD treatment, they are ineligible for public funding, and hence generally operate without any public oversight.

[3]"Credentialing entity" is defined as "a nonprofit organization that develops and administers professional certification programs according to nationally recognized recovery housing standards."

[4]See https://www.oxfordhouse.org/userfiles/file/, https://narronline.org/about-us/, and http://www.varronline.org/ for information on Oxford Houses, the National Alliance of Recovery Residences, and the Virginia Association of Recovery Residences respectively.

[5]For examples, see Polcin and Henderson, 2008 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2556949/); Groh, Jason, Ferrari and Davis, 2009 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2916198/); and Polcin *et al*, 2010 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3008818/).

[6]See Lo Sasso et al, 2012 (https://doi.org/10.1016/j.evalprogplan.2011.06.006).

[7]See The Surgeon General's Report on Alcohol, Drugs, and Health, 2016 (https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdfpage 5-11) and Facing Addiction in America – The Surgeon General's Spotlight on Opioids, 2018 (https://addiction.surgeongeneral.gov/sites/default/files/OC_SpotlightOnOpioids.pdfpages 25-26).

[8]See https://www.samhsa.gov/sites/default/files/housing-best-practices-100819.pdf.

[9]See https://www.governing.com/gov-institute/voices/col-regulation-sober-living-homes-recovery-residences-need.html- need.html.

[10]See https://www.gao.gov/products/GAO-18-315.

[11]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[12]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[13]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."

Agency's Response to Economic Impact Analysis: The agency concurs with Department of Planning and Budget's economic impact analysis.

Summary:

Pursuant to Chapter 220 of the 2019 Acts of Assembly, this action establishes a new regulation for the certification of recovery residences and includes (i) the acceptable credentialing entities, (ii) a process for the maintenance of a list by the Department of Behavioral Health and Developmental Services of certified recovery houses, (iii) a requirement that an application contain proof of good standing from one of the specific credentialing entities in order for a recovery residence to be added to the list, and (iv) restrictions and the penalty for violations.

CHAPTER 270
CERTIFIED RECOVERY RESIDENCES

12VAC35-270-10. Definitions.

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

"Certification list" means the list of certified recovery residences maintained by DBHDS.

"Certified recovery residence" means a recovery residence that has been certified by a credentialing entity and is on the certification list maintained by DBHDS.

"Credentialing entity" means a nonprofit organization that develops and administers professional certification programs according to nationally recognized recovery housing standards.

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

"Recovery residence" means a housing facility that (i) provides alcohol-free and illicit-drug-free housing to individuals with substance abuse disorders and individuals with co-occurring mental illnesses and substance abuse disorders and (ii) does not include clinical treatment services.

12VAC35-270-20. Recovery residence.

Any person, nonprofit organization, or business entity seeking to operate a certified recovery residence under this chapter shall for each location (i) meet the qualifications, policies, and practices established by a credentialing entity and (ii) be certified or accredited by or hold a charter from one of the following credentialing entities:

1. The Virginia Association of Recovery Residences; or

2. Oxford House.

12VAC35-270-30. List of certified recovery residences.

A. DBHDS shall maintain a list of certified recovery residences on its website.

B. A certified recovery residence seeking to be included on the certification list shall submit a completed application on a form provided by DBHDS.

C. A certified recovery residence seeking to be included on the certification list shall provide evidence of accreditation or certification by, a charter from, or membership in a credentialing entity listed in 12VAC35-270-20.

12VAC35-270-40. Restrictions and violations.

A. No person shall advertise, represent, or otherwise imply to the public that a recovery residence or other housing facility is a certified recovery residence unless such recovery residence or other housing facility has been placed on the certification list by DBHDS in accordance with this chapter.

B. Any recovery residence that fails to maintain accreditation or certification by, a charter from, or membership in a credentialing entity as required by this chapter shall be removed from the certification list.

C. DBHDS may institute civil proceedings in the name of the Commonwealth to enjoin any person from violating the provisions of this chapter and to recover a civil penalty of at least $200 but no more than $1,000 for each violation. Such proceedings shall be brought in the general district or circuit court for the county or city in which the violation occurred or where the defendant resides. Civil penalties assessed under this section shall be paid into the Behavioral Health and Developmental Services Trust Fund established in § 37.2-318 of the Code of Virginia.

NOTICE: Forms used in administering the regulation have been filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (12VAC35-270)

Application for Inclusion on the DBHDS Recovery Residences Certification List, Office of Recovery Service Form (eff. 8/2019)

VA.R. Doc. No. R20-6077; Filed December 20, 2019, 1:17 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Fast-Track Regulation

Title of Regulation: **18VAC30-21. Regulations Governing Audiology and Speech-Language Pathology (amending 18VAC30-21-80).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Audiology and Speech-Language Pathology, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 597-4130, or email audbd@dhp.virginia.gov.

Basis: Regulations Governing Audiology and Speech-Language Pathology (18VAC30-20) are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400 provides the Board of Audiology and Speech-Language Pathology the authority to promulgate regulations to administer the regulatory system.

Purpose: The purpose of the amendment is to ease the path to licensure by endorsement for certain applicants who have met the current and restricted certification requirement but have less than 12 months of practice prior to application. These applicants are recent graduates in audiology or speech-language pathology who became licensed in another state but are now relocating to Virginia. Since the applicants have completed their education and examination within the past 12 months, it is not necessary to have active practice to ensure current competency for the health and safety of patients or clients in Virginia, and the board should be able to grant them a full license without requiring six months of provisional

licensure. The amendments will have no negative impact on the public's health, safety, or welfare.

Rationale for Using Fast-Track Rulemaking Process: The board is amending the regulation to eliminate an unnecessary barrier to licensure by some recent graduates, so it is expected to be noncontroversial.

Substance: 18VAC30-21-80 is amended to allow the board to grant licensure by endorsement for an applicant who graduated from an accredited program in audiology or speech-language pathology within 12 months immediately preceding application. Such applicant may be issued a license without evidence of active practice if the applicant holds a current and unrestricted Certificate of Clinical Competence in the area in which the applicant seeks licensure issued by the American Speech-Language-Hearing Association or certification issued by the American Board of Audiology or any other accrediting body recognized by the board.

Issues: The primary advantage of this change is a less burdensome pathway to licensure for recent graduates who may want to locate their practice in Virginia. There are no disadvantages to the public. There are no advantages and disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Audiology and Speech-Language Pathology (Board) proposes to permit the granting of licensure by endorsement for an applicant who graduated from an accredited program in audiology or speech-language pathology within 12 months immediately preceding application without evidence of active practice if the applicant holds either (1) a current and unrestricted Certificate of Clinical Competence in the area in which he seeks licensure issued by the American Speech-Language-Hearing Association or (2) a certification issued by the American Board of Audiology or any other accrediting body recognized by the Board.

Background. The Regulations Governing Audiology and Speech-Language Pathology require applicants for Virginia licensure in audiology or speech-language pathology who have been licensed in another United States jurisdiction to apply via the licensure by endorsement route. Under the current regulation, applicants for licensure by endorsement must, among other requirements, submit documentation of evidence of either a) active practice in another United States jurisdiction for at least one of the past three years, or b) practice for six months with a provisional license and provide evidence of a recommendation for licensure by the applicant's supervisor. This active practice requirement is designed to ensure current competency for the health and safety of patients or clients.[2] Since the applicants affected by the proposed amendment would have completed their education and examination within the past 12 months, the Board does not believe the active practice requirement is necessary to ensure that these individuals have current competency. Additionally, the standard route to initial Virginia licensure contains no active practice requirement.

Estimated Benefits and Costs. Under the current regulation, applicants for Virginia licensure as audiologists or speech-language pathologists who are licensed in another United States jurisdiction and have graduated from an accredited program in audiology or speech-language pathology within 12 months immediately preceding application would be required to spend six months in a provisional status under the supervision of a Virginia licensee prior to gaining Virginia licensure. The proposed amendment would affectively negate this requirement and permit such individuals to become fully licensed right away. This is clearly beneficial for the affected individuals in that their initial job opportunities and earnings are likely to be higher. Additionally, employers of audiologists and speech-language pathologists may gain a slightly larger pool of fully licensed applicants to choose from. There does not appear to be any cost associated with the proposed amendment.

Businesses and Other Entities Affected. The proposed amendment affects applicants for Virginia licensure as audiologists or speech-language pathologists who are licensed in another United States jurisdiction and have graduated from an accredited program in audiology or speech-language pathology within 12 months immediately preceding application, as well as their potential employers.[3] The Department of Health Professions reports that it knows of fewer than 10 past applicants who would have been affected by the amendment. Thus the likely number of affected entities is small. The proposed amendment does not appear to impose costs.

Localities[4] Affected.[5] The proposed amendment applies statewide and does not disproportionately affect any particular locality. The proposed amendment does not appear to introduce costs for local governments.

Projected Impact on Employment. The proposed amendment is not likely to substantially affect total employment.

Effects on the Use and Value of Private Property. The proposal may allow a few firms to employ audiologists or speech-language pathologists who are licensed in another United States jurisdiction and have graduated from an accredited program in audiology or speech-language pathology within 12 months without supervision. This may moderately reduce their costs, moderately increasing their net value.

The proposed amendment does not affect real estate development costs.

Adverse Effect on Small Businesses:[6] The proposed amendment does not appear to adversely affect small businesses.

[2]Source: Department of Health Professions

[3]The Department of Health Professions licenses individual audiologists and speech-language pathologists, but not their employers. Consequently, the number of licensed individuals is available, but the number of employers is not.

[4]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[5]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[6]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."

Agency's Response to Economic Impact Analysis: The Board of Audiology and Speech-Language Pathology concurs with the analysis of the Department of Planning and Budget.

Summary:

The amendment allows the Board of Audiology and Speech-Language Pathology to grant licensure by endorsement to an applicant who graduated from an accredited program in audiology or speech-language pathology within the 12 months immediately preceding application. The applicant may be issued a license without evidence of active practice if the applicant holds a current and unrestricted Certificate of Clinical Competence in the area in which the applicant seeks licensure issued by American Speech-Language-Hearing Association or certification issued by the American Board of Audiology or any other accrediting body recognized by the board.

18VAC30-21-80. Qualifications for licensure by endorsement.

An applicant for licensure in audiology or speech-language pathology who has been licensed in another United States jurisdiction shall apply for licensure in Virginia in accordance with application requirements in 18VAC30-21-50 and submission of documentation of:

1. Ten continuing education hours for each year in which ~~he~~ the applicant has been licensed in the other jurisdiction, not to exceed 30 hours, or a current and unrestricted Certificate of Clinical Competence in the area in which ~~he~~ the applicant seeks licensure issued by ASHA or certification issued by the American Board of Audiology or any other accrediting body recognized by the board. Verification of currency shall be in the form of a certified letter from a recognized accrediting body issued within six months prior to filing an application for licensure;

2. Passage of the qualifying examination from an accrediting body recognized by the board;

3. Current status of licensure in any other United States jurisdiction showing that the license is current and unrestricted or, if lapsed, is eligible for reinstatement and that no disciplinary action is pending or unresolved. The board may deny a request for licensure to any applicant who has been determined to have committed an act in violation of 18VAC30-21-160; and

4. Evidence of active practice in another United States jurisdiction for at least one of the past three years or practice for six months with a provisional license in accordance with 18VAC30-21-70 and by providing evidence of a recommendation for licensure by ~~his~~ the applicant's supervisor. An applicant who graduated from an accredited program in audiology or speech-language pathology within 12 months immediately preceding application may be issued a license without evidence of active practice if the applicant holds a current and unrestricted Certificate of Clinical Competence in the area in which the applicant seeks licensure issued by ASHA or certification issued by the American Board of Audiology or any other accrediting body recognized by the board.

VA.R. Doc. No. R20-6086; Filed December 17, 2019, 6:03 p.m.

Fast-Track Regulation

Title of Regulation: **18VAC30-21. Regulations Governing Audiology and Speech-Language Pathology (amending 18VAC30-21-100).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Audiology and Speech-Language Pathology, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 597-4130, or email audbd@dhp.virginia.gov.

Basis: Regulations Governing Audiology and Speech-Language Pathology (18VAC30-21) is promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400 provides the Board of Audiology and Speech-Language Pathology the authority to promulgate regulations to administer the regulatory system. General authority for a continuing competency requirement for renewal of licensure is found in § 54.1-103 of the Code of Virginia.

Purpose: The purpose of the amendment is to increase access to continuing education (CE). To the extent audiologists or speech-language pathologists can more readily obtain CE at less cost to licensees, the public health and safety is better protected.

Rationale for Using Fast-Track Rulemaking Process: Adding another approved provider of continuing education benefits some licensees who receive in-service training from a health

care organization accredited by DNV GL Healthcare, therefore such amendment is not expected to be controversial.

Substance: 18VAC30-21-100 is amended to add DNV GL Healthcare as a recognized accrediting body for health care organizations that are approved to provide CE for licensees. In addition, the name of the Joint Commission on Accreditation of Healthcare Organizations is amended to reflect a change in the name of that entity to "The Joint Commission."

Issues: The primary advantage of this change is additional opportunities to obtain CE through employers of some licensees. There are no disadvantages to the public. There are no advantages and disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. In response to a petition for rulemaking, the Board of Audiology and Speech-Language Pathology (Board) proposes to establish that health care organizations accredited by DNV GL Healthcare are approved sources of continuing education.

Background. Regulations Governing Audiology and Speech-Language Pathology (Regulation) require that in order to renew an active license, a licensee shall complete at least 10 contact hours of continuing education prior to the renewal date each year. The current regulation specifies that the continuing education must be activities, programs, or courses related to audiology or speech-language pathology, depending on the license held, and offered or approved by one of the following accredited sponsors or organizations sanctioned by the profession:

1. The Speech-Language-Hearing Association of Virginia or a similar state speech-language-hearing association of another state;

2. The American Academy of Audiology;

3. The American Speech-Language-Hearing Association;

4. The Accreditation Council on Continuing Medical Education of the American Medical Association offering Category I continuing medical education;

5. Local, state, or federal government agencies;

6. Colleges and universities;

7. International Association of Continuing Education and Training; or

8. Health care organizations accredited by the Joint Commission on Accreditation of Healthcare Organizations.

The Joint Commission on Accreditation of Healthcare Organizations has changed its name to The Joint Commission. The Board proposes to amend that entity's name in the regulation to reflect that change. Also, the Board proposes to state in the regulation that health care organizations accredited by DNV GL Healthcare are also approved sources of continuing education.

Starting in 2008, the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) has granted accreditation deeming authority to DNV GL Healthcare as an option to accreditation by The Joint Commission for participation in Medicare. On February 26, 2019, a petition for rulemaking[2] was submitted to the Board to "recognize health care organizations accredited by DNV-GL Healthcare for approval of continuing education." Twenty-two hospital systems nationally, including the Riverside and Sentara health systems in Virginia, are now accredited by DNV GL rather than The Joint Commission.[3]

Estimated Benefits and Costs. To the extent that accreditation from DNV GL signifies as much competence to provide quality continuing education pertaining to audiologists and speech-language pathologists as does accreditation from The Joint Commission, the proposed amendment appears to be beneficial. Audiologists and speech language pathologists would have additional sources of quality continuing education available. This would be particularly convenient, and perhaps lower cost, for licensees who are employees of a health care organization accredited by DNV GL. Such individuals could potentially newly have training provided by their employer qualify for continuing education. If these licensees would otherwise have obtained these hours of continuing education from other sources, these other sources may encounter reduced demand for their services, potentially resulting in reduced revenue.

Businesses and Other Entities Affected. The proposed amendments potentially affect the 542 licensed audiologists and 4,351 licensed speech-language pathologists in the Commonwealth, and their employers.[4] Licensees who are employees of a health care organization accredited by DNV GL would be particularly affected. There are two health care organizations accredited by DNV GL in Virginia. Providers of continuing education to audiologists and speech-language pathologists would also potentially be affected. Data for the number of providers of continuing education to audiologists and speech-language pathologists is not available.[5] The proposal would not increase implementation or compliance costs.

Localities[6] Affected.[7] The proposed amendments apply statewide. Employees of health care organizations accredited by DNV GL would be particularly affected. The two Virginia health care organizations currently accredited by DNV GL have locations in the Cities of Chesapeake, Franklin, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, Virginia Beach, and Williamsburg and the Counties of Accomack, Essex, Gloucester, Hanover, Isle of Wight, King William, Lancaster, Mathews, Middlesex, New Kent,

Northampton, Northumberland, Richmond, Sussex, and York. The proposed amendments do not introduce costs for local governments.

Projected Impact on Employment. The proposed amendments are not likely to substantially affect total employment.

Effects on the Use and Value of Private Property. The proposal to establish that health care organizations accredited by DNV GL Healthcare are approved sources of continuing education would likely increase the number of sources of qualifying continuing education for audiologists and speech-language pathologists, potentially reducing the cost of obtaining such continuing education. To the extent that these costs are incurred or partially incurred by firms that employ audiologists and speech-language pathologists, this may moderately increase the net value of such firms.

The proposal may also result in some private providers of continuing education facing additional competition for their services, potentially moderately reducing revenue. This may moderately reduce the net value of such continuing education providers.

The proposed amendments do not affect real estate development costs.

Adverse Effect on Small Businesses:[8]

Types and Estimated Number of Small Businesses Affected. The proposal to establish that health care organizations accredited by DNV GL Healthcare are approved sources of continuing education potentially may moderately reduce demand for services from some small providers of continuing education to audiologists and speech-language pathologists. Data is not available to estimate the number of such small businesses.

Costs and Other Effects. The proposed amendments do not increase costs. Some small providers of continuing education may encounter reduced demand for their services and consequently reduced revenue.

Alternative Method that Minimizes Adverse Impact. The proposal to establish that health care organizations accredited by DNV GL Healthcare are approved sources of continuing education creates benefit for licensed audiologists and licensed speech-language pathologists. The benefit cannot be achieved without the resulting potential loss of business for some small continuing education providers.

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[2]See https://townhall.virginia.gov/l/viewpetition.cfm?petitionid=293

[3]Source: Department of Health Professions

[4]The Department of Health Professions licenses individual audiologists and speech-language pathologists, but not their employers. Consequently, the number of licensed individuals is available, but the number of employers is not.

[5]The Department of Health Professions does not license providers of continuing education and thus does not collect associated data.

[6]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[7] § 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[8]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."

Agency's Response to Economic Impact Analysis: While the Board of Audiology and Speech-Language Pathology concurs with the analysis of the Department of Planning and Budget on amendment to 18VAC30-21, Regulations Governing Audiology and Speech-Language Pathology, the board strongly disagrees with the determination that the action needs to be referred to the Joint Commission on Administrative Rules (JCAR). The economic impact analysis acknowledges that the proposed action provides additional, less costly opportunities for licensees of the board to obtain continuing education. The board has adopted a less restrictive, less burdensome regulation, so the referral to JCAR is unwarranted.

Summary:

The amendment adds DNV GL Healthcare as a recognized accrediting body for health care organizations that are approved to provide continuing education for licensees. The amendment is in response to a petition for rulemaking.

18VAC30-21-100. Continuing education requirements for renewal of an active license.

A. In order to renew an active license, a licensee shall complete at least 10 contact hours of continuing education prior to the renewal date each year. Up to 10 contact hours of continuing education in excess of the number required for renewal may be transferred or credited to the next renewal year. One hour of the 10 hours required for annual renewal may be satisfied through delivery of professional services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for three hours of providing such volunteer services, as documented by the health department or free clinic.

B. Continuing education shall be activities, programs, or courses related to audiology or speech-language pathology, depending on the license held, and offered or approved by one of the following accredited sponsors or organizations sanctioned by the profession:

1. The Speech-Language-Hearing Association of Virginia or a similar state speech-language-hearing association of another state;

2. The American Academy of Audiology;

3. The American Speech-Language-Hearing Association;

4. The Accreditation Council on Continuing Medical Education of the American Medical Association offering Category I continuing medical education;

5. Local, state, or federal government agencies;

6. Colleges and universities;

7. International Association of Continuing Education and Training; or

8. Health care organizations accredited by ~~the~~ The Joint Commission ~~on Accreditation of Healthcare Organizations~~ or DNV GL Healthcare.

C. If the licensee is dually licensed by this board as an audiologist and speech-language pathologist, a total of no more than 15 hours of continuing education are required for renewal of both licenses with a minimum of 7.5 contact hours in each profession.

D. A licensee shall be exempt from the continuing education requirements for the first renewal following the date of initial licensure in Virginia under 18VAC30-21-60.

E. The licensee shall retain all continuing education documentation for a period of three years following the renewal of an active license. Documentation from the sponsor or organization shall include the title of the course, the name of the sponsoring organization, the date of the course, and the number of hours credited.

F. The board may grant an extension of the deadline for continuing education requirements, for up to one year, for good cause shown upon a written request from the licensee prior to the renewal date of each year.

G. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

H. The board shall periodically conduct an audit for compliance with continuing education requirements. Licensees selected for an audit conducted by the board shall complete the Continuing Education Form and provide all supporting documentation within 30 days of receiving notification of the audit.

I. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

VA.R. Doc. No. R20-6107; Filed December 17, 2019, 6:02 p.m.

BOARD OF DENTISTRY

Proposed Regulation

Title of Regulation: **18VAC60-30. Regulations Governing the Practice of Dental Assistants (amending 18VAC60-30-60, 18VAC60-30-120; adding 18VAC60-30-116).**

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

Public Hearing Information:

February 28, 2020 - 9 a.m. - Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room 4, Henrico, VA 23233

Public Comment Deadline: March 20, 2020.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, or email sandra.reen@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400 provides the Board of Dentistry the authority to promulgate regulations to administer the regulatory system. Specific authority for regulation of the profession of dental assisting is found in § 54.1-2729.01 of the Code of Virginia.

Purpose: The proposed regulatory action amends the educational requirements to become a dental assistant II (DAII) from a program based on completion of required hours to a competency-based program based on satisfactory completion of didactic coursework and clinical experiences. The expanded duties permitted for practice by a DAII in Virginia are outside the scope of practice for dental assistants in most other states. However, the current qualifications for a DAII appear to be more burdensome and costly than most dental assistants can afford. Therefore, the board is proposing to modify the qualifications to a competency-based model that would allow a well-trained assistant to complete the coursework and clinical training in fewer hours. To ensure some standardization in the determination of competency by supervising dentists, the dentists will be required to undergo a calibration of the procedures in which they are training. The combination of didactic hours, competency determination in specific procedures, and both written and clinical examination should provide evidence of competency to protect the public health and safety.

Substance: Following recommendations from the Regulatory Advisory Panel, the board amended the educational requirements to become a dental assistant II from a program based on completion of required hours to a competency-based program based on satisfactory completion of didactic coursework and clinical experiences.

A new section (18VAC60-30-116) specifies the requirements for educational programs training people for registration as

dental assistants II to include requirements for the programs (i) to be accredited by the Commission on Dental Accreditation of the American Dental Association; (ii) to have a program coordinator who is registered in Virginia as a dental assistant II or licensed in Virginia as a dental hygienist or dentist; (iii) to have a clinical practice advisor who is a licensed dentist in Virginia; (iv) to have a registered dental assistant II who assists in teaching the laboratory training component of the program with a minimum of two years of experience in performing clinical dental assisting; and (v) to have a participation agreement with any dentist who has successfully completed a calibration exercise on evaluating the clinical skills of a student and who agrees to supervise clinical experience.

The clinical experience component with live patients must be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist has to attest to successful completion of the clinical competencies and restorative experiences.

18VAC60-30-120 is amended to delete a certain number of hours in the didactic portion to a competency-based program that includes basic histology, understanding of the periodontium and temporal mandibular joint, pulp tissue and nerve innervation, occlusion and function, muscles of mastication, and any other item related to the restorative dental process. A written examination is required at the conclusion of didactic coursework.

The laboratory training hours are also reduced but specified to be completed on a manikin simulator to competency. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training may be completed in a dental office on a live patient in the three modules with specified components. A clinical competency exam is also required.

Issues: The primary advantage to the public is the possibility of more access to affordable dental care through greater utilization of expanded duty dental assistant. If dental assistants are appropriately trained in the laboratory on a manikin simulator and then have clinical experience with a calibrated dentist, there should be no disadvantages to the changes.

There are no advantages or disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Dentistry proposes to amend the educational requirements to become a dental assistant II from a program based on completion of required hours to a competency-based program.

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

Estimated Economic Impact. "Dental assistant I" is defined in the Regulations Governing the Practice of Dental Assistants as any unlicensed person under the direction of a dentist or a dental hygienist who renders assistance for services provided to the patient as authorized under this regulation but shall not include an individual serving in purely an administrative, secretarial, or clerical capacity. Individuals who become qualified and are registered as a dental assistant II may, under the direction and direct supervision of a dentist, perform intraoral procedures that are not permitted for a dental assistant I. Those intraoral procedures are: 1) performing pulp capping procedures, 2) packing and carving of amalgam restorations, 3) placing and shaping composite resin restorations with a slow speed handpiece, 4) taking final impressions, 5) use of a non-epinephrine retraction cord, and 6) final cementation of crowns and bridges after adjustment and fitting by the dentist.

Registration of dental assistants II became effective in 2011, yet only 26 persons are currently registered as a dental assistant II.[2] For several years, the Board has discussed the need to re-examine the requirements to determine whether they could be made less burdensome. In this action, the Board proposes amendments in order to reduce the burden of becoming a dental assistant II in order to encourage more participation, while ensuring that registrants are qualified to provide the associated services.

Under both the current and proposed regulations, there are three types of required training: 1) didactic course work, 2) laboratory training, and 3) clinical experience. The current regulation requires at least 50 hours of didactic course work on dental anatomy and operative dentistry. The proposed regulation does not specify number of hours; instead, topics to be covered within dental anatomy and operative dentistry are listed. Education programs may cover these topics in significantly fewer than 50 hours.

There are three separate modules within laboratory training for both the current and proposed regulations. The Board proposes greatly reduced minimum number of hours for all three modules, while adding specific demonstrations of competency on a manikin in each module.[3] Clinical experience has the same three modules. The Board again proposes greatly reduced minimum number of hours for all three modules. Here the Board proposes to add specific demonstrations of competency on a live patient for each module.[4] In this way, students who are quick learners or who come into the program with some relevant skills may complete laboratory training and clinical experience much more quickly and potentially at lower cost.

There is currently only one active dental assistant II program in the Commonwealth, which is at Germanna Community

College. Under the requirements of the current regulation, there are four courses with the following costs:

Oral Anatomy and Operative Dentistry	$750.00
Module 1: Amalgam Restorations: Placing, Packing, Carving, & Polishing (includes lab & clinical)	$491.25
Module 2: Composite Resin Restorations: Placing & Shaping (includes lab & clinical)	$491.25
Module 3: Indirect Restoration Techniques (includes lab & clinical)	$491.25

Oral Anatomy and Operative Dentistry is mandatory for all students. Students can choose between taking one or two of the modules, or all three. Once registered, they would only be permitted to perform procedures in the modules that they have successfully completed and demonstrated competency.

According to DHP, Germanna and other educational institutions that have indicated interest in starting a dental assistant II program have indicated that they could offer the program at lower cost than under the proposed regulation. Demonstrations of competency would likely produce at least as much assurance of patient safety as greater required hours of training without such specific demonstrations of competency. Thus, the proposed amendments would likely produce net benefits for the Commonwealth.

Businesses and Entities Affected. The proposed amendments potentially affect the one community college that currently has a dental assistant II program (Germanna Community College), and other educational institutions that may wish to establish dental assistant II programs. According to DHP, Fortis College, J. Sargeant Reynolds Community College, and ECPI University have all expressed interest. The proposed amendments also potentially affect the 3,260 dental offices[5] in the Commonwealth, as well as dental assistants and other staff in those offices.

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

Projected Impact on Employment. The proposed amendments may encourage more individuals to seek to become trained and employed as a dental assistant II. This potential increase in demand may lead to the establishment of dental assistant II education programs, with commensurate increase in employed staff.

Effects on the Use and Value of Private Property. The proposed amendments are unlikely to significantly affect the use and value of private property.

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 are unlikely to 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.

Localities. The proposed amendments do not adversely affect localities.

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

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[2]Source: Department of Health Professions

[3]See 18VAC60-30-120 B 3 in the proposed regulation for the specific changes: https://townhall.virginia.gov/l/ViewXML.cfm?textid=13137

[4]See 18VAC60-30-120 B 4 in the proposed regulation for the specific changes: https://townhall.virginia.gov/l/ViewXML.cfm?textid=13137

[5]Data source: Virginia Employment Commission

Agency's Response to Economic Impact Analysis: The Board of Dentistry concurs with the economic impact analysis of the Department of Planning and Budget.

Summary:

The proposed action changes the qualifications for registration as a dental assistant II from a program of completion of required hours to a competency-based program of didactic coursework and clinical experience.

18VAC60-30-60. Delegation to dental assistants II.

~~The following duties~~ Duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in 18VAC60-30-120~~:~~.

~~1. Performing pulp capping procedures;~~

~~2. Packing and carving of amalgam restorations;~~

~~3. Placing and shaping composite resin restorations with a slow speed handpiece;~~

~~4. Taking final impressions;~~

~~5. Use of a non-epinephrine retraction cord; and~~

~~6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.~~

18VAC60-30-116. Requirements for educational programs.

In order to train persons for registration as a dental assistant II, an educational program shall meet the following requirements:

1. The program shall be provided by an educational institution that maintains a program accredited by the Commission on Dental Accreditation of the American Dental Association.

2. The program shall have a program coordinator who is registered in Virginia as a dental assistant II or is licensed in Virginia as a dental hygienist or dentist. The program coordinator shall have administrative responsibility and accountability for operation of the program.

3. The program shall have a clinical practice advisor who is a licensed dentist in Virginia and who may also serve as the program coordinator. The clinical practice advisor shall assist in the laboratory training component of the program and conduct the program's calibration exercise for dentists who supervise the student's clinical experience.

4. A dental assistant II, registered in Virginia, who assists in teaching the laboratory training component of the program shall have a minimum of two years of clinical experience in performing duties delegable to a dental assistant II.

5. The program shall enter into a participation agreement with any dentist who agrees to supervise clinical experience. The dentist shall successfully complete the program's calibration exercise on evaluating the clinical skills of a student. The dentist supervisor may be the employer of the student.

6. Each program shall enroll practice sites for clinical experience, which may be a dental office, a nonprofit dental clinic, or an educational institution clinic.

7. All treatment of patients shall be under the immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to the successful completion of the clinical competencies and restorative experiences.

18VAC60-30-120. Educational requirements for dental assistants II.

A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board.

B. To be registered as a dental assistant II, a person shall complete ~~the following requirements~~ a competency-based program from an educational institution that ~~maintains a program in dental assisting, dental hygiene or dentistry accredited by CODA~~ meets the requirements of 18VAC60-30-116 and includes all of the following:

1. ~~At least 50 hours of didactic course work~~ Didactic coursework in dental anatomy ~~and operative dentistry that may be completed online~~ that includes basic histology, understanding of the periodontium and temporal mandibular joint, pulp tissue and nerve innervation, occlusion and function, muscles of mastication, and any other item related to the restorative dental process.

2. Didactic coursework in operative dentistry to include materials used in direct and indirect restorative techniques, economy of motion, fulcrum techniques, tooth preparations, etch and bonding techniques and systems, and luting agents.

3. Laboratory training ~~that may~~ to be completed in the following modules ~~with no more than 20% of the specified instruction to be completed as homework in a dental office~~:

a. ~~At least 40~~ No less than 15 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures and no less than six class I and six class II restorations completed on a manikin simulator to competency;

b. ~~At least 60~~ No less than 40 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures,and no less than 12 class I, 12 class II, five class III, five class IV, and five class V restorations completed on a manikin simulator to competency; and

c. At least ~~20~~ 10 hours of ~~taking~~ making final impressions ~~and use~~, placement of a non-epinephrine retraction cord~~; and~~, final cementation of crowns and bridges after preparation, and adjustment and fitting by the dentist, and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a manikin simulator to competency.

~~d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.~~

~~3.~~ 4. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training ~~that may be completed in a dental office,~~ in the following modules:

a. At least ~~80~~ 30 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and no less than six class I and six class II restorations completed on a live patient to competency;

b. At least ~~120~~ 60 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and no less than six class I, six class II, five class III, three class IV, and five class V restorations completed on a live patient to competency; and

c. At least ~~40~~ 30 hours of ~~taking~~ making final impressions ~~and use~~; placement of ~~a~~ non-epinephrine retraction cord; ~~and~~ final cementation of crowns and bridges after preparation, adjustment, and fitting by the dentist; and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a live patient to competency.

~~d. At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.~~

~~4.~~ 5. Successful completion of the following competency examinations given by the accredited educational programs:

a. A written examination at the conclusion ~~of the 50 hours~~ of didactic coursework; and

b. A ~~practical examination at the conclusion of each module of laboratory training; and~~

~~c. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules~~ clinical competency exam.

C. ~~All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.~~ An applicant may be registered as a dental assistant II with specified competencies set forth in subdivision a, b, or c of subdivisions B 3 and B 4 of this section.

VA.R. Doc. No. R18-5287; Filed December 17, 2019, 4:35 p.m.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Proposed Regulation

Title of Regulation: **18VAC65-20. Regulations of the Board of Funeral Directors and Embalmers (amending 18VAC65-20-10, 18VAC65-20-50, 18VAC65-20-60, 18VAC65-20-70, 18VAC65-20-130, 18VAC65-20-151, 18VAC65-20-152, 18VAC65-20-153, 18VAC65-20-154, 18VAC65-20-170, 18VAC65-20-171, 18VAC65-20-240, 18VAC65-20-400, 18VAC65-20-435, 18VAC65-20-436, 18VAC65-20-440, 18VAC65-20-500, 18VAC65-20-510, 18VAC65-20-580, 18VAC65-20-700).**

Statutory Authority: §§ 54.1-2400 and 54.1-2803 of the Code of Virginia.

Public Hearing Information:

January 14, 2020 - 10 a.m. - Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Suite 201, Board Room 4, Henrico, Virginia.

March 10, 2020 - 9:45 a.m. - Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Suite 201, Training Room 2, Henrico, Virginia.

Public Comment Deadline: March 20, 2020.

Agency Contact: Corie Tillman Wolf, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4479, FAX (804) 527-4471, or email fanbd@dhp.virginia.gov.

Basis: Regulations of the Board of Funeral Directors and Embalmersare promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the board with authority to promulgate regulations to administer the regulatory system. Section 54.1-2803 of the Code of Virginia provides the specific powers and duties of board.

Purpose: The purpose of this regulatory action is to provide clear, enforceable provisions. Both the licensees and the public need clarity on these matters so that public health and safety is not jeopardized.

Substance: The board is amending its regulations governing the practice of funeral services by clarifying certain provisions, updating provisions, and strengthening rules for surface transportation and removal and courtesy cards.

Changes include a new definition for "affiliation" of a branch to the main establishment, an allowance for newly licensed persons to be exempt from continuing education for the first renewal, an allowance for a funeral establishment experiencing an emergency to utilize the building in another establishment until restoration, a requirement for a registered surface transportation and removal service to hold liability insurance, an allowance for a crematory to test operation of a retort before it is registered, and establishment of grounds for disciplinary action in the case of an inappropriate sexual relationship between a supervisor and funeral intern.

Issues: The primary advantage of the amendments to the public is assurance of proper care of the human remains of loved ones and retention of important documents in event of a change of ownership. There are no disadvantages to the public. The only advantage to the Commonwealth is more clarity in regulation, which will assist the board in interpretation of the law. There are no disadvantages to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Funeral Directors and Embalmers (Board) proposes

to amend 18VAC65-20 Regulations of the Board of Funeral Directors and Embalmers in order to implement the results of a periodic review. Accordingly, the Board proposes to make a number of changes to the regulation, the majority of which serve to clarify or update existing requirements. Examples of such changes include: allowing the board to send renewal notices electronically, defining "affiliation" as it applies to branches or chapels that may be affiliated with a funeral home, moving information on renewal fees and late fees from the text to the table that contains the overall fee structure that is in the current regulation, and adding "inappropriate sexual contact" between a supervisor and an intern to the list of practices that are considered unprofessional conduct. The following section summarizes the more substantive changes.

Background. The proposed amendments were developed as part of a periodic review completed in 2018, and thus affect almost all aspects of service provision. The most substantive changes are briefly summarized below:

1. Providers of Surface Transport and Removal (ST&R) services would be required to inform the Board within 14 days (rather than 30) if the manager of record has changed. This would make the requirements consistent with the requirements for managers of record at funeral establishments and crematories (18VAC65-20-60 Accuracy of information).

2. Providers of ST&R services would be required to provide proof of bonding or liability insurance coverage related to the operation of the service (18VAC65-20-400 Registration of surface transportation and removal services).

3. Courtesy card holders would be explicitly prohibited from "establishing or engaging generally in the business of funeral directing and embalming in Virginia" (18VAC65-20-440 Courtesy Cards). The courtesy card is intended to allow limited practice (removal, arranging, embalming) in occasional circumstances, but not general practice in Virginia. Such circumstances typically arise when a death occurs in Virginia but the family of the deceased is in another state and wishes to hire funeral director who is familiar to them from that state.

4. In order to renew a courtesy card, the courtesy card holder would be required to provide evidence of an active and unrestricted license for funeral service, funeral directing, or embalming from the licensing authorities in the state in which they practice (18VAC65-20-130 Renewal of license; registration). While these requirements are already in place for first-time courtesy card applicants, renewal applicants are currently only required to submit a form and a fee.

5. Licensees applying for their first renewal would now be exempt from the continuing education requirements (18VAC65-20-151 Continued competency requirements for renewal of an active license).

6. In the event of an emergency that prevents the use of a funeral establishment the impacted service providers may receive approval from the Board to continue to operate out of another licensed funeral establishment for up to 60 days, with a 30-day extension if they show good cause (18VAC65-20-170 Requirements for an establishment license). Although the Board previously allowed this as a hardship waiver, the proposed addition of this provision to the regulations would allow small or independent funeral homes that don't have branches or affiliates to plan for contingencies that might require evacuating the establishment for an extended period of time.

7. Applicants for funeral service licensure by examination were previously required to submit an application package at least 30 days prior to the date of a state examination, and could have provided unofficial mortuary school transcripts in their applications. However, the state examination is now computerized, so the proposed amendment would remove the 30-day requirement and specifically require official transcripts (18VAC65-20-240 Requirements for funeral service licensure by examination).

8. In instances where the funeral establishment is sold, and when transferred documents include preneed contracts, the new owner would be required to retain and maintain those documents in accordance with the existing regulations that currently apply to price lists, itemized statements, and embalming reports (18VAC65-20-700 Retention of Documents).

Estimated Benefits and Costs. In general, the proposed amendments add clarity to a number of current requirements, which is likely to benefit regulants and consumers. According to the Department of Health Professions, items 1 and 2 relating to ST&R services have been promulgated in response to specific incidents that had been reported to the Board where customers have been "left high and dry" without a registered ST&R provider and/or suffered delays. Requiring ST&R businesses to report updated information regarding the manager of record may help the Board respond to such situations in a timely manner.

However, greater consumer protection also incurs certain costs. For any ST&R service providers that may have found it profitable to operate without liability insurance, the proposed requirement is clearly costly. Such firms may be able to absorb the costs, pass them on to customers, or may have to exit the industry depending on their size, the competition they face, and whether or not they already have liability insurance. Smaller providers that find it prohibitively expensive to acquire liability insurance may also have been less likely to implement all of the necessary safety precautions for transporting human remains. On the other hand, providers

who newly acquire liability insurance as a result of this proposal and remain in business may pass along their additional costs to their customers. Hence, consumers may face a mix of costs and benefits depending on the providers in their local market.

Although obtaining liability insurance could impose a cost to ST&R services as discussed, it appears that most funeral establishments already require evidence of liability insurance when contracting with ST&R service providers. The Department of Planning and Budget contacted two small, family-owned Virginia licensed ST&R companies during its review. Both companies stated that they currently maintain liability insurance, and that it is required by the funeral homes that they work with. To the extent that surviving individuals or families directly contract with ST&R companies, it is possible that they did not inquire about or require liability insurance. The proposal to require liability insurance may thus be beneficial for such individuals or families.

Items 3 and 4 relating to courtesy card holders could potentially limit operations in the state by those without a Virginia license, to the extent that courtesy card holders were previously operating with a lapsed or restricted license, or exceeding the privileges afforded to them by the card. At the same time, items 5 and 7, related to first-time license applicants and first-time renewals respectively, make the requirements more flexible, thereby marginally benefiting individuals wishing to obtain a Virginia license. This is likely to benefit current (1,463) and future funeral service licensees and the customers they serve.

Items 6 and 8 potentially benefit small and independent funeral establishments, including crematoriums. Larger funeral service providers with multiple branches and facilities may have been able to respond to a flood or fire by relocating any remains and scheduled funerals within their service network at fairly short notice. However, smaller establishments with a single location would normally stand to lose business to a competitor. The ability to plan for such emergencies and contract with other establishments to use their facility enables the independent facilities to keep their customers and honor their contracts. Similarly, the provision that the new owners of a funeral services business maintain preneed contracts could be used to encourage individuals and families to enter into preneed contracts with small independent funeral homes without worrying about whether those establishments will still be in business when their services become necessary. This in turn could benefit the smaller providers by allowing them to "lock in" some future demand for their services.

Businesses and Other Entities Affected. The proposed amendments affect 420 licensed funeral establishments and 79 licensed branch establishments, 110 courtesy card holders who are licensed in another jurisdiction, 44 registered ST&R services, 115 registered crematories, and 1,463 funeral service licensees with current active licenses.

Localities[2] Affected.[3] The proposed amendments do not introduce new costs for local governments and are unlikely to affect any locality in particular, assuming all localities have at least one funeral services establishment.

Projected Impact on Employment. The proposed amendments are unlikely to affect total employment in the industry. Even if some businesses may face new costs, the demand for funeral services as a whole is unlikely to respond to a marginal change in prices, which insulates workers in the funeral services industry.

Effects on the Use and Value of Private Property. The value of small, independent funeral establishments could potentially increase if the proposed changes have the effect of encouraging planning for emergencies and preneed contracts. The proposal to require liability insurance for ST&R companies may reduce the value of any such firms that did not already have liability insurance. Real estate development costs are not affected.

Adverse Effect on Small Businesses:[4]

Types and Estimated Number of Small Businesses Affected. The proposed amendments affect 420 licensed funeral establishments and 79 licensed branch establishments, 44 registered ST&R services and 115 registered crematories. However, the Board has no estimate of the number of small businesses affected. It is likely that most individual establishments and branch establishments would meet the criteria to be a small business. However, some of these establishments may be owned by large national companies.

Costs and Other Effects. ST&R companies that are small businesses and did not previously have liability insurance could be adversely affected by the new requirement but only to the extent that they are unable to pass on these costs to their customers.

Small independent funeral establishments stand to potentially benefit from proposed provisions that encourage emergency planning and signing preneed contracts.

Alternative Method that Minimizes Adverse Impact. There is no alternative that would meet policy goals and have lower adverse impact.

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[2]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[3]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[4]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."

Agency's Response to Economic Impact Analysis: The Board of Funeral Directors and Embalmers concurs with the Analysis of the Department of Planning and Budget.

Summary:

The proposed amendments clarify and update provisions and include (i) a new definition for "affiliation" of a branch to the main establishment, (ii) an allowance for newly licensed persons to be exempt from continuing education for the first renewal, (iii) an allowance for a funeral establishment experiencing an emergency to utilize the building in another establishment until restoration, (iv) a requirement for a registered surface transportation and removal service to hold liability insurance, (v) an allowance for a crematory to test operation of a retort before it is registered, and (vi) establishment of grounds for disciplinary action in the case of an inappropriate sexual relationship between a supervisor and funeral intern.

CHAPTER 20
REGULATIONS GOVERNING THE PRACTICE OF ~~THE BOARD OF~~ FUNERAL ~~DIRECTORS AND EMBALMERS~~ SERVICES

Part I
General Provisions

18VAC65-20-10. Definitions.

Words and terms used in this chapter shall have the definitions ascribed in § 54.1-2800 of the Code of Virginia or in 16 CFR Part 453, Funeral Industry Practices, of the Federal Trade Commission, which is incorporated by reference in this chapter. In addition, the following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Affiliation" or "affiliated" means a relationship involving a degree of common or subsidiary ownership between two establishments or entities.

"Branch" or "chapel" means a funeral service establishment that is affiliated with a licensed main establishment and that conforms with the requirements of § 54.1-2811 of the Code of Virginia.

"Courtesy card" means the card issued by the board ~~which~~ that grants limited and restricted funeral service privileges in the Commonwealth to out-of-state funeral service licensees, funeral directors, and embalmers.

"Cremation container" means a container in which human remains are transported to the crematory and placed in the retort for cremation.

"Cremation urn" means a wood, metal, stone, plastic, or composition container or a container of other material, which is designed for encasing cremated ashes.

"Cremation vault" or "cremation outer burial container" means any container that is designed for encasement of an inner container or urn containing cremated ashes. Also known as a cremation box.

"FTC" means the Federal Trade Commission.

"Manager of record" means a funeral service licensee or licensed funeral director who is responsible for the direct supervision and management of a funeral service establishment or branch facility.

18VAC65-20-50. Posting of license.

A. Each licensee shall post an original or photocopy of his license in a place conspicuous to consumers of funeral services in each establishment or branch where he ~~is employed~~ practices.

B. The establishment license shall be posted in a place conspicuous to consumers of funeral services.

18VAC65-20-60. Accuracy of information.

A. All changes in the address of record or the public address, if different from the address of record, or in the name of a licensee or registrant shall be furnished to the board within 30 days after the change occurs.

B. Any change in ownership or manager of record for an establishment or crematory shall be reported to the board within 14 days of the change.

C. A surface transportation and removal service shall notify the board within ~~30~~ 14 days of any change in the name of the manager ~~on~~ of record with the board.

D. All notices required by law and by this chapter to be ~~mailed~~ provided by the board to any registrant or licensee shall be validly given when mailed to the latest address of record on file with the board and shall not relieve the licensee, funeral service intern, establishment, crematory, or firm of obligation to comply. Renewal notices may be mailed or sent electronically by the board.

18VAC65-20-70. Required fees.

A. The following fees shall apply for initial licensure or registration:

1. License to practice funeral service or as a funeral director or an embalmer	$325
2. Funeral service establishment license	$600
3. Surface transportation and removal service registration	$325
4. Courtesy card	$325
5. Crematory	$250
6. Waiver of full-time manager requirement	$150

B. The following fees shall apply for renewal of licensure or registration:

1. License to practice funeral service or as a funeral director or an embalmer	$225
2. Funeral service establishment license	$400
3. Surface transportation and removal service registration	$300
4. Courtesy card	$300
5. Crematory	$200
6. Waiver of full-time manager requirement	$100
7. Inactive funeral service, funeral director, or embalmer license	$115

C. The following fees shall apply for late renewal of licensure or registration up to one year following expiration:

1. License to practice funeral service or as a funeral director or an embalmer	$75
2. Funeral service establishment license	$135
3. Surface transportation and removal service registration	$100
4. Courtesy card	$100
5. Crematory	$75
6. Waiver of full-time manager requirement	$35
7. Inactive funeral service, funeral director, or embalmer license	$40

D. The following fees shall apply for reinstatement of licensure or registration:

1. License to practice funeral service or as a funeral director or an embalmer	$400
2. Establishment license	$635
3. Surface transportation and removal service registration	$425
4. Courtesy card	$425
5. Crematory	$275
6. Reinstatement following suspension	$1,000
7. Reinstatement following revocation	$2,000

E. Other fees.

1. Change of manager or establishment name	$100
2. Verification of license or registration to another state	$50
3. Duplicate license, registration, or courtesy card	$25
4. Duplicate wall certificates	$60
5. Change of ownership	$100
6. Nonroutine reinspection (i.e., structural change to preparation room, change of location or ownership)	$400

F. Fees for approval of continuing education providers.

1. Application or renewal for continuing education provider	$400
2. Late renewal of continuing education provider approval	$100
3. Review of additional courses not included on initial or renewal application (per application for review of additional courses not per individual course)	$300

~~G. For each renewal in the two years after January 14, 2015, the following shortfall reduction fee shall be assessed:~~

~~1. License to practice funeral service or as a funeral director or an embalmer~~	~~$40~~
~~2. Funeral service establishment license~~	~~$75~~
~~3. Surface transportation and removal service registration~~	~~$60~~
~~4. Courtesy card~~	~~$60~~
~~5. Crematory~~	~~$40~~
~~6. Continuing education provider~~	~~$75~~

18VAC65-20-130. Renewal of license; registration.

A. A person, establishment, crematory, courtesy card holder, or surface transportation and removal service that desires to renew its license or registration for the next year shall, not later than the expiration date as provided in 18VAC65-20-120, submit the renewal form and applicable fee.

1. In order to renew an active funeral service, funeral director, or embalmer license, a licensee shall be required to comply with continuing competency requirements set forth in 18VAC65-20-151.

2. The board shall not renew a license for any licensee who fails to attest to compliance with continuing competency requirements on the renewal form.

3. In order to renew a courtesy card, the courtesy card holder shall provide documentation of current, unrestricted licensure for funeral service, funeral directing, or embalming from the licensing authority in the states in which the courtesy card holder is licensed to practice.

B. A person who or entity that desires to renew an expired license for up to one year following expiration shall comply with requirements of subsection A of this section and also submit the applicable fee for late renewal.

C. A person who or entity ~~which~~ that fails to renew a license, registration, or courtesy card by the expiration dates prescribed in 18VAC65-20-120 shall be deemed to have an invalid license, registration, or courtesy card and continued practice may subject the licensee to disciplinary action by the board.

18VAC65-20-151. Continued competency requirements for renewal of an active license.

A. Funeral service licensees, funeral directors, or funeral embalmers shall be required to have completed a minimum of five hours per year of continuing education offered by a board-approved sponsor for licensure renewal in courses that emphasize the ethics, standards of practice, preneed contracts, and funding, or federal or state laws and regulations governing the profession of funeral service.

1. One hour per year shall cover compliance with laws and regulations governing the profession, and at least one hour per year shall cover preneed funeral arrangements. The one-hour requirement on compliance with laws and regulations may be met once every two years by attendance at a meeting of the board or at a committee of the board or an informal conference or formal hearing.

2. One hour of the five hours required for annual renewal may be satisfied through delivery of professional services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for one hour of providing such volunteer services, as documented by the health department or free clinic. For the purposes of continuing education credit for volunteer service, an approved sponsor shall be a local health department or free clinic.

B. Courses must be directly related to the scope of practice of funeral service. Courses for which the principal purpose is to promote, sell, or offer goods, products, or services to funeral homes are not acceptable for the purpose of credit toward renewal.

C. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing education requirement.

D. The board may grant an exemption for all or part of the continuing education requirements for one renewal cycle due to circumstances determined by the board to be beyond the control of the licensee.

E. A licensee shall be exempt from the continuing education requirements for the first renewal following the date of initial licensure by examination in Virginia.

18VAC65-20-152. Continuing education providers.

A. Unless disqualified by action of the board, courses offered by the following providers are approved for continuing education credit:

1. Local, state, or federal government agencies;

2. Regionally accredited colleges and universities; or

3. Board-recognized national, regional, state, and local associations or organizations as follows:

a. National Funeral Directors Association and state chapters;

b. National Funeral Directors and Morticians Association and state chapters;

c. Association of Independent Funeral Homes of Virginia;

d. Cremation Association of North America;

e. American Board of Funeral Service Education;

f. International Conference of Funeral Service Examining Boards;

g. Virginia Morticians Association; and

h. Other similar associations or organizations as approved by action of the board.

B. Course providers not listed in subsection A of this section may apply for approval by the board as continuing education providers.

1. To be considered for board approval, a continuing education provider shall submit 60 days prior to offering a continuing education course:

a. Documentation of an instructional plan and course objectives for the continuing education ~~courses~~ course that ~~meet~~ meets the criteria set forth in 18VAC65-20-151 B;

b. A syllabus of the course ~~or courses~~ to be offered with the credentials of the course instructors, a description of each session, including number of continuing education hours; and

c. The continuing education provider fee set forth under 18VAC65-20-70.

2. Board approval of continuing education providers under this subsection shall expire on July 1 of each year and may be renewed upon resubmission of documentation on courses and instructors and the provider fee as required by the board.

3. ~~Continued~~ Renewed approval of a continuing education provider may be granted without submission of ~~the provider~~ an additional course review fee if the provider submits a statement that courses and instructors offered for the coming year will not change from the previous year. If there will be additions or alterations to the continuing education offerings of a provider, resubmission of course documentation and ~~a provider~~ an additional course review fee is required.

4. If additional courses are submitted for board approval beyond those courses submitted with an initial or renewal application, the continuing education provider shall remit the fee for review under 18VAC65-20-70.

C. Continuing education providers approved under subsection A or B of this section shall:

1. Maintain and provide to the board upon request documentation of the course titles and objectives and of licensee attendance and completion of courses for a period of two years;

2. Monitor attendance at classroom or similar educational experiences for compliance with law and regulations; and

3. Provide a certificate of completion for licensees who successfully complete a course.

18VAC65-20-153. Documenting compliance with continuing education requirements.

A. All licensees with active status are required to maintain original documentation of continuing education for a period of two years after the corresponding annual renewal period.

B. After the end of each renewal period, the board may conduct a random audit of licensees to verify compliance with the requirement for that renewal period.

C. Upon request, a licensee shall provide documentation within 14 days as follows:

1. Official transcripts showing credit hours earned from an accredited institution; or

2. Certificates of completion from approved providers.

D. Compliance with continuing education requirements, including the subject and purpose of the courses as prescribed in 18VAC65-20-151 B, the maintenance of records and the relevance of the courses to the category of licensure is the responsibility of the licensee. The board may request additional information if such compliance is not clear from the transcripts or certificates.

E. Continuing education hours required by disciplinary order shall not be used to satisfy renewal requirements.

18VAC65-20-154. Inactive license.

A. A funeral service licensee, a funeral director, or an embalmer who holds a current, unrestricted license in Virginia shall, upon a request for inactive status on the renewal application and submission of the required renewal fee ~~of $115~~, be issued an inactive license. ~~The fee for late renewal up to one year following expiration of an inactive license shall be $40.~~

1. An inactive licensee shall not be entitled to perform any act requiring a license to practice funeral service in Virginia.

2. The holder of an inactive license shall not be required to meet continuing education requirements, except as may be required for reactivation in subsection B of this section.

B. A funeral service licensee, a funeral director, or an embalmer who holds an inactive license may reactivate his license by:

1. Paying the difference between the renewal fee for an inactive license and that of an active license for the year in which the license is being reactivated; and

2. Providing proof of completion of the number of continuing competency hours required for the period in which the license has been inactive, not to exceed three years.

Part III
Requirements for Licensure

18VAC65-20-170. Requirements for an establishment license.

A. No person shall maintain, manage, or operate a funeral service establishment in the Commonwealth, unless such establishment holds a license issued by the board. The name of the funeral service licensee or licensed funeral director designated by the ownership to be manager of record for the establishment shall be included on the license.

B. Except as provided in § 54.1-2810 of the Code of Virginia, every funeral service establishment and every branch or chapel of such establishment, regardless of how owned, shall have a separate manager of record who has responsibility for the establishment as prescribed in 18VAC65-20-171. The owner of the establishment shall not abridge the authority of the manager of record relating to compliance with the laws governing the practice of funeral services and regulations of the board.

C. At least 30 days prior to opening an establishment, an owner or licensed manager seeking an establishment license shall submit simultaneously a completed application, any additional documentation as may be required by the board to determine eligibility, and the applicable fee. An incomplete package will be returned to the licensee. A license shall not be issued until an inspection of the establishment has been completed and approved.

D. Within 30 days following a change of ownership, the owner or licensed manager shall request a reinspection of the

establishment, submit an application for a new establishment license with documentation that identifies the new owner, and pay the licensure and reinspection fees as required by 18VAC65-20-70. Reinspection of the establishment may occur on a schedule determined by the board, but shall occur no later than one year from the date of the change.

E. The application for licensure of a branch or chapel shall specify the name of the main establishment and contain an attestation of the affiliation of the branch or chapel and the main establishment.

F. In the event of an emergency requiring the evacuation or discontinued use of a funeral establishment, the impacted establishment may be approved by the board to continue operations out of another licensed funeral establishment for a period of no more than 60 days. The impacted establishment may request an extension of emergency operations for an additional 30 days upon good cause shown. In requesting approval for conducting emergency operations under this section, the impacted funeral establishment shall submit documentation that identifies the manager of record for both the impacted establishment and establishment for emergency operations and any agreement for emergency usage.

18VAC65-20-171. Responsibilities of the manager of record.

A. Every funeral establishment shall have a manager of record who is employed full time by and in charge of the establishment.

B. The manager shall be fully accountable for the operation of the establishment as it pertains to the laws and regulations governing the practice of funeral services, to include ~~but not be limited to~~:

1. Maintenance of the facility within standards established in this chapter;

2. Retention of reports and documents as prescribed by the board in 18VAC65-20-700 during the period in which he serves as manager of record; ~~and~~

3. Reporting to the board of any changes in information as required by 18VAC65-20-60; and

4. Correcting or seeking corrections of any deficiencies identified during the course of an inspection of the establishment.

18VAC65-20-240. Requirements for funeral service licensure by examination.

A. Application requirements. ~~1.~~ Applicants shall submit official mortuary school transcripts and national examination board scores as part of an application package, including the required fee and any additional documentation as may be required to determine eligibility.

~~2. An individual applying for the state examination shall submit the application package not less than 30 days prior to an examination date. The board may, for good cause shown by the applicant, waive the time for the filing of any application.~~

B. National examination requirements. Prior to applying for licensure by examination, every applicant shall pass the National Board Examination of the International Conference of Funeral Service Examining Boards.

C. State examination requirements. All applicants shall pass the Virginia State Board Examination.

Part IV
Registration

18VAC65-20-400. Registration of surface transportation and removal services.

All persons applying to own or operate a surface transportation and removal service, according to requirements of § 54.1-2819 of the Code of Virginia, shall submit an application package for registration which shall include:

1. A completed and signed application;

2. The fee prescribed in 18VAC65-20-70 A 3;

3. Additional documentation as may be required by the board to determine eligibility of the applicant, including~~, but not limited to,~~ evidence of training of the service manager and staff in compliance with standards of the Occupational Safety and Health Administration (OSHA) for universal precautions and ~~blood-borne~~ bloodborne pathogens, and proof of bonding or liability insurance coverage related to the operation of the service; and

4. The name of the manager for the service.

18VAC65-20-435. Registration of crematories.

A. At least 30 days prior to opening a crematory, any person intending to own or operate a crematory shall apply for registration with the board by submitting a completed application and fee as prescribed in 18VAC65-20-70. The name of the individual designated by the ownership to be the crematory manager shall be included on the application. The owner of the crematory shall not abridge the authority of the crematory manager relating to compliance with the laws governing the practice of funeral services and regulations of the board. The designated crematory manager may be the manager of record of a funeral establishment colocated on the same premises.

B. Every crematory, regardless of how owned, shall have a manager who has (i) achieved certification by the Cremation Association of North America (CANA); the International Cemetery, Cremation and Funeral Association (ICCFA); or other certification recognized by the board and (ii) received training in compliance with standards of the Occupational

Health and Safety Administration (OSHA) for universal precautions and ~~blood-borne~~ bloodborne pathogens.

C. The manager shall be fully accountable for the operation of the crematory as it pertains to the laws and regulations governing the practice of funeral services, to include but not be limited to:

1. Maintenance of the facility within standards established in this chapter;

2. Retention of reports and documents as prescribed by the board in 18VAC65-20-436 during the period in which he serves as crematory manager; and

3. Reporting to the board of any changes in information as required by 18VAC65-20-60.

D. All persons who operate the retort in a crematory shall have certification by the Cremation Association of North America (CANA); the International Cemetery, Cremation and Funeral Association (ICCFA); or other certification recognized by the board. Persons receiving training toward certification to operate a retort shall be allowed to work under the supervision of an operator who holds certification for a period not to exceed six months.

E. A crematory providing cremation services directly to the public shall also be licensed as a funeral service establishment or shall be a branch of a licensed establishment.

F. When a crematory application is pending and the conduct of a cremation is necessary to ensure the proper function of retort equipment, the board may authorize the crematory to conduct a test cremation prior to registration. Once the crematory equipment is deemed functional and an initial crematory inspection is completed, the board may issue the crematory a registration to operate.

G. The board may take disciplinary action against a crematory registration for a violation of § 54.1-2818.1 of the Code of Virginia or for the inappropriate handling of dead human bodies or cremains.

18VAC65-20-436. Standards for registered crematories or funeral establishments relating to cremation.

A. Authorization to cremate.

1. A crematory shall require a cremation authorization form executed in person or electronically in a manner that provides a copy of an original signature in accordance with § 54.1-2818.1 of the Code of Virginia.

2. The cremation authorization form shall include an attestation of visual identification of the deceased from a viewing of the remains or a photograph of the remains signed by the person making the identification. Visual identification may be made by viewing unique identifiers or markings on the remains. The identification attestation shall either be given on the cremation authorization form or on an identification form attached to the cremation authorization form.

3. In the event visual identification is not feasible, a crematory may use other positive identification of the deceased in consultation with law enforcement, a medical examiner, or medical personnel as a prerequisite for cremation pursuant to § 54.1-2818.1 of the Code of Virginia.

B. Standards for cremation. The following standards shall be required for every crematory:

1. Every crematory shall provide evidence at the time of an inspection of a permit to operate issued by the Department of Environmental Quality (DEQ).

2. A crematory shall not knowingly cremate a body with a pacemaker, defibrillator, or other potentially hazardous implant in place.

3. A crematory shall not cremate the human remains of more than one person simultaneously in the same chamber of the retort or cremation unit, unless the crematory has received specific written authorization to do so from the person signing the cremation authorization form.

4. A crematory shall not cremate nonhuman remains in a retort permitted by DEQ for cremation of human remains.

5. Whenever a crematory is unable to cremate the remains within 24 hours upon taking custody thereof, the crematory shall maintain the remains in refrigeration at approximately 40° Fahrenheit or less, unless the remains have been embalmed.

C. Handling of human remains.

1. Human remains shall be transported to a crematory in a cremation container and shall not be removed from the container unless the crematory has been provided with written instructions to the contrary by the person who signed the authorization form. A cremation container shall substantially meet all the following standards:

a. Be composed of readily combustible materials suitable for cremation;

b. Be able to be closed in order to provide complete covering for the human remains;

c. Be resistant to leakage or spillage; and

d. Be rigid enough for handling with ease.

2. No crematory shall require that human remains be placed in a casket before cremation nor shall it require that the cremains be placed in a cremation urn, cremation vault, or receptacle designed to permanently encase the cremains after cremation. Cremated remains shall be placed in a plastic bag inside a rigid container provided by the crematory or by the ~~next of kin~~ next of kin for return to the

funeral establishment or to the ~~next-of-kin~~ next of kin. If cremated remains are placed in a biodegradable container, a biodegradable bag shall be used. If placed in a container designed for scattering, the cremated remains may be placed directly into the container if the ~~next-of-kin~~ next of kin so authorized in writing.

3. The identification of the decedent shall be physically attached to the remains, and appropriate identification placed on the exterior of the cremation container. The crematory operator shall verify the identification on the remains with the identification attached to the cremation container and with the identification attached to the cremation authorization. The crematory operator shall also verify the identification of the cremains and place evidence of such verification in the cremation record.

D. Recordkeeping. A crematory shall maintain the records of cremation for a period of three years from the date of the cremation that indicate the name of the decedent, the date and time of the receipt of the body, and the date and time of the cremation and shall include:

1. The cremation authorization form signed by the person authorized by law to dispose of the remains and the form on which the ~~next-of-kin~~ next of kin or the person authorized by § 54.1-2818.1 of the Code of Virginia to make the identification has made a visual identification of the deceased or evidence of positive identification if visual identification is not feasible;

2. The permission form from the medical examiner;

3. The DEQ permit number of the retort used for the cremation and the name of the retort operator; and

4. The form verifying the release of the cremains, including date and time of release, the name of the person and the entity to whom the cremains were released, and the name of the decedent.

Part V
Issuance of Courtesy Cards

18VAC65-20-440. Courtesy cards.

A. An out-of-state person applying for a courtesy card pursuant to § 54.1-2801 B of the Code of Virginia shall hold a valid license for funeral service, funeral directing, or embalming in another state, territory, or the District of Columbia.

B. An applicant for a courtesy card shall submit:

1. A completed application and prescribed fee; and

2. Verification of ~~a~~ current, unrestricted licensure for funeral service ~~license in good standing from the applicant's licensing authority~~, funeral directing, or embalming from the licensing authorities in the states in which the courtesy card holder is licensed to practice.

C. The holder of a Virginia courtesy card shall only engage in the practice for which he is currently licensed in another jurisdiction. The privilege to practice shall not include the right to establish or engage generally in the business of funeral directing and embalming in Virginia.

Part VI
Refusal, Suspension, Revocation, and Disciplinary Action

18VAC65-20-500. Disciplinary action.

In accordance with the provisions of § 54.1-2806 of the Code of Virginia, the following practices are considered unprofessional conduct and may subject the licensee to disciplinary action by the board:

1. Breach of confidence. The unnecessary or unwarranted disclosure of confidences by the funeral licensee.

2. Unfair competition.

a. Interference by a funeral service licensee, funeral director, or registered surface transportation and removal service when another has been called to take charge of a dead human body and the caller or agent of the caller has the legal right to the body's disposition.

b. Consent by a funeral service licensee or funeral director to take charge of a body unless authorized by the person or his agent having the legal right to disposition.

3. False advertising.

a. No licensee or registrant shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly to be made, an advertisement of any sort regarding services or anything so offered to the public ~~which~~ that contains any promise, assertion, representation, or statement of fact which is untrue, deceptive, or misleading.

b. The following practices, both written and verbal, shall constitute false, deceptive, or misleading advertisement within the meaning of subdivision 4 of § 54.1-2806 of the Code of Virginia:

(1) Advertising containing inaccurate statements; and

(2) Advertisement which gives a false impression as to ability, care, and cost of conducting a funeral, or that creates an impression of things not likely to be true.

c. The following practices are among those ~~which~~ that shall constitute an untrue, deceptive, and misleading representation or statement of fact:

(1) Representing that funeral goods or services will delay the natural decomposition of human remains for a long term or indefinite time; and

(2) Representing that funeral goods have protective features or will protect the body from gravesite

substances over or beyond that offered by the written warranty of the manufacturer.

4. Inappropriate handling and storage of dead human bodies, consistent with § 54.1-2811.1 of the Code of Virginia and regulations of the board. Transportation and removal vehicles shall be of such nature as to eliminate exposure of the deceased to the public during transportation. During the transporting of a human body, consideration shall be taken to avoid unnecessary delays or stops during travel.

5. Failure to furnish price information disclosing the cost to the purchaser for each of the specific funeral goods and funeral services used in connection with the disposition of deceased human bodies.

6. Conducting the practice of funeral services in such a manner as to constitute a danger to the health, safety, and well-being of the staff or the public.

7. Inability to practice with skill or safety because of physical, mental, or emotional illness, or substance abuse.

8. Failure to register as a supervisor for a funeral service intern or failure to provide reports to the board as required by the Code of Virginia and 18VAC65-40-320.

9. Failure to comply with applicable federal and state laws and regulations, including requirements for continuing education.

10. Inappropriate sexual contact between a supervisor and a funeral service intern if the sexual contact is a result of the exploitation of trust, knowledge, or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on the practice of funeral services or on intern training.

Part VII
Standards for Embalming and Refrigeration

18VAC65-20-510. Embalming.

A. In accordance with the provisions of subdivision 26 of § 54.1-2806 and subsection B of § 54.1-2811.1 of the Code of Virginia, express permission by a next of kin for embalming means written authorization to embalm as a specific and separate statement on a document or contract provided by the funeral establishment. Express permission may include direct, verbal authorization to embalm, provided it is followed as soon as possible by a written document or statement signed by the next of kin confirming the verbal authorization to embalm and including the time, date, and name of the person who gave verbal authorization.

B. Every funeral establishment shall record and maintain a separate, identifiable report for each embalming procedure conducted, which shall at a minimum include the following information:

1. The name of the deceased and the date of death;

2. The date and location of the embalming;

3. The name and signature of the embalmer and the Virginia license number of the embalmer; ~~and~~

4. If the embalming was performed by a funeral service intern, the name and signature of the supervisor; and

5. The name of each student and the signature of the supervisor of any mortuary science student who assisted in the embalming.

18VAC65-20-580. Preparation room equipment.

The preparation room or rooms shall be equipped with:

1. A ventilation system which operates and is appropriate to the size and function of the room;

2. Running hot and cold water;

3. Flush or slop sink connected with public sewer or with septic tank where no public sewer is available;

4. Metal, fiberglass, or porcelain morgue table;

5. Covered waste container;

6. Instruments and apparatus for the embalming process;

7. A means or method for the sterilization or disinfection of reusable instruments by chemical bath or soak; autoclave (steam); or ultraviolet light;

8. Disinfectants and antiseptic solutions;

9. Clean gowns or aprons, preferably impervious to water;

10. Rubber gloves for each embalmer ~~or,~~ intern, or student using the room;

11. An electric aspirator or hydroaspirator equipped with a vacuum breaker;

12. An eye wash station that is readily accessible; and

13. A standard first aid kit, ~~which~~ that is immediately accessible, either in the preparation room or outside the door to the preparation room.

18VAC65-20-700. Retention of documents.

A. The following retention schedule shall apply:

1. Price lists shall be retained for three years after the date on which they are no longer effective;

2. Itemized statements shall be retained for three years from the date on which the arrangements were made; and

3. Embalming reports shall be retained at the location of the embalming for three years after the date of the embalming.

B. The manager of record shall be responsible for retention and maintenance of all required documents.

C. Documents shall be maintained on the premises of the funeral establishment and made available for inspection.

D. In instances where the funeral establishment is sold, documents shall be transferred to the new owner, unless the existing firm is relocating to a new facility. The new owner shall retain transferred documents in accordance with the provisions of this section. When transferred documents include preneed contracts, the documents shall be retained and maintained in accordance with the provisions of the Code of Virginia and regulations of the board.

VA.R. Doc. No. R19-5988; Filed December 19, 2019, 4:47 p.m.

Fast-Track Regulation

Titles of Regulations: **18VAC65-20. Regulations of the Board of Funeral Directors and Embalmers (amending 18VAC65-20-110).**

18VAC65-40. Regulations for the Funeral Service Internship Program (amending 18VAC65-40-40).

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

Agency Contact: Corie Tillman Wolf, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4479, FAX (804) 527-4471, or email fanbd@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Funeral Directors and Embalers the authority to promulgate regulations to administer the regulatory system. The specific mandate for collection of a handling fee is found in § 2.2-4805 of the Virginia Debt Collection Act

Purpose: The rationale for the regulatory change is compliance with the Virginia Debt Collection Act (§ 2.2-4800 et seq.) of the Code of Virginia, in which the General Assembly has determined that the cost for handling returned checks or dishonored credit or debit cards is $50. The department and its regulatory boards license and discipline health care practitioners, and its mission of protecting the health and safety of the public must be supported by its licensing and miscellaneous fees.

Rationale for Using Fast-Track Rulemaking Process: The rulemaking is concurring with financial policy of the Commonwealth and is expected to be noncontroversial.

Substance: All board regulations are being amended to delete the returned check fee of $35 and replace it with a handling fee of $50 for a returned check, dishonored credit card, or dishonored debit card.

Issues: There are no primary advantages or disadvantages to the public. The primary advantage to the department is compliance with auditors from the Office of the Comptroller. There are no disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Funeral Directors and Embalmers (Board) proposes to amend 18VAC65-20 Regulations of the Board of Funeral Directors and Embalmers and 18VAC65-40 Regulations for the Funeral Service Internship Program to state that the handling fee for a returned check or dishonored credit card or debit card is $50, replacing a current $35 charge.

Background. Code of Virginia § 2.2-614.1 specifies that:

> If any check or other means of payment tendered to a public body in the course of its duties is not paid by the financial institution on which it is drawn, because of insufficient funds in the account of the drawer, no account is in the name of the drawer, or the account of the drawer is closed, and the check or other means of payment is returned to the public body unpaid, the amount thereof shall be charged to the person on whose account it was received, and his liability and that of his sureties, shall be as if he had never offered any such payment. A penalty of $35 or the amount of any costs, whichever is greater, shall be added to such amount.

Based on this Code provision, the current regulations include a $35 returned check charge.

On the other hand, § 2.2-4805 of the Code of Virginia specifies that "Returned checks or dishonored credit card or debit card payments shall incur a handling fee of $50 unless a higher amount is authorized by statute to be added to the principal account balance." According to the Department of Health Professions (DHP), the Office of the Attorney General has advised that the handling fee of $50 in § 2.2-4805 of the Code of Virginia governs.

Estimated Benefits and Costs. Based on the view of the Office of the Attorney General that § 2.2-4805 of the Code of Virginia prevails, the fee by law for a returned check or dishonored credit card or debit card is $50. The Board's proposal therefore conforms the regulation to current law. DHP has indicated that in practice they will continue to charge the $35 fee until this proposed regulatory action becomes effective. The services provided by DHP are funded by the fees paid by the regulated individuals and entities. To the extent that the $50 fee more accurately represents the cost

incurred by DHP, the proposed change may be beneficial in that the cost would need not be subsidized by other regulants who did not cause the cost to be incurred.

Businesses and Other Entities Affected. The proposal pertains to fee-paying individuals and entities regulated by the Board. As of June 30, 2019, there were 14 continuing education providers, 109 courtesy card holders,[2] 115 crematories, 2 embalmers, 36 funeral directors, 419 funeral establishments, 186 funeral service interns, 1,516 funeral service licensees, 567 funeral supervisors, and 44 surface transport and removal service providers regulated by the Board. If any of these individuals or entities have a check returned or a credit card or debit card dishonored, the proposal would increase their cost by $15.

Localities[3] Affected.[4] The proposal does not disproportionately affect any particular localities or introduce costs for local governments.

Projected Impact on Employment. The proposal does not affect employment.

Effects on the Use and Value of Private Property. The proposal does not substantially affect the use and value of private property or real estate development costs.

Adverse Effect on Small Businesses[5]:

Types and Estimated Number of Small Businesses Affected. The proposal would potentially affect the 14 continuing education providers, 115 crematories, 419 funeral establishments, and 44 surface transport and removal service providers if they were to have a check returned or a credit card or debit card dishonored. Most of these entities would likely qualify as a small business.

Costs and Other Effects. If any of these entities were to have a check returned or a credit card or debit card dishonored, the proposal would increase their cost by $15.

Alternative Method that Minimizes Adverse Impact. There are no clear alternative methods that both reduce adverse impact and meet the intended policy goals.

[2]"Courtesy card" means the card issued by the Board which grants limited and restricted funeral service privileges in the Commonwealth to out-of-state funeral service licensees, funeral directors, and embalmers.

[3]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[4]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[5]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."

Agency's Response to Economic Impact Analysis: The Board of Funeral Directors and Embalmers concurs with the analysis of the Department of Planning and Budget.

Summary:

The amendments replace the returned check fee of $35 with a fee of $50 for handling a returned check or dishonored credit card or debit card payment in compliance with § 2.2-4805 of the Code of Virginia.

18VAC65-20-110. Additional fee information.

A. There shall be a handling fee of ~~$35~~ $50 for returned checks or dishonored credit cards or debit cards.

B. Fees shall not be refunded once submitted.

C. The fee for the Virginia State Board Examination shall be paid directly to the examination service contracted by the board for its administration.

18VAC65-40-40. Fees.

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

1. Funeral service intern registration	$150
2. Funeral service intern renewal	$125
3. Late fee for renewal up to one year after expiration	$45
4. Duplicate copy of intern registration	$25
5. ~~Returned check~~ Handling fee for returned check or dishonored credit card or debit card	~~$35~~ $50
6. Registration of supervisor	$35
7. Change of supervisor	$35
8. Reinstatement fee	$195

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

VA.R. Doc. No. R20-6174; Filed December 18, 2019, 7:36 a.m.

BOARD OF MEDICINE

Fast-Track Regulation

Titles of Regulations: **18VAC85-20. Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic (amending 18VAC85-20-22).**

18VAC85-40. Regulations Governing the Practice of Respiratory Therapists (amending 18VAC85-40-35).

18VAC85-50. Regulations Governing the Practice of Physician Assistants (amending 18VAC85-50-35).

18VAC85-80. Regulations Governing the Practice of Occupational Therapy (amending 18VAC85-80-26).

18VAC85-101. Regulations Governing the Practice of Radiologic Technology (amending 18VAC85-101-25).

18VAC85-110. Regulations Governing the Practice of Licensed Acupuncturists (amending 18VAC85-110-35).

18VAC85-120. Regulations Governing the Licensure of Athletic Trainers (amending 18VAC85-120-35).

18VAC85-130. Regulations Governing the Practice of Licensed Midwives (amending 18VAC85-130-30).

18VAC85-140. Regulations Governing the Practice of Polysomnographic Technologists (amending 18VAC85-140-40).

18VAC85-150. Regulations Governing the Practice of Behavior Analysis (amending 18VAC85-150-40).

18VAC85-160. Regulations Governing the Registration of Surgical Assistants and Surgical Technologists (amending 18VAC85-160-40).

18VAC85-170. Regulations Governing the Practice of Genetic Counselors (amending 18VAC85-170-40).

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

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.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system. The specific mandate for collection of a handling fee is found in § 2.2-4805 of the Virginia Debt Collection Act

Purpose: The rationale for the regulatory change is compliance with the Virginia Debt Collection Act (§ 2.2-4800 et seq.) of the Code of Virginia, in which the General Assembly has determined that the cost for handling returned checks or dishonored credit or debit cards is $50. The department and its regulatory boards license and discipline health care practitioners, and its mission of protecting the health and safety of the public must be supported by its licensing and miscellaneous fees.

Rationale for Using Fast-Track Rulemaking Process: The rulemaking is concurring with financial policy of the Commonwealth and is expected to be noncontroversial.

Substance: All board regulations are being amended to delete the returned check fee of $35 and replace it with a handling fee of $50 for a returned check, dishonored credit card, or dishonored debit card.

Issues: There are no primary advantages or disadvantages to the public. The primary advantage to the department is compliance with auditors from the Office of the Comptroller. There are no disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Medicine (Board) proposes to amend 12 regulations (see above) to state that the handling fee for a returned check or dishonored credit card or debit card is $50, replacing a current $35 charge.

Background. Code of Virginia § 2.2-614.1 specifies that:

> If any check or other means of payment tendered to a public body in the course of its duties is not paid by the financial institution on which it is drawn, because of insufficient funds in the account of the drawer, no account is in the name of the drawer, or the account of the drawer is closed, and the check or other means of payment is returned to the public body unpaid, the amount thereof shall be charged to the person on whose account it was received, and his liability and that of his sureties, shall be as if he had never offered any such payment. A penalty of $35 or the amount of any costs, whichever is greater, shall be added to such amount.

Based on this Code provision, the current regulations include a $35 returned check charge.

On the other hand, Code of Virginia § 2.2-4805 specifies that "Returned checks or dishonored credit card or debit card payments shall incur a handling fee of $50 unless a higher amount is authorized by statute to be added to the principal account balance." According to the Department of Health Professions (DHP), the Office of the Attorney General has advised that the handling fee of $50 in Virginia Code § 2.2-4805 governs.

Estimated Benefits and Costs. Based on the view of the Office of the Attorney General that Virginia Code § 2.2-4805 prevails, the fee by law for a returned check or dishonored credit card or debit card is $50. The Board's proposal therefore conforms the regulation to current law. DHP has indicated that in practice they will continue to charge the $35 fee until this proposed regulatory action becomes effective. The services provided by DHP are funded by the fees paid by the regulated individuals and entities. To the extent that the $50 fee more accurately represents the cost incurred by DHP, the proposed change may be beneficial in that the cost would need not be subsidized by other regulants who did not cause the cost to be incurred.

Businesses and Other Entities Affected. The proposal pertains to fee-paying individuals and entities regulated by the Board. As of June 30, 2019, there were 169 assistant behavior analysts, 1,692 athletic trainers, 1,220 behavior analysts, 1,763 chiropractors, 258 genetic counselors, 4,277 interns and residents, 548 licensed acupuncturists, 87 licensed midwives, 562 limited radiologic technologists, 38,227 medicine and surgery licensees, 4,422 occupational therapists, 1,633 occupational therapy assistants, 3,681 osteopathy and surgery licensees, 4,202 physician assistants, 545 podiatrists, 486 polysomnographic technologists, 4,413 radiologic technologists, 12 radiologist assistants, 3,961 respiratory therapists, 91 restricted volunteer-doctors, 256 surgical assistants, 289 surgical technologists, and 21 university limited licensees regulated by the Board.[2] If any of these individuals have a check returned or a credit card or debit card dishonored, the proposal would increase their cost by $15.

Localities[3] Affected.[4] The proposal does not disproportionately affect any particular localities or introduce costs for local governments.

Projected Impact on Employment. The proposal does not affect employment.

Effects on the Use and Value of Private Property. The proposal does not substantially affect the use and value of private property or real estate development costs.

Adverse Effect on Small Businesses.[5] The proposal does not substantively adversely affect small businesses.

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[2]Data source: DHP

[3]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[4]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[5]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."

Agency's Response to Economic Impact Analysis: The Board of Medicine concurs with the analysis of the Department of Planning and Budget.

Summary:

The amendments replace the returned check fee of $35 with a fee of $50 for handling a returned check or dishonored credit card or debit card payment in compliance with § 2.2-4805 of the Code of Virginia.

18VAC85-20-22. Required fees.

A. Unless otherwise provided, fees established by the board shall not be refundable.

B. All examination fees shall be determined by and made payable as designated by the board.

C. The application fee for licensure in medicine, osteopathic medicine, and podiatry shall be $302, and the fee for licensure in chiropractic shall be $277.

D. The fee for a temporary authorization to practice medicine pursuant to clauses (i) and (ii) of § 54.1-2927 B of the Code of Virginia shall be $25.

E. The application fee for a limited professorial or fellow license issued pursuant to 18VAC85-20-210 shall be $55. The annual renewal fee shall be $35. For renewal of a limited professorial or fellow license in 2020, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

F. The application fee for a limited license to interns and residents pursuant to 18VAC85-20-220 shall be $55. The annual renewal fee shall be $35. For renewal of a limited license to interns and residents in 2020, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

G. The fee for a duplicate wall certificate shall be $15. The fee for a duplicate license shall be $5.00.

H. The fee for biennial renewal shall be $337 for licensure in medicine, osteopathic medicine, and podiatry and $312 for licensure in chiropractic, due in each even-numbered year in the licensee's birth month. An additional fee for processing a late renewal application within one renewal cycle shall be $115 for licensure in medicine, osteopathic medicine, and podiatry and $105 for licensure in chiropractic. For renewal of licensure in 2020, the fee shall be $270 for licensure in medicine, osteopathic medicine, and podiatry and $250 for licensure in chiropractic.

I. The fee for requesting reinstatement of licensure or certification pursuant to § 54.1-2408.2 of the Code of Virginia or for requesting reinstatement after any petition to reinstate the certificate or license of any person has been denied shall be $2,000.

J. The fee for reinstatement of a license issued by the Board of Medicine pursuant to § 54.1-2904 of the Code of Virginia that has expired for a period of two years or more shall be $497 for licensure in medicine, osteopathic medicine, and podiatry ($382 for reinstatement application in addition to the late fee of $115) and $472 for licensure in chiropractic ($367 for reinstatement application in addition to the late fee of $105). The fee shall be submitted with an application for licensure reinstatement.

K. The fee for a letter of verification of licensure shall be $10, and the fee for certification of grades to another jurisdiction by the board shall be $25.

L. The fee for biennial renewal of an inactive license shall be $168, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $55 for each renewal

cycle. For renewal of an inactive license in 2020, the fee shall be $135.

M. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $75, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $25 for each renewal cycle. For renewal of a restricted volunteer license in 2020, the fee shall be $60.

N. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

18VAC85-40-35. Fees.

The following fees are required:

1. The application fee, payable at the time the application is filed, shall be $130.

2. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license holder's birth month. For 2021, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. The fee for reinstatement of a license issued by the Board of Medicine pursuant to § 54.1-2904 of the Code of Virginia, which has lapsed for a period of two years or more, shall be $180 and must be submitted with an application for licensure reinstatement.

5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

8. The fee for a letter of good standing or verification to another jurisdiction shall be $10. The fee for certification of grades to another jurisdiction shall be $25.

9. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

18VAC85-50-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The initial application fee for a license, payable at the time application is filed, shall be $130.

2. The biennial fee for renewal of an active license shall be $135 and for renewal of an inactive license shall be $70, payable in each odd-numbered year in the birth month of the licensee. For 2021, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. A restricted volunteer license shall expire 12 months from the date of issuance and may be renewed without charge by receipt of a renewal application that verifies that the physician assistant continues to comply with provisions of § 54.1-2951.3 of the Code of Virginia.

5. The fee for review and approval of a new protocol submitted following initial licensure shall be $15.

6. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

8. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

9. The fee for a letter of good standing or verification to another jurisdiction shall be $10.

10. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

18VAC85-80-26. Fees.

A. The following fees have been established by the board:

1. The initial fee for the occupational therapist license shall be $130; for the occupational therapy assistant, it shall be $70.

2. The fee for reinstatement of the occupational therapist license that has been lapsed for two years or more shall be $180; for the occupational therapy assistant, it shall be $90.

3. The fee for active license renewal for an occupational therapist shall be $135; for an occupational therapy assistant, it shall be $70. The fees for inactive license renewal shall be $70 for an occupational therapist and $35 for an occupational therapy assistant. Renewals shall be due in the birth month of the licensee in each even-numbered year. For 2020, the fee for renewal of an active license as an occupational therapist shall be $108; for an occupational therapy assistant, it shall be $54. For renewal of an inactive license in 2020, the fees shall be $54 for an occupational therapist and $28 for an occupational therapy assistant.

4. The additional fee for processing a late renewal application within one renewal cycle shall be $50 for an occupational therapist and $30 for an occupational therapy assistant.

5. The fee for a letter of good standing or verification to another jurisdiction for a license shall be $10.

6. The fee for reinstatement of licensure pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

8. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

9. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

B. Unless otherwise provided, fees established by the board shall not be refundable.

18VAC85-101-25. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. Initial licensure fees.

1. The application fee for radiologic technologist or radiologist assistant licensure shall be $130.

2. The application fee for the radiologic technologist-limited licensure shall be $90.

3. All examination fees shall be determined by and made payable as designated by the board.

C. Licensure renewal and reinstatement for a radiologic technologist or a radiologist assistant.

1. The fee for active license renewal for a radiologic technologist shall be $135, and the fee for inactive license renewal shall be $70. For 2021, the fees for renewal shall be $108 for an active license as a radiologic technologist and $54 for an inactive license. If a radiologist assistant holds a current license as a radiologic technologist, the renewal fee shall be $50. If a radiologist assistant does not hold a current license as a radiologic technologist, the renewal fee shall be $150. For renewal of a radiologist assistant license in 2021, the fee shall be $40 for a radiologist assistant with a current license as a radiologic technologist and $120 for a radiologist assistant without a current license as a radiologic technologist.

2. An additional fee of $50 to cover administrative costs for processing a late renewal application within one renewal cycle shall be imposed by the board.

3. The fee for reinstatement of a radiologic technologist or a radiologist assistant license that has lapsed for a period of two years or more shall be $180 and shall be submitted with an application for licensure reinstatement.

4. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

D. Licensure renewal and reinstatement for a radiologic technologist-limited.

1. The fee for active license renewal shall be $70, and the fee for inactive license renewal shall be $35. For 2021, the fees for renewal shall be $54 for an active license as a radiologic technologist and $28 for an inactive license.

2. An additional fee of $25 to cover administrative costs for processing a late renewal application within one renewal cycle shall be imposed by the board.

3. The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $120 and shall be submitted with an application for licensure reinstatement.

4. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

E. Other fees.

1. The application fee for a traineeship as a radiologic technologist or a radiologic technologist-limited shall be $25.

2. The fee for a letter of good standing or verification to another state for licensure shall be $10; the fee for certification of scores to another jurisdiction shall be $25.

3. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

4. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

18VAC85-110-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The application fee for a license to practice as an acupuncturist shall be $130.

2. The fee for biennial active license renewal shall be $135. The fee for biennial inactive license renewal shall be $70. For 2021, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

3. The additional fee for processing a late renewal within one renewal cycle shall be $50.

4. The fee for reinstatement of a license which has expired for two or more years shall be $180.

5. The fee for a letter of good standing or verification of a license to another jurisdiction shall be $10.

6. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate wall certificate shall be $15.

8. The fee for a duplicate renewal license shall be $5.00.

9. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

10. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

18VAC85-120-35. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. The following fees have been adopted by the board:

1. The application fee shall be $130.

2. The fee for renewal of licensure shall be $135 and shall be due in the licensee's birth month, in each odd-numbered year.

3. A fee of $50 for processing a late renewal within one renewal cycle shall be paid in addition to the renewal fee.

4. The fee for reinstatement of a license that has expired for two or more years shall be $180 and shall be submitted with an application for reinstatement.

5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate renewal license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

8. The fee for a letter of verification to another jurisdiction shall be $10.

9. The fee for an inactive license shall be $70, and the fee for a late renewal shall be $25.

10. For 2021, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

18VAC85-130-30. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The application fee for a license to practice as a midwife shall be $277.

2. The fee for biennial active license renewal shall be $312; the additional fee for late renewal of an active license within one renewal cycle shall be $105.

3. The fee for biennial inactive license renewal shall be $168; the additional fee for late renewal of an inactive license within one renewal cycle shall be $55.

4. The fee for reinstatement of a license that has expired for a period of two years or more shall be $367 in addition to the late fee. The fee shall be submitted with an application for licensure reinstatement.

5. The fee for a letter of good standing or verification of a license to another jurisdiction shall be $10.

6. The fee for an application for reinstatement if a license has been revoked or if an application for reinstatement has been previously denied shall be $2,000.

7. The fee for a duplicate wall certificate shall be $15.

8. The fee for a duplicate renewal license shall be $5.00.

9. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

10. For 2021, the fee for renewal of an active license shall be $250, and the fee for renewal of an inactive license shall be $125.

18VAC85-140-40. Fees.

The following fees are required:

1. The application fee, payable at the time the application is filed, shall be $130.

2. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license holder's birth month. For 2021, the renewal fee for an active license shall be $108, and the renewal fee for an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $180 and must be submitted with an application for licensure reinstatement.

5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

8. The fee for a letter of good standing or verification to another jurisdiction shall be $10.

18VAC85-150-40. Fees.

A. The following fees have been established by the board:

1. The initial fee for the behavior analyst license shall be $130; for the assistant behavior analyst license, it shall be $70.

2. The fee for reinstatement of the behavior analyst license that has been lapsed for two years or more shall be $180; for the assistant behavior analyst license, it shall be $90.

3. The fee for active license renewal for a behavior analyst shall be $135; for an assistant behavior analyst, it shall be $70. The fees for inactive license renewal shall be $70 for a behavior analyst and $35 for an assistant behavior analyst. Renewals shall be due in the birth month of the licensee in each odd-numbered year. For 2021, the renewal of an active license as a behavior analyst shall be $108, and the renewal fee for an inactive license shall be $54; the renewal fee for an active license as an assistant behavior analyst shall be $54, and the renewal fee for an inactive license shall be $28.

4. The additional fee for processing a late renewal application within one renewal cycle shall be $50 for a behavior analyst and $30 for an assistant behavior analyst.

5. The fee for a letter of good standing or verification to another jurisdiction for a license shall be $10.

6. The fee for reinstatement of licensure pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

8. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

B. Unless otherwise provided, fees established by the board shall not be refundable.

18VAC85-160-40. Fees.

A. The following fees have been established by the board:

1. The fee for registration as a surgical assistant or surgical technologist shall be $75.

2. The fee for renewal of registration shall be $70. Renewals shall be due in the birth month of the registrant in each even-numbered year. For 2020, the renewal fee shall be $54.

3. The additional fee for processing a late renewal application within one renewal cycle shall be $25.

4. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

B. Unless otherwise provided, fees established by the board are not refundable.

18VAC85-170-40. Fees.

The following fees are required:

1. The application fee for licensure, payable at the time the application is filed, shall be $130.

2. The application fee for a temporary license, payable at the time the application is filed, shall be $50.

3. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license holder's birth month. For 2021, the renewal fee for an active license shall be $108, and the renewal fee for an inactive license shall be $54.

4. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

5. The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $180 and shall be submitted with an application for licensure reinstatement.

6. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

8. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

9. The fee for a letter of good standing or letter of verification to another jurisdiction shall be $10.

VA.R. Doc. No. R20-6175; Filed December 20, 2019, 1:17 p.m.

BOARD OF NURSING

Proposed Regulation

Title of Regulation: **18VAC90-19. Regulations Governing the Practice of Nursing (amending 18VAC90-19-30, 18VAC90-19-210).**

Statutory Authority: §§ 54.1-2400 and 54.1-3505 of the Code of Virginia.

Public Hearing Information:

January 28, 2020 - 10 a.m. - Department of Health Professions, Board Room 2, Perimeter Center, 9960 Mayland Drive, Suite 201, Richmond, VA 23233

Public Comment Deadline: March 20, 2020.

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

Basis: Regulations are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400 provides the Board of Nursing the authority to promulgate regulations to administer the regulatory system. The specific authority for the Board of Nursing to register clinical nurse specialist is found in §§ 54.1-3005 and 54.1-3018.1 of the Code of Virginia.

Purpose: Regulations were recently amended to align regulatory provisions on national certification with the language in § 54.1-3018.1 of the Code of Virginia, and the amendments became effective March 22, 2019. The proposed amendments clarify that the board will accept a specialty examination that has now been retired but the certification has been maintained or will accept the core examination for national certification as a clinical nurse specialist. Amendments are also necessary to assure that a registered nurse who has allowed his certified nurse specialist (CNS) registration to lapse for more than one renewal cycle is safe and competent to resume advanced practice by providing evidence of current certification.

Substance: The proposed amendments to 18VAC90-19-210 clarify that the board will accept for registration evidence of a clinical nurse specialist certification that has been retired or is the core certification, provided the certification has been maintained and is current. Likewise, a retired or core certification that remains current qualifies a clinical nurse specialist to renew registration.

In subsection B of 18VAC90-19-210, the proposed amendment addresses renewal of a lapsed registration and reinstatement of a registration that has been suspended or revoked. Regulations are aligned with those in 18VAC90-19-190 relating to the reinstatement of a nursing license.

Issues: The primary advantage of the amendment is clearer language to avoid confusion and to facilitate registration as a CNS. There are no disadvantages. There are no advantages or disadvantages to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation.In response to a petition for rulemaking[2] and a recent case decision,[3] the Board of Nursing (Board) proposes to revise the regulation to accept a retired certification, either a clinical nurse specialist (CNS) certification or a core certification, as the required certification for initial registration or renewal provided it has been maintained and is current. The Board also proposes to amend the rules for reinstatement of an expired CNS registration to be similar to the rules for reinstatement of a registered nurse (RN) license.

Background. The CNS registration may be issued to RNs who are able to provide advanced services according to the specialized training received from a program satisfactory to the Board. In February 2019, the Virginia Association of Clinical Nurse Specialists filed the petition for rulemaking and among other things requested that a retired certification be accepted. According to the Department of Health Professions (DHP), sometimes the issuing entity retires (or discontinues) a particular certification but allows the existing certificate holders to maintain it. The Board notes it was allowed by the Office of the Attorney General to interpret the current regulation to accept an applicant who had a retired certification but was advised that the regulation needed to be revised to specify such acceptance. The Board now proposes to reflect this new policy in the regulation and also proposes to amend the reinstatement of a registration to be similar to that of the reinstatement of an RN license.

Estimated Benefits and Costs. Currently, there are 418 certified nurse specialists registered in Virginia. According to DHP, the proposed amendments could qualify a few applicants who would otherwise not be registered to practice in the role of a CNS. An RN with the specialist certification would be expected to receive slightly higher compensation than one without it. Thus, the proposed amendments could improve earning potential of RNs with a retired (but current) qualifying certification. The condition that the retired certification has been maintained and is current should minimize the potential health and safety risks to patients receiving advanced nursing services.

Additionally, the Board proposes to revise the requirements for reinstatement of an expired CNS registration to mimic the rules for reinstatement of an expired RN license. Under the current language, reinstatement of a CNS registration requires evidence of continued competency and payment of both the reinstatement fee ($125) and the renewal fee ($80). The proposed changes effectively separate the reinstatement procedure into three separate categories: reinstatement within one renewal cycle, reinstatement after one renewal cycle, and reinstatement of a suspended or revoked license.

The reinstatement within one renewal cycle would require the same continued competency requirements and renewal fee, but would require a late fee ($35) instead of the reinstatement fee ($125). Thus, the applicants for reinstatement within one renewal cycle would pay $90 less in fees. The fees for reinstatement after one renewal cycle would remain the same (a renewal fee and a reinstatement fee). The reinstatement of a suspended or revoked license would require a renewal fee plus a higher reinstatement fee ($300). Thus, the applicants in the third category would face an additional $175 fee burden. Applicants in both the second and third categories may also face additional burdens regarding submission of additional evidence of competency, depending on how the Board chooses to implement this requirement.

These potential effects would materialize only when an application is filed for reinstatement. However, DHP staff do not have any data on the number of reinstatements of a suspended or revoked registration cases.

Businesses and Other Entities Affected. The proposed amendments to the regulation are expected to affect only a few of the 418 CNSs, as well as perhaps a few RNs who may newly qualify as CNSs.

Localities[4] Affected.[5] The proposed amendments should not affect any locality more than others. The proposed amendments do not introduce costs for localities.

Projected Impact on Employment. The proposed amendments should not significantly affect total employment but may allow a few CNS with retired certifications to earn slightly more.

Effects on the Use and Value of Private Property. The proposed amendments would not affect the use and value of private property.

Adverse Effect on Small Businesses:[6] The proposed amendments do not appear to adversely affect small businesses.

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[2]https://townhall.virginia.gov/l/viewpetition.cfm?petitionid=294

[3]The Agency Background Document, page 8.

[4]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[5]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[6]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."

Agency's Response to Economic Impact Analysis: The Board of Nursing concurs with the analysis of the Department of Planning and Budget.

Summary:

The proposed amendments clarify that the Board of Nursing will accept for registration evidence of a clinical nurse specialist (CNS) certification that has been retired or is the core certification, provided the certification has been maintained and is current. Similarly, a retired or core certification that remains current qualifies a clinical nurse specialist to renew registration. The proposed amendments also amend the requirements for renewal of a lapsed registration or reinstatement of a registration to be similar to the requirements for reinstatement of a registered nurse license. The action is in response to a petition for rulemaking.

18VAC90-19-30. Fees.

A. Fees required by the board are:

1. Application for licensure by examination - RN	$190
2. Application for licensure by endorsement - RN	$190
3. Application for licensure by examination - LPN	$170
4. Application for licensure by endorsement - LPN	$170
5. Reapplication for licensure by examination	$50
6. Biennial licensure renewal - RN	$140
7. Biennial inactive licensure renewal - RN	$70
8. Biennial licensure renewal - LPN	$120
9. Biennial inactive licensure renewal - LPN	$60
10. Late renewal - RN	$50
11. Late renewal - RN inactive	$25
12. Late renewal - LPN	$40
13. Late renewal - LPN inactive	$20
14. Reinstatement of lapsed license - RN	$225
15. Reinstatement of lapsed license - LPN	$200
16. Reinstatement of suspended or revoked license or registration	$300
17. Duplicate license	$15
18. Replacement wall certificate	$25
19. Verification of license	$35
20. Transcript of all or part of applicant or licensee records	$35
21. Returned check charge	$35
22. Application for CNS registration	$130
23. Biennial renewal of CNS registration	$80
24. Reinstatement of lapsed CNS registration	$125
25. Verification of CNS registration to another jurisdiction	$35
26. Late renewal of CNS registration	$35

B. For renewal of licensure or registration from July 1, 2017, through June 30, 2019, the following fees shall be in effect:

1. Biennial licensure renewal - RN	$105
2. Biennial inactive licensure renewal - RN	$52
3. Biennial licensure renewal - LPN	$90
4. Biennial inactive licensure renewal - LPN	$45
5. Biennial renewal of CNS registration	$60

Part IV
Clinical Nurse Specialists

18VAC90-19-210. Clinical nurse specialist registration.

A. Initial registration. An applicant for initial registration as a clinical nurse specialist shall:

1. Be currently licensed as a registered nurse in Virginia or hold a current multistate licensure privilege as a registered nurse;

2. Submit evidence of current national clinical nurse specialist certification, including core certification or a certification that has been retired, as required by § 54.1-3018.1 of the Code of Virginia or have an exception available from March 1, 1990, to July 1, 1990; and

3. Submit the required application and fee.

B. Renewal of registration.

1. Registration as a clinical nurse specialist shall be renewed biennially at the same time the registered nurse license is renewed. If registered as a clinical nurse specialist with a multistate licensure privilege to practice in Virginia as a registered nurse, a licensee born in an even-numbered year shall renew his license by the last day of the birth month in even-numbered years and a licensee born in an odd-numbered year shall renew his license by the last day of the birth month in odd-numbered years.

2. The clinical nurse specialist shall complete the renewal form and submit it with the required fee. An attestation of current national certification as a clinical nurse specialist, including core certification or a certification that has been retired, is required unless registered in accordance with an exception.

3. Registration as a clinical nurse specialist shall lapse if the registered nurse license is not renewed or the multistate licensure privilege is lapsed or registration as a clinical nurse specialist is not renewed and may be reinstated within one renewal period upon:

a. Reinstatement of RN license or multistate licensure privilege, if lapsed;

b. Payment of ~~reinstatement and~~ current renewal fees and late renewal fees; and

c. Submission of evidence of continued national certification as a clinical nurse specialist, including core certification or a certification that has been retired, unless registered in accordance with an exception.

C. Reinstatement of registration.

1. A clinical nurse specialist whose registration has lapsed for more than one renewal period may be reinstated by submission of:

a. A reinstatement application and reinstatement fee;

b. Evidence of a current RN license or multistate privilege; and

c. Evidence of current national certification as a clinical nurse specialist, including core certification or a certification that has been retired, unless registered in accordance with an exception.

2. A clinical nurse specialist whose registration has been suspended or revoked by the board may apply for reinstatement by:

a. Filing a reinstatement application;

b. Fulfilling requirements specified in subdivision 1 c of this subsection; and

c. Paying the fee for reinstatement after suspension or revocation.

The board may request additional evidence that the clinical nurse specialist is prepared to resume practice in a competent manner. A clinical nurse specialist whose registration has been revoked may not apply for reinstatement sooner than three years from entry of the order of revocation.

VA.R. Doc. No. R19-28; Filed December 18, 2019, 8:03 a.m.

Fast-Track Regulation

Titles of Regulations: **18VAC90-30. Regulations Governing the Licensure of Nurse Practitioners (amending 18VAC90-30-50).**

18VAC90-40. Regulations for Prescriptive Authority for Nurse Practitioners (amending 18VAC90-40-70).

Statutory Authority: §§ 54.1-2400 and 54.1-3005 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

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.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Boards of Medicine and Nursing the authority to promulgate regulations to administer the regulatory system. The specific mandate for collection of a handling fee is found in § 2.2-4805 of the Virginia Debt Collection Act

Purpose: The rationale for the regulatory change is compliance with the Virginia Debt Collection Act (§ 2.2-4800 et seq.) of the Code of Virginia, in which the General Assembly has determined that the cost for handling returned

checks or dishonored credit or debit cards is $50. The department and its regulatory boards license and discipline health care practitioners, and its mission of protecting the health and safety of the public must be supported by its licensing and miscellaneous fees.

Rationale for Using Fast-Track Rulemaking Process: The rulemaking is concurring with financial policy of the Commonwealth and is expected to be noncontroversial.

Substance: All board regulations are being amended to delete the returned check fee of $35 and replace it with a handling fee of $50 for a returned check, dishonored credit card, or dishonored debit card.

Issues: There are no primary advantages or disadvantages to the public. The primary advantage to the department is compliance with auditors from the Office of the Comptroller. There are no disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Boards of Medicine and Nursing (Boards) propose to amend 18VAC90-30 Regulations Governing the Licensure of Nurse Practitioners and 18VAC90-40 Regulations for Prescriptive Authority for Nurse Practitioners to state that the handling fee for a returned check or dishonored credit card or debit card is $50.

Background. Code of Virginia § 2.2-614.1 specifies that:

> If any check or other means of payment tendered to a public body in the course of its duties is not paid by the financial institution on which it is drawn, because of insufficient funds in the account of the drawer, no account is in the name of the drawer, or the account of the drawer is closed, and the check or other means of payment is returned to the public body unpaid, the amount thereof shall be charged to the person on whose account it was received, and his liability and that of his sureties, shall be as if he had never offered any such payment. A penalty of $35 or the amount of any costs, whichever is greater, shall be added to such amount.

Based on this Code provision, the current regulations include a $35 returned check charge.

On the other hand, Code of Virginia § 2.2-4805 specifies that "Returned checks or dishonored credit card or debit card payments shall incur a handling fee of $50 unless a higher amount is authorized by statute to be added to the principal account balance." According to the Department of Health Professions (DHP), the Office of the Attorney General has advised that the handling fee of $50 in Virginia Code § 2.2-4805 governs.

Estimated Benefits and Costs. Based on the view of the Office of the Attorney General that Virginia Code § 2.2-4805 prevails, the fee by law for a returned check or dishonored credit card or debit card is $50. The Boards' proposal therefore conforms the regulations to current law. DHP has indicated that in practice they will continue to charge the $35 fee until this proposed regulatory action becomes effective. The services provided by DHP are funded by the fees paid by the regulated individuals and entities. To the extent that the $50 fee more accurately represents the cost incurred by DHP, the proposed change may be beneficial in that the cost would need not be subsidized by other regulants who did not cause the cost to be incurred.

Businesses and Other Entities Affected. The proposal potentially affects the 11,569 nurse practitioners licensed in the Commonwealth.[2] If any of these individuals have a check returned or a credit card or debit card dishonored, the proposal would increase their cost by $15.

Localities[3] Affected.[4]The proposal does not disproportionately affect any particular localities or introduce costs for local governments.

Projected Impact on Employment. The proposal does not affect employment.

Effects on the Use and Value of Private Property. The proposal does not substantially affect the use and value of private property or real estate development costs.

Adverse Effect on Small Businesses.[5] The proposal does not substantively adversely affect small businesses.

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[2]Source: DHP

[3]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[4]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[5]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."

Agency's Response to Economic Impact Analysis: The Boards of Medicine and Nursing concur with the analysis of the Department of Planning and Budget.

Summary:

The amendments replace the returned check fee of $35 with a fee of $50 for handling a returned check or dishonored credit card or debit card payment in compliance with § 2.2-4805 of the Code of Virginia.

18VAC90-30-50. Fees.

A. Fees required in connection with the licensure of nurse practitioners are:

1. Application	$125
2. Biennial licensure renewal	$80
3. Late renewal	$25
4. Reinstatement of licensure	$150
5. Verification of licensure to another jurisdiction	$35
6. Duplicate license	$15
7. Duplicate wall certificate	$25
8. ~~Return check charge~~ Handling fee for returned check or dishonored credit card or debit card	~~$35~~ $50
9. Reinstatement of suspended or revoked license	$200

B. For renewal of licensure from July 1, 2017, through June 30, 2019, the following fee shall be in effect:

Biennial renewal	$60

18VAC90-40-70. Fees for prescriptive authority.

A. The following fees have been established by the boards:

1. Initial issuance of prescriptive authority	$75
2. Biennial renewal	$35
3. Late renewal	$15
4. Reinstatement of lapsed authorization	$90
5. Reinstatement of suspended or revoked authorization	$85
6. Duplicate of authorization	$15
7. ~~Return check charge~~ Handling fee for returned check or dishonored credit card or debit card	~~$35~~ $50

B. For renewal of licensure from July 1, 2017, through June 30, 2019, the following fee shall be in effect:

Biennial renewal	$26

VA.R. Doc. No. R20-6167; Filed December 20, 2019, 1:18 p.m.

BOARD OF OPTOMETRY

Fast-Track Regulation

Title of Regulation: **18VAC105-20. Regulations Governing the Practice of Optometry (amending 18VAC105-20-20).**

Statutory Authority: §§ 54.1-2400 and 54.1-3223 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Optometry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 597-4130, FAX (804) 527-4471, or email leslie.knachel@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Optometry the authority to promulgate regulations to administer the regulatory system. The specific mandate for collection of a handling fee is found in § 2.2-4805 of the Virginia Debt Collection Act

Purpose: The rationale for the regulatory change is compliance with the Virginia Debt Collection Act (§ 2.2-4800 et seq.) of the Code of Virginia, in which the General Assembly has determined that the cost for handling returned checks or dishonored credit or debit cards is $50. The department and its regulatory boards license and discipline health care practitioners, and its mission of protecting the health and safety of the public must be supported by its licensing and miscellaneous fees.

Rationale for Using Fast-Track Rulemaking Process: The rulemaking is concurring with financial policy of the Commonwealth and is expected to be noncontroversial.

Substance: All board regulations are being amended to delete the returned check fee of $35 and replace it with a handling fee of $50 for a returned check, dishonored credit card, or dishonored debit card.

Issues: There are no primary advantages or disadvantages to the public. The primary advantage to the department is compliance with auditors from the Office of the Comptroller. There are no disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Optometry (Board) proposes to amend 18VAC105-20 Regulations of the Virginia Board of Optometry to state that the handling fee for a returned check or dishonored credit card or debit card is $50, replacing a current $35 charge.

Background. Code of Virginia § 2.2-614.1 specifies that:

> If any check or other means of payment tendered to a public body in the course of its duties is not paid by the financial institution on which it is drawn, because of insufficient funds in the account of the drawer, no account is in the name of the drawer, or the account of the drawer is closed, and the check or other means of payment is returned to the public body unpaid, the amount thereof shall be charged to the person on whose account it was received, and his liability and that of his

sureties, shall be as if he had never offered any such payment. A penalty of $35 or the amount of any costs, whichever is greater, shall be added to such amount.

Based on this Code provision, the current regulation includes a $35 returned check charge.

On the other hand, Code of Virginia § 2.2-4805 specifies that "Returned checks or dishonored credit card or debit card payments shall incur a handling fee of $50 unless a higher amount is authorized by statute to be added to the principal account balance." According to the Department of Health Professions (DHP), the Office of the Attorney General has advised that the handling fee of $50 in Virginia Code 2.2-4805 governs.

Estimated Benefits and Costs. Based on the view of the Office of the Attorney General that Virginia Code 2.2-4805 prevails, the fee by law for a returned check or dishonored credit card or debit card is $50. The Board's proposal therefore conforms the regulation to current law. DHP has indicated that in practice they will continue to charge the $35 fee until this proposed regulatory action becomes effective. The services provided by DHP are funded by the fees paid by the regulated individuals and entities. To the extent that the $50 fee more accurately represents the cost incurred by DHP, the proposed change may be beneficial in that the cost would need not be subsidized by other regulants who did not cause the cost to be incurred.

Businesses and Other Entities Affected. The proposal pertains to fee-paying individuals regulated by the Board. As of September 30, 2019, there were 1,732 optometrists licensed by the Board.[2] If any of these individuals have a check returned or a credit card or debit card dishonored, the proposal would increase their cost by $15.

Localities[3] Affected.[4] The proposal does not disproportionately affect any particular localities or introduce costs for local governments.

Projected Impact on Employment. The proposal does not affect employment.

Effects on the Use and Value of Private Property. The proposal does not substantially affect the use and value of private property or real estate development costs.

Adverse Effect on Small Businesses.[5] The proposal does not substantively adversely affect small businesses.

[2]Data source: DHP

[3]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[4]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[5]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."

Agency's Response to Economic Impact Analysis: The Board of Optometry concurs with the Analysis of the Department of Planning and Budget.

Summary:

The amendments replace the returned check fee of $35 with a fee of $50 for handling a returned check or dishonored credit card or debit card payment in compliance with § 2.2-4805 of the Code of Virginia.

18VAC105-20-20. Fees.

A. Required fees.

Initial application and licensure (including TPA certification)	$250
Annual licensure renewal without TPA certification	$150
Annual licensure renewal with TPA certification	$200
Late renewal without TPA certification	$50
Late renewal with TPA certification	$65
~~Returned~~ Handling fee for returned check or dishonored credit card or debit card	~~$35~~ $50
Professional designation application	$100
Annual professional designation renewal (per location)	$50
Late renewal of professional designation	$20
Reinstatement application fee (including renewal and late fees)	$400
Reinstatement application after disciplinary action	$500
Duplicate wall certificate	$25
Duplicate license	$10
Licensure verification	$10

B. Unless otherwise specified, all fees are nonrefundable.

C. From October 31, 2018, to December 31, 2018, the following fees shall be in effect:

Annual licensure renewal without TPA certification	$75
Annual licensure renewal with TPA certification	$100
Annual professional designation renewal (per location)	$25

VA.R. Doc. No. R20-6197; Filed December 20, 2019, 1:25 p.m.

BOARD OF PHARMACY

Forms

REGISTRAR'S NOTICE: Forms used in administering the regulation have been filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

Title of Regulation: **18VAC110-60. Regulations Governing Pharmaceutical Processors.**

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

FORMS (18VAC110-60)

Application for registration of a patient, online form available at https://www.license.dhp.virginia.gov/apply

Application for registration of a parent or legal guardian, online form available at https://www.license.dhp.virginia.gov/apply

Application for registration of a practitioner to issue certifications, online form available at https://www.license.dhp.virginia.gov/apply

Application for Pharmaceutical Processor Permit (eff. 6/2019)

Patient Parent or Legal Guardian Reporting Requirements (eff. 6/2019)

Practitioner Reporting Requirements (eff. 6/2019)

Registration of CBD or THC-A Oil Products (eff. 6/2019)

Pharmaceutical Processor Inspection Form (eff. 10/2019)

Application for Registration as a Registered Agent (eff. 12/2019)

VA.R. Doc. No. R20-6274; Filed December 30, 2019, 8:28 a.m.

BOARD OF PHYSICAL THERAPY

Fast-Track Regulation

Title of Regulation: **18VAC112-20. Regulations Governing the Practice of Physical Therapy (amending 18VAC112-20-27).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

Agency Contact: Corie Tillman Wolf, Executive Director, Board of Physical Therapy, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4674, FAX (804) 527-4413, or email ptboard@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Physical Therapy the authority to promulgate regulations to administer the regulatory system. The specific mandate for collection of a handling fee is found in § 2.2-4805 of the Virginia Debt Collection Act

Purpose: The rationale for the regulatory change is compliance with the Virginia Debt Collection Act (§ 2.2-4800 et seq.) of the Code of Virginia, in which the General Assembly has determined that the cost for handling returned checks or dishonored credit or debit cards is $50. The department and its regulatory boards license and discipline health care practitioners, and its mission of protecting the health and safety of the public must be supported by its licensing and miscellaneous fees.

Rationale for Using Fast-Track Rulemaking Process: The rulemaking is concurring with financial policy of the Commonwealth and is expected to be noncontroversial.

Substance: All board regulations are being amended to delete the returned check fee of $35 and replace it with a handling fee of $50 for a returned check, dishonored credit card, or dishonored debit card.

Issues: There are no primary advantages or disadvantages to the public. The primary advantage to the department is compliance with auditors from the Office of the Comptroller. There are no disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Physical Therapy (Board) proposes to amend 18VAC112-20 Regulations Governing the Practice of Physical Therapy to state that the handling fee for a returned check or dishonored credit card or debit card is $50, replacing a current $35 charge.

Background. Code of Virginia § 2.2-614.1 specifies that:

> If any check or other means of payment tendered to a public body in the course of its duties is not paid by the financial institution on which it is drawn, because of insufficient funds in the account of the drawer, no account is in the name of the drawer, or the account of the drawer is closed, and the check or other means of payment is returned to the public body unpaid, the amount thereof shall be charged to the person on whose account it was received, and his liability and that of his

sureties, shall be as if he had never offered any such payment. A penalty of $35 or the amount of any costs, whichever is greater, shall be added to such amount.

Based on this Code provision, the current regulation includes a $35 returned check charge.

On the other hand, Code of Virginia § 2.2-4805 specifies that "Returned checks or dishonored credit card or debit card payments shall incur a handling fee of $50 unless a higher amount is authorized by statute to be added to the principal account balance." According to the Department of Health Professions (DHP), the Office of the Attorney General has advised that the handling fee of $50 in Virginia Code 2.2-4805 governs.

Estimated Benefits and Costs. Based on the view of the Office of the Attorney General that Virginia Code 2.2-4805 prevails, the fee by law for a returned check or dishonored credit card or debit card is $50. The Board's proposal therefore conforms the regulation to current law. DHP has indicated that in practice they will continue to charge the $35 fee until this proposed regulatory action becomes effective. The services provided by DHP are funded by the fees paid by the regulated individuals and entities. To the extent that the $50 fee more accurately represents the cost incurred by DHP, the proposed change may be beneficial in that the cost would need not be subsidized by other regulants who did not cause the cost to be incurred.

Businesses and Other Entities Affected. The proposal pertains to fee-paying individuals regulated by the Board. As of June 30, 2019, there were 8,240 physical therapists and 3,525 physical therapist assistants regulated by the Board.[2] If any of these individuals have a check returned or a credit card or debit card dishonored, the proposal would increase their cost by $15.

Localities[3] Affected.[4] The proposal does not disproportionately affect any particular localities or introduce costs for local governments.

Projected Impact on Employment. The proposal does not affect employment.

Effects on the Use and Value of Private Property. The proposal does not substantially affect the use and value of private property or real estate development costs.

Adverse Effect on Small Businesses.[5] The proposal does not substantively adversely affect small businesses.

[2]Data source: DHP

[3]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[4]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[5]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."

Agency's Response to Economic Impact Analysis: The Board of Physical Therapy concurs with the analysis of the Department of Planning and Budget.

Summary:

The amendments replace the returned check fee of $35 with a fee of $50 for handling a returned check or dishonored credit card or debit card payment in compliance with § 2.2-4805 of the Code of Virginia.

18VAC112-20-27. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. Licensure by examination.

1. The application fee shall be $140 for a physical therapist and $100 for a physical therapist assistant.

2. The fees for taking all required examinations shall be paid directly to the examination services.

C. Licensure by endorsement. The fee for licensure by endorsement shall be $140 for a physical therapist and $100 for a physical therapist assistant.

D. Licensure renewal and reinstatement.

1. The fee for active license renewal for a physical therapist shall be $135 and for a physical therapist assistant shall be $70 and shall be due by December 31 in each even-numbered year.

2. The fee for an inactive license renewal for a physical therapist shall be $70 and for a physical therapist assistant shall be $35 and shall be due by December 31 in each even-numbered year.

3. A fee of $50 for a physical therapist and $25 for a physical therapist assistant for processing a late renewal within one renewal cycle shall be paid in addition to the renewal fee.

4. The fee for reinstatement of a license that has expired for two or more years shall be $180 for a physical therapist and $120 for a physical therapist assistant and shall be submitted with an application for licensure reinstatement.

E. Other fees.

1. The fee for an application for reinstatement of a license that has been revoked shall be $1,000; the fee for an application for reinstatement of a license that has been suspended shall be $500.

2. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

3. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

4. The fee for a letter of good standing/verification to another jurisdiction shall be $10.

5. The application fee for direct access certification shall be $75 for a physical therapist to obtain certification to provide services without a referral.

VA.R. Doc. No. R20-6211; Filed December 20, 2019, 1:22 p.m.

BOARD OF COUNSELING

Final Regulation

Title of Regulation: **18VAC115-30. Regulations Governing the Certification of Substance Abuse Counselors and Substance Abuse Counseling Assistants (amending 18VAC115-30-10 through 18VAC115-30-62, 18VAC115-30-110 through 18VAC115-30-150; adding 18VAC115-30-15, 18VAC115-30-63, 18VAC115-30-111; repealing 18VAC115-30-90).**

Statutory Authority: §§ 54.1-2400 and 54.1-3505 of the Code of Virginia.

Effective Date: February 19, 2020.

Agency Contact: Jaime Hoyle, Executive Director, Board of Counseling, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4406, FAX (804) 527-4435, or email jaime.hoyle@dhp.virginia.gov.

Summary:

The amendments include (i) clarifying and specifying requirements for supervised practice, (ii) adding time limits for completion of experience, (iii) adding requirements for continuing education for renewal, and (iv) adding standards of practice.

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

Part I
General Provisions

18VAC115-30-10. Definitions.

A. The following words and terms when used in this chapter shall have the meaning ascribed to them in § 54.1-3500 of the Code of Virginia:

"Board"

"Certified substance abuse counselor"

"Certified substance abuse counseling assistant"

"Licensed substance abuse treatment practitioner"

"Practice of substance abuse treatment"

"Substance abuse" and "substance dependence"

"Substance abuse treatment"

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

"Applicant" means an individual who has submitted a completed application with documentation and the appropriate fees to be examined for certification as a substance abuse counselor or substance abuse counseling assistant.

"Candidate" means a person who has been approved to take the examinations for certification as a substance abuse counselor or substance abuse counseling assistant.

"Clinical supervision" means the ongoing process performed by a clinical supervisor who monitors the performance of the person supervised and provides regular, documented face-to-face consultation, guidance and education with respect to the clinical skills and competencies of the person supervised.

"Clinical supervisor" means one who provides case-related supervision, consultation, education and guidance for the applicant. The supervisor must be credentialed as defined in 18VAC115-30-60 C.

"Competency area" means an area in which a person possesses knowledge and skill and the ability to apply them in the clinical setting.

"Contact hour" means the amount of credit awarded for 60 minutes of participation in and successful completion of a continuing education program.

"Didactic" means teaching-learning methods that impart facts and information, usually in the form of one-way communication (includes directed readings and lectures).

~~"Endorsement" means the waiver of the examination requirement for certification as a substance abuse counselor for persons currently certified or licensed in another jurisdiction.~~

"Group supervision" means the process of clinical supervision of no less than two nor more than six persons in a group setting provided by a ~~qualified~~ clinical supervisor.

"NAADAC" means the ~~National Association of Alcoholism and Drug Abuse Counselors~~ Association of Addiction Professionals.

"NCC AP" means the National Certification Commission for Addiction Professionals, an affiliate of NAADAC.

"Regionally accredited" means accredited by one of the regional accreditation agencies recognized by the U.S. Department of Education as responsible for accrediting senior postsecondary institutions.

"Substance abuse counseling" means applying a counseling process, treatment strategies and rehabilitative services to help an individual to:

1. Understand his substance use, abuse or dependency; and

2. Change his drug-taking behavior so that it does not interfere with effective physical, psychological, social or vocational functioning.

18VAC115-30-15. Maintenance of current name and address.

A. Certified substance abuse counselors or counseling assistants shall notify the board of any change of name, email address, or address of record within 60 days.

B. Failure to receive a renewal notice and application forms shall not excuse the certified substance abuse counselor or counseling assistant from the renewal requirement.

18VAC115-30-30. Fees required by the board.

A. The board has established the following fees applicable to the certification of substance abuse counselors and substance abuse counseling assistants:

Substance abuse counselor annual certification renewal	$65
Substance abuse counseling assistant annual certification renewal	$50
Substance abuse counselor initial certification by examination: Application processing and initial certification	$115
Substance abuse counseling assistant initial certification by examination: Application processing and initial certification	$115
Initial certification by endorsement of substance abuse counselors: Application processing and initial certification	$115
Registration of supervision	$65
Add or change ~~supervisor~~ to supervision	$30
Duplicate certificate	$10
Certificate verification	$25
Late renewal	$25
Reinstatement of a lapsed certificate	$125
Replacement of or additional wall certificate	$25
Returned check	$35
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

C. Examination fees shall be paid directly to the examination services according to its requirements.

Part II
Requirements for Certification

18VAC115-30-40. Prerequisites for certification by examination for substance abuse counselors.

A. ~~A candidate~~ Every applicant for certification as a substance abuse counselor ~~shall meet all the requirements of this section and~~ by examination shall pass ~~the~~ a written examination ~~prescribed in 18VAC115-30-90~~ approved by the board. The board shall determine the passing score on the examination.

1. If an applicant fails to achieve a passing score within two years of board approval to sit for the examination, the applicant shall reapply according to regulations in effect at that time.

2. An applicant who has applied twice and has not passed the examination shall not be approved to retake the examination, unless the applicant can provide evidence of extenuating circumstances for failure to pass the examination within the four-year period.

B. Every applicant for examination for certification by the board shall:

1. Meet the educational and experience requirements prescribed in 18VAC115-30-50 and 18VAC115-30-60; and

2. Submit the following to the board:

a. A completed application form;

b. Official transcript documenting coursework and attainment of a bachelor's or post-baccalaureate degree;

c. Official transcripts or certificates verifying completion of the didactic training requirement set forth in subsection B of 18VAC115-30-50;

d. ~~Verification~~ Attestation of supervisor's education and experience as required under 18VAC115-30-60 if supervised experience was not previously approved by the board;

e. Verification of supervision forms documenting fulfillment of the experience requirements of 18VAC115-30-60;

f. ~~Documentation~~ Verification of any other health or mental health license or certificate ever held in Virginia

or in another jurisdiction. In order to qualify for certification by examination, the applicant shall have no unresolved action against a license or certificate. The board will consider history of disciplinary action on a case-by-case basis;

g. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB); ~~and~~

h. The application processing and initial certification fee; and

i. Attestation of having read and understood the laws and regulations governing the practice of substance abuse counseling in Virginia.

18VAC115-30-45. Prerequisites for certification by endorsement for substance abuse counselors.

Every applicant for certification by endorsement shall submit:

1. A completed application;

2. The application processing and initial certification fee;

3. Verification of all health or mental health licenses or certificates ever held in Virginia or in any other jurisdiction. In order to qualify for endorsement, the applicant shall have no unresolved action against a license or certificate. The board will consider history of disciplinary action on a case-by-case basis. The board will also determine whether any or all other professional licenses or certificates held in another jurisdiction are substantially equivalent to those sought in Virginia;

4. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB);

5. ~~Affidavit~~ Attestation of having read and understood the regulations and laws governing the practice of substance abuse counseling in Virginia; ~~and~~

6. Further documentation of one of the following:

a. ~~Licensure~~ Active, unrestricted licensure or certification as a substance abuse counselor in another jurisdiction ~~in good standing~~ obtained by standards substantially equivalent to the education and experience requirements set forth in this chapter as verified ~~by a certified copy of the original application submitted~~ directly from the out-of-state licensing agency~~,~~ or a copy of the regulations in effect at the time of initial licensure or certification ~~and verification of a passing score on a licensure examination in the jurisdiction in which licensure or certification was obtained, and that is deemed substantially equivalent by the board~~; or

b. Verification of a current certification in good standing issued by ~~NAADAC~~ NCC AP or other board-recognized national certification in substance abuse counseling obtained by educational and experience standards substantially equivalent to those set forth in this chapter; and

7. Verification of a passing score on an examination in the jurisdiction in which licensure or certification was obtained or on a board-approved national examination at the level for which the applicant is seeking certification in Virginia.

18VAC115-30-50. Educational requirements for substance abuse counselors.

A. An applicant for examination for certification as a substance abuse counselor shall:

1. Have a bachelor's or post-baccalaureate degree; and

2. Have completed ~~400~~ 240 clock hours of didactic training in substance abuse education from one of the following programs:

a. ~~An~~ A regionally accredited university or college; or

b. Seminars and workshops that meet the requirements of subsection B of this section and are offered or approved by one of the following:

(1) ~~The American Association of Marriage and Family Counselors and its state affiliates~~ Federal, state, or local governmental agencies; public school systems; or licensed health facilities.

(2) The American Association of Marriage and Family Therapists and its state affiliates.

(3) The American Association of State Counseling Boards.

(4) The American Counseling Association and its state and local affiliates.

(5) The American Psychological Association and its state affiliates.

(6) The Commission on Rehabilitation Counselor Certification.

(7) NAADAC~~, The Association for Addiction Professionals~~ and its state and local affiliates.

(8) National Association of Social Workers.

(9) National Board for Certified Counselors.

(10) A national behavioral health organization or certification body recognized by the board.

(11) Individuals or organizations that have been approved as continuing competency sponsors by the American Association of State Counseling Boards or a counseling board in another state.

B. Substance abuse education.

1. ~~The education will include 220~~ Of the 240 hours ~~spent in receiving~~ of didactic training in substance abuse counseling, a minimum of 120 hours shall be completed prior to registration of supervision.

2. Each applicant shall have received a minimum of ~~10~~ 16 clock hours in each of the following ~~eight~~ 13 areas:

a. ~~Understanding the dynamics~~ Dynamics of human behavior;

b. Signs and symptoms of substance abuse;

c. ~~Treatment approaches~~ Counseling theories and techniques;

d. Continuum of care and case management skills;

e. Recovery process and relapse prevention methods;

f. ~~Ethics~~ Professional orientation and ethics;

g. ~~Professional identity in the provision of substance abuse services~~ Pharmacology of abused substances; ~~and~~

h. ~~Crisis~~ Trauma and crisis intervention~~.~~;

i. Co-occurring disorders;

j. Cultural competency;

~~In addition, each applicant shall have at least 20 hours in each of the following two areas:~~

~~(i)~~ k. Substance abuse counseling approaches and treatment planning ~~and substance abuse research~~; ~~and~~

~~(ii)~~ l. Group counseling; and

m. Prevention, screening, and assessment of substance use and abuse.

~~2. The education shall also consist of 180 hours of experience performing the following tasks with substance abuse clients:~~

~~a. Screening clients to determine eligibility and appropriateness for admission to a particular program;~~

~~b. Intake of clients by performing the administrative and initial assessment tasks necessary for admission to a program;~~

~~c. Orientation of new clients to program's rules, goals, procedures, services, costs and the rights of the client;~~

~~d. Assessment of client's strengths, weaknesses, problems, and needs for the development of a treatment plan;~~

~~e. Treatment planning with the client to identify and rank problems to be addressed, establish goals, and agree on treatment processes;~~

~~f. Counseling the client utilizing specialized skills in both individual and group approaches to achieve treatment goals and objectives;~~

~~g. Case management activities that bring services, agencies, people and resources together in a planned framework of action to achieve established goals;~~

~~h. Crisis intervention responses to clients' needs during acute mental, emotional or physical distress;~~

~~i. Education of clients by providing information about drug abuse and available services and resources;~~

~~j. Referral of clients in order to meet identified needs unable to be met by the counselor and assisting the client in effectively utilizing those resources;~~

~~k. Reporting and charting information about client's assessment, treatment plan, progress, discharge summaries and other client related data; and~~

~~l. Consultation with other professionals to assure comprehensive quality care for the client.~~

~~Each of these tasks shall be performed for at least eight hours under supervision and shall be verified as a part of the application by the supervisor.~~

C. Groups and classes attended as a part of a therapy or treatment program will not be accepted as any part of the educational experience.

18VAC115-30-60. Experience requirements for substance abuse counselors.

A. Registration. Supervision in Virginia shall be registered and approved by the board prior to the beginning of supervised experience in order to be counted toward certification. Supervision ~~obtained without prior board approval~~ will not be accepted if it does not meet the requirements set forth in subsections B and C of this section. To register supervision for board approval prior to obtaining the supervised experience, an applicant shall submit in one package:

1. A supervisory contract;

2. ~~Verification~~ Attestation of the supervisor's education and experience as required under ~~subsection~~ subsections C and D of this section; ~~and~~

3. The registration fee;

4. An official transcript documenting attainment of a bachelor's or post-baccalaureate degree; and

5. Evidence of completion of at least 120 hours of didactic education as required by 18VAC115-30-50 B.

B. Experience requirements.

1. An applicant for certification as a substance abuse counselor shall have had 2,000 hours of supervised

experience in the ~~delivery of clinical~~ practice of substance abuse counseling services.

2. The supervised experience shall include a minimum of one hour and a maximum of four hours per ~~week of supervision~~ 40 hours of work experience between the supervisor and the applicant to total 100 hours within the required experience. No more than half of these hours may be satisfied with group supervision. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

3. ~~Applicants must document successful completion of their~~ The supervised experience ~~on the Verification of Supervision Form at the time of application~~ shall be completed in not less than 12 months and not more than 60 months.

a. Supervisees who began a supervised experience before [~~(insert effective date of this regulation)~~ February 19, 2020,] shall complete the supervised experience by [~~(insert 60 months after the effective date)~~ February 19, 2025].

b. An individual who does not complete the supervised experience within 60 months may request an extension and shall submit evidence to the board demonstrating the extenuating circumstances that prevented completion of the supervised experience within the required timeframe.

4. Supervised experience obtained more than 10 years from [~~(insert effective date of this regulation)~~ February 19, 2020,] shall not be accepted for certification by examination. The board may make an exception for an applicant who has been providing substance abuse counseling for a minimum of 2,000 hours within the past 60 months and who can submit evidence of such experience.

5. During the supervised experience, supervisees shall use their names and the title "supervisee" in all written communications. Clients shall be informed in writing of the supervisee's status and the supervisor's name, professional address, and phone number.

6. The supervised experience shall consist of 160 hours of experience performing the following tasks with substance abuse clients. Each of the following tasks shall be performed for at least eight hours under supervision as verified by the supervisor on an application for certification:

a. Screening clients to determine eligibility and appropriateness for admission to a particular program;

b. Intake of clients by performing the administrative and initial assessment tasks necessary for admission to a program;

c. Orientation of new clients to program's rules, goals, procedures, services, costs, and the rights of the client;

d. Assessment of client's strengths, weaknesses, problems, and needs for the development of a treatment plan;

e. Treatment planning with the client to identify and rank problems to be addressed, establish goals, and agree on treatment processes;

f. Counseling the client utilizing specialized skills in both individual and group approaches to achieve treatment goals and objectives;

g. Case management activities that bring services, agencies, people, and resources together in a planned framework of action to achieve established goals;

h. Crisis intervention responses to a client's needs during acute mental, emotional, or physical distress;

i. Education of clients by providing information about drug abuse and available services and resources;

j. Referral of clients in order to meet identified needs unable to be met by the counselor and assisting the client in effectively utilizing those resources;

k. Reporting and charting information about a client's assessment, treatment plan, progress, discharge summaries, and other client-related data; and

l. Consultation with other professionals to assure comprehensive quality care for the client.

C. Supervisor qualifications. A board-approved clinical supervisor shall hold an active, unrestricted license or certification and shall be:

1. A licensed substance abuse treatment practitioner;

2. A licensed professional counselor, licensed clinical psychologist, licensed clinical social worker, licensed marriage and family therapist, medical doctor, or registered nurse~~, and possess either~~ who has either:

~~a~~ a. A board-recognized national certification in substance abuse counseling obtained by standards substantially equivalent to those set forth in this chapter~~.~~;

b. A certification as a substance abuse counselor issued by this board; or

~~a~~ c. A minimum of one year [of] experience in substance abuse counseling and at least 100 hours of didactic training covering the areas outlined in 18VAC115-30-50 B ~~1~~ 2 a through ~~h~~ 2 m; or

3. A substance abuse counselor certified by the Virginia Board of Counseling who has~~: a. Board-recognized national certification in substance abuse counseling obtained by standards substantially equivalent to those set~~

~~forth in this chapter; or b. Two~~ two years of experience as a Virginia board-certified substance abuse counselor.

D. Supervisor training. In order to be approved by the board after [~~(insert 12 months after the effective date of this regulation)~~ February 19, 2021], a clinical supervisor shall obtain professional training in supervision consisting of three credit hours or four quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-30-50.

E. Supervisory responsibilities.

1. Supervisors shall assume responsibility for the professional activities of the ~~prospective applicants~~ supervisee under their supervision.

2. Supervisors shall not provide supervision for activities for which ~~prospective applicants~~ supervisees have not had appropriate education.

3. Supervisors shall provide supervision only for those substance abuse counseling services that they are qualified to render.

4. At the time of ~~formal~~ the application for certification by examination, the board-approved supervisor shall document minimal competencies in the areas in 18VAC115-30-60 B 6, the ~~applicant's~~ total hours of supervision, ~~length of work experience, competence in substance abuse counseling~~ and any needs for additional supervision or training. The supervisor shall document successful completion of the applicant's supervised experience on the Verification of Supervision Form and shall maintain documentation for five years post supervision.

5. Supervision by any individual whose relationship to the supervisee compromises the objectivity of the supervisor is prohibited.

18VAC115-30-61. Prerequisites for certification by examination for substance abuse counseling assistant.

A. ~~A candidate~~ Every applicant for certification as a substance abuse counseling assistant shall ~~meet all the requirements of this section, including passing~~ pass a written examination approved by the board. The board shall determine the passing score on the examination ~~prescribed in 18VAC115-30-90~~.

1. If an applicant fails to achieve a passing score within two years of board approval to sit for the examination, the applicant shall reapply according to regulations in effect at that time.

2. An applicant who has applied twice and has not passed the examination shall not be approved to retake the examination, unless the applicant can provide evidence of extenuating circumstances for failure to pass the examination within the four-year period.

B. Every applicant for examination for certification by the board shall:

1. Meet the educational and experience requirements prescribed in 18VAC115-30-62 and 18VAC115-30-63; and

2. Submit the following to the board within the ~~time frame~~ timeframe established by the board:

a. A completed application form;

b. Official transcript documenting attainment of a high school diploma ~~or~~, a general education development (GED) certificate, or a post-secondary degree; ~~and~~

c. The application processing and initial certification fee;

d. Verification of all health or mental health licenses or certificates ever held in Virginia or in any other jurisdiction. In order to qualify for certification, the applicant shall have no unresolved action against a license or certificate. The board will consider the history of disciplinary action on a case-by-case basis; and

e. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB).

18VAC115-30-62. Educational requirements for substance abuse counseling assistants.

A. An applicant for certification as a substance abuse counseling assistant shall:

1. Have ~~an official~~ obtained a high school diploma ~~or~~, a general educational development (GED) certificate, or a post-secondary degree; and

2. Have completed ~~300 clock hours of~~ substance abuse education from one of the following programs:

a. ~~An~~ A regionally accredited university or college; or

b. Seminars and workshops that meet the educational requirements specified in subsection B of this section and are offered or approved by one of the following:

(1) ~~The American Association of Marriage and Family Counselors and its state affiliates~~ Federal, state, or local governmental agencies; public school systems; or licensed health facilities.

(2) The American Association of Marriage and Family Therapists and its state affiliates.

(3) The American Association of State Counseling Boards.

(4) The American Counseling Association and its state and local affiliates.

(5) The American Psychological Association and its state affiliates.

(6) The Commission on Rehabilitation Counselor Certification.

(7) NAADAC~~, The Association for Addiction Professionals~~ and its state and local affiliates.

(8) National Association of Social Workers.

(9) National Board for Certified Counselors.

(10) A national behavioral health organization or certification body recognized by the board.

(11) Individuals or organizations that have been approved as continuing competency sponsors by the American Association of State Counseling Boards or a counseling board in another state.

B. Substance abuse education. ~~1.~~ The education will include 120 hours spent in receiving didactic training in substance abuse counseling. Each applicant shall have received a minimum of ~~10~~ eight clock hours in each of the following ~~eight~~ 13 areas:

a. Understanding the dynamics of human behavior;

b. Signs and symptoms of substance abuse;

c. ~~Treatment approaches~~ Counseling theories and techniques;

d. Case management skills and continuum of care;

e. Recovery process and relapse prevention methods;

f. ~~Ethics~~ Professional orientation and ethics;

g. ~~Professional identity in the provision of substance abuse services~~ Cultural competency; ~~and~~

h. ~~Crisis~~ Trauma and crisis intervention;

i. Pharmacology of abused substances;

j. Co-occurring disorders;

k. Substance abuse counseling approaches and treatment planning;

l. Group counseling; and

m. Prevention, screening, and assessment of substance use and abuse.

~~2. The education shall include 180 hours of experience performing the following tasks with substance abuse clients while under supervision:~~

~~a. Screening clients and gathering information used in making the determination for the need for additional professional assistance;~~

~~b. Intake of clients by performing the administrative tasks necessary for admission to a program;~~

~~c. Orientation of new clients to program's rules, goals, procedures, services, costs and the rights of the client;~~

~~d. Assisting the client in identifying and ranking problems to be addressed, establish goals, and agree on treatment processes;~~

~~e. Implementation of a substance abuse treatment plan as directed by the supervisor;~~

~~f. Implementation of case management activities that bring services, agencies, people and resources together in a planned framework of action to achieve established goals;~~

~~g. Assistance in identifying appropriate crisis intervention responses to clients' needs during acute mental, emotional or physical distress;~~

~~h. Education of clients by providing information about drug abuse and available services and resources;~~

~~i. Facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical valuation or treatment planning;~~

~~j. Reporting and charting information about client's treatment, progress, and other client-related data; and~~

~~k. Consultation with other professionals to assure comprehensive quality care for the client.~~

~~Each of these tasks shall be performed for at least eight hours under supervision and shall be verified as a part of the application by the supervisor.~~

~~C. Groups and classes attended as a part of a therapy or treatment program shall not be accepted as any part of the educational experience.~~

18VAC115-30-63. Experience requirements for substance abuse counseling assistants.

A. In addition to the didactic training required in 18VAC115-30-62, the education shall include 180 hours of experience in a practicum or internship consistent with § 54.1-3507.2 C of the Code of Virginia performing the following tasks with substance abuse clients while under supervision:

1. Screening clients and gathering information used in making the determination for the need for additional professional assistance;

2. Intake of clients by performing the administrative tasks necessary for admission to a program;

3. Orientation of new clients to program's rules, goals, procedures, services, costs, and the rights of the client;

4. Assisting the client in identifying and ranking problems to be addressed, establishing goals, and agreeing on treatment processes;

5. Implementation of a substance abuse treatment plan as directed by the supervisor;

6. Implementation of case management activities that bring services, agencies, people, and resources together in a planned framework of action to achieve established goals;

7. Assistance in identifying appropriate crisis intervention responses to a client's needs during acute mental, emotional, or physical distress;

8. Education of clients by providing information about drug abuse and available services and resources;

9. Facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical valuation or treatment planning;

10. Reporting and charting information about the client's treatment, progress, and other client-related data; and

11. Consultation with other professionals to assure comprehensive quality care for the client.

B. Each of these tasks shall be performed for at least eight hours under supervision and shall be verified as a part of the application by the supervisor.

C. Groups and classes attended as a part of a therapy or treatment program shall not be accepted as any part of the educational experience.

~~Part III~~
~~Examinations~~

18VAC115-30-90. ~~General examination requirements for substance abuse counselors and substance abuse counseling assistants.~~ (Repealed.)

~~A. Every applicant for certification as a substance abuse counselor or substance abuse counseling assistant by examination shall pass a written examination approved by the board. The board shall determine the passing score on the examination.~~

~~B. Every applicant for certification by endorsement shall have passed an examination deemed by the board to be substantially equivalent to the Virginia examination.~~

Part ~~IV~~ III
Renewal and Reinstatement

18VAC115-30-110. Annual renewal of certificate.

A. Every certificate issued by the board shall expire on June 30 of each year.

B. Along with the renewal form, the certified substance abuse counselor or certified substance abuse counseling assistant shall submit the renewal fee prescribed in 18VAC115-30-30 and shall attest to completion of continuing education as required by 18VAC115-30-111.

~~C. Certified individuals shall notify the board of a change in the address of record or the public address, if different from the address of record within 60 days. Failure to receive a renewal notice and application forms shall not excuse the certified substance abuse counselor from the renewal requirement.~~

18VAC115-30-111. Continuing education requirements.

A. Certified substance abuse counselors shall be required to have completed a minimum of 10 contact hours of continuing education in substance abuse and certified substance abuse counseling assistants shall be required to have completed a minimum of five contact hours of continuing education in substance abuse prior to renewal each year.

1. Continuing education hours shall be offered by an approved provider listed in 18VAC115-30-50 A or 18VAC115-30-62 A, and the course content shall be consistent with 18VAC115-30-50 B or 18VAC115-30-62 B.

2. Attestation of completion of continuing education is not required for the first renewal following initial certification in Virginia.

B. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the certificate holder prior to the renewal date. Such extension shall not relieve the certificate holder of the continuing education requirement.

C. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the certificate holder such as temporary disability, mandatory military service, or officially declared disasters upon written request from the certificate holder prior to the renewal date.

D. All certificate holders are required to maintain original documentation, including official transcripts showing credit hours earned or certificates of participation, for a period of three years following renewal.

E. The board may conduct an audit of certificate holders to verify compliance with the requirement for a renewal period. Upon request, a certificate holder shall provide documentation of credit hours or participation.

F. Continuing education hours required by disciplinary order shall not be used to satisfy renewal requirements.

18VAC115-30-120. Reinstatement.

A. A person whose certificate has expired may renew it within one year after its expiration date by paying the late renewal fee prescribed in 18VAC115-30-30 and the certification fee prescribed for the year the certificate was not renewed.

B. A person who fails to renew a certificate after one year or more shall ~~apply~~:

1. Apply for reinstatement~~, pay~~;

2. Pay the reinstatement fee for a lapsed certificate ~~and submit~~;

3. Submit verification of any other health or mental health license or certificate ever held in another jurisdiction;

4. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank; and

5. Submit evidence of a minimum of 20 hours of substance abuse education that is consistent with course content specified in ~~subsection B of~~ 18VAC115-30-50 B for substance abuse counselors and in 18VAC115-30-62 for substance abuse counseling assistants to demonstrate the continued ability to perform the functions within the scope of practice of the certificate. Courses shall be offered or approved by a provider listed in 18VAC115-30-50 A or 18VAC115-30-62 A.

Part V
Standards of Practice; Disciplinary Actions; Reinstatement

18VAC115-30-140. Standards of practice.

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board.

B. Persons certified by the board shall:

1. Practice in a manner that is in the best interest of the public and does not endanger the public health, safety, or welfare.

2. Be able to justify all services rendered to clients as necessary for diagnostic or therapeutic purposes.

3. Practice only within the competency area for which they are qualified by training or experience.

4. Report to the board known or suspected violations of the laws and regulations governing the practice of certified substance abuse counselors or certified substance abuse counseling assistants.

5. Neither accept nor give commissions, rebates, or other forms of remuneration for referral of clients for professional services. Make appropriate consultations and referrals based on the best interest of clients.

6. Stay abreast of new developments, concepts, and practices that are necessary to providing appropriate services.

7. Document the need for and steps taken to terminate a counseling relationship when it becomes clear that the client is not benefiting from the relationship. Document the assistance provided in making arrangements for the continuation of treatment for clients when necessary, following termination of a counseling relationship.

8. Not willfully or negligently breach the confidentiality between a practitioner and a client. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

C. In regard to client records, persons certified by the board shall:

~~6.~~ 1. Disclose counseling records to others only in accordance with ~~the requirements of state and federal statutes and regulations, including, but not limited to §§ 32.1-127.1:03 (Patient Health Records Privacy Act), 2.2-3704 (Virginia Freedom of Information Act), and 54.1-2400.1 (Mental Health Service Providers; Duty to Protect Third Parties; Immunity) of the Code of Virginia; 42 USC § 290dd-2 (Confidentiality of Drug and Alcohol Treatment Records); and 42 CFR Part 2 (Alcohol and Drug Abuse Patient Records and Regulations)~~ applicable law.

2. Maintain client records securely, inform all employees of the requirements of confidentiality, and provide for the destruction of records that are no longer useful in a manner that ensures client confidentiality.

3. Ensure confidentiality in the usage of client records and clinical materials by obtaining informed consent from the client or the client's legally authorized representative before (i) videotaping, (ii) audio recording, (iii) permitting third-party observation, or (iv) using identifiable client records and clinical materials in teaching, writing, or public presentations.

4. Maintain timely, accurate, legible, and complete written or electronic records for each client, to include counseling dates and identifying information to substantiate the substance abuse counseling plan, client progress, and termination.

5. Maintain client records for a minimum of five years or as otherwise required by law from the date of termination of the counseling relationship with the following exceptions:

a. At minimum, records of a minor child shall be maintained for five years after attaining the age of majority (18 years);

b. Records that are required by contractual obligation or federal law to be maintained for a longer period of time; or

c. Records that have been transferred to another mental health service provider or given to the client or the client's legally authorized representative.

D. In regard to dual relationships, persons certified by the board shall:

~~7.~~ 1. Not engage in dual relationships with clients, former clients, supervisees, and supervisors that are harmful to the client's or supervisee's ~~well-being,~~ well-being or ~~which~~ that would impair the substance abuse counselor's, substance abuse counseling assistant's, or supervisor's objectivity and professional judgment~~,~~ or increase the risk of client or supervisee exploitation. This prohibition includes~~, but is not limited to,~~ such activities as counseling close friends, former sexual partners, employees, or relatives~~;~~ or engaging in business relationships with clients.

~~Engaging~~ 2. Not engage in sexual intimacies or romantic relationships with current clients or supervisees ~~is strictly prohibited~~. For at least five years after cessation or termination of professional services, certified substance abuse counselors and certified substance abuse counseling assistants shall not engage in sexual intimacies or romantic relationships with a client or those included in collateral therapeutic services. ~~Since~~ Because sexual or romantic relationships are potentially exploitative, certified substance abuse counselors and certified substance abuse counseling assistants shall bear the burden of demonstrating that there has been no exploitation. A client's consent to, initiation of, or participation in sexual behavior or involvement with a certified substance abuse counselor or certified substance abuse counseling assistants does not change the nature of the conduct nor lift the regulatory prohibition.

~~8.~~ 3. Recognize conflicts of interest and inform all parties of obligations, responsibilities, and loyalties to third parties.

E. Upon learning of evidence that indicates a reasonable probability that another mental health provider is or may be guilty of a violation of standards of conduct as defined in statute or regulation, persons certified by the board shall advise their clients of their right to report such misconduct to the Department of Health Professions in accordance with § 54.1-2400.4 of the Code of Virginia.

18VAC115-30-150. Grounds for ~~revocation, suspension, restriction or denial of certificate; petition for rehearing~~ disciplinary action, denial of initial certification, or denial of renewal of certification.

In accordance with subdivision 7 of § ~~54.1-2400(7)~~ 54.1-2400 and § 54.1-2401 of the Code of Virginia, the board may revoke, suspend, restrict, impose a monetary penalty, or decline to issue or renew a certificate based upon the following conduct:

1. Conviction of a felony or of a misdemeanor involving moral turpitude, or violation of or aid to another in violating any provision of Chapter 35 (§ 54.1-3500 et seq.) of Title 54.1 of the Code of Virginia, any other statute applicable to the practice of substance abuse counseling, or any provision of this chapter;

2. Procuring a certificate, including submission of an application or supervisory forms, by fraud or misrepresentation;

3. Conducting one's practice in such a manner so as to make it a danger to the health and welfare of one's clients or to the public; or if one is unable to practice substance abuse counseling with reasonable skill and safety to clients by reason of illness, abusive use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition;

4. ~~Negligence in professional conduct or nonconformance with the standards of practice outlined in 18VAC115-30-140 or~~ Violating or abetting another person in the violation of any provision of any statute applicable to the practice of substance abuse counseling or any regulation in this chapter;

5. Performance of functions outside the board-certified area of competency in accordance with regulations set forth in this chapter and §§ 54.1-3507.1 and 54.1-3507.2 of the Code of Virginia;

6. Performance of an act likely to deceive, defraud, or harm the public;

7. Intentional or negligent conduct that causes or is likely to cause injury to a client;

8. Failure to cooperate with an employee of the Department of Health Professions in the conduct of an investigation;

9. Failure to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia or elder abuse or neglect as required in § 63.2-1606 of the Code of Virginia; or

10. Action taken against a health or mental health license, certification, registration, or application in Virginia or another jurisdiction.

VA.R. Doc. No. R17-4945; Filed December 23, 2019, 3:43 p.m.

Final Regulation

REGISTRAR'S NOTICE: The Board of Counseling is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 6 of the Code of Virginia, which excludes regulations of the regulatory boards served by the Department of Health Professions pursuant to Title 54.1 of the Code of Virginia that are limited to reducing fees charged to regulants and applicants. The Board of Counseling will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **18VAC115-80. Regulations Governing the Registration of Qualified Mental Health Professionals (amending 18VAC115-80-20).**

Statutory Authority: §§ 54.1-2400 and 54.1-3505 of the Code of Virginia.

Effective Date: February 19, 2020.

Agency Contact: Jaime Hoyle, Executive Director, Board of Counseling, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4406, or email jaime.hoyle@dhp.virginia.gov.

Summary:

The amendments reduce the application fee for registration as a qualified mental health professional-trainee to $25.

18VAC115-80-20. Fees required by the board.

A. The board has established the following fees applicable to the registration of qualified mental health professionals:

Registration as a QMHP-A	$50
Registration as a QMHP-C	$50
Registration as a QMHP-trainee	$25
Renewal of registration	$30
Late renewal	$20
Reinstatement of a lapsed registration	$75
Duplicate certificate of registration	$10
Returned check	$35
Reinstatement following revocation or suspension	$500

B. Unless otherwise provided, fees established by the board shall not be refundable.

VA.R. Doc. No. R20-6239; Filed December 31, 2019, 10:13 a.m.

BOARD OF PSYCHOLOGY

Fast-Track Regulation

Titles of Regulations: **18VAC125-20. Regulations Governing the Practice of Psychology (amending 18VAC125-20-30).**

18VAC125-30. Regulations Governing the Certification of Sex Offender Treatment Providers (amending 18VAC125-30-20).

Statutory Authority: §§ 54.1-2400 and 54.1-3605 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

Agency Contact: Jaime Hoyle, Executive Director, Board of Psychology, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4406, FAX (804) 327-4435, or email jaime.hoyle@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Psychology the authority to promulgate regulations to administer the regulatory system. The specific mandate for collection of a handling fee is found in § 2.2-4805 of the Virginia Debt Collection Act

Purpose: The rationale for the regulatory change is compliance with the Virginia Debt Collection Act (§ 2.2-4800 et seq.) of the Code of Virginia, in which the General Assembly has determined that the cost for handling returned checks or dishonored credit or debit cards is $50. The department and its regulatory boards license and discipline health care practitioners, and its mission of protecting the health and safety of the public must be supported by its licensing and miscellaneous fees.

Rationale for Using Fast-Track Rulemaking Process: The rulemaking is concurring with financial policy of the Commonwealth and is expected to be noncontroversial.

Substance: All board regulations are being amended to delete the returned check fee of $35 and replace it with a handling fee of $50 for a returned check, dishonored credit card, or dishonored debit card.

Issues: There are no primary advantages or disadvantages to the public. The primary advantage to the department is compliance with auditors from the Office of the Comptroller. There are no disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Psychology (Board) proposes to amend 18 VAC 125-20 Regulations Governing the Practice of Psychology and 18 VAC 125-30 Regulations Governing the Certification of Sex Offender Treatment Providers to state that the handling fee for a returned check or dishonored credit card or debit card is $50, replacing a current $35 charge.

Background. Code of Virginia § 2.2-614.1 specifies that:

> If any check or other means of payment tendered to a public body in the course of its duties is not paid by the financial institution on which it is drawn, because of insufficient funds in the account of the drawer, no account is in the name of the drawer, or the account of the drawer is closed, and the check or other means of payment is returned to the public body unpaid, the

amount thereof shall be charged to the person on whose account it was received, and his liability and that of his sureties, shall be as if he had never offered any such payment. A penalty of $35 or the amount of any costs, whichever is greater, shall be added to such amount.

Based on this Code provision, the current regulations include a $35 returned check charge.

On the other hand, Code of Virginia § 2.2-4805 specifies that "Returned checks or dishonored credit card or debit card payments shall incur a handling fee of $50 unless a higher amount is authorized by statute to be added to the principal account balance." According to the Department of Health Professions (DHP), the Office of the Attorney General has advised that the handling fee of $50 in Virginia Code § 2.2-4805 governs.

Estimated Benefits and Costs. Based on the view of the Office of the Attorney General that Virginia Code § 2.2-4805 prevails, the fee by law for a returned check or dishonored credit card or debit card is $50. The Board's proposal therefore conforms the regulations to current law. DHP has indicated that in practice they will continue to charge the $35 fee until this proposed regulatory action becomes effective. The services provided by DHP are funded by the fees paid by the regulated individuals and entities. To the extent that the $50 fee more accurately represents the cost incurred by DHP, the proposed change may be beneficial in that the cost would need not be subsidized by other regulants who did not cause the cost to be incurred.

Businesses and Other Entities Affected. The proposal pertains to fee-paying individuals regulated by the Board. As of June 30, 2019, there were 29 applied psychologists, 3,739 clinical psychologists, 8 residents in school psychology, 865 residents in training, 100 school psychologists, 603 school psychologists-limited, 438 sex offender treatment providers, and 157 sex offender treatment provider trainees regulated by the Board. If any of these individuals have a check returned or a credit card or debit card dishonored, the proposal would increase their cost by $15.

Localities[2] Affected.[3] The proposal does not disproportionately affect any particular localities or introduce costs for local governments.

Projected Impact on Employment. The proposal does not affect employment.

Effects on the Use and Value of Private Property. The proposal does not substantially affect the use and value of private property or real estate development costs.

Adverse Effect on Small Businesses.[4] The proposal does not substantively adversely affect small businesses.

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[2]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[3]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[4]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."

Agency's Response to Economic Impact Analysis: The Board of Psychology concurs with the analysis of the Department of Planning and Budget.

Summary:

The amendments replace the returned check fee of $35 with a fee of $50 for handling a returned check or dishonored credit card or debit card payment in compliance with § 2.2-4805 of the Code of Virginia.

18VAC125-20-30. Fees required by the board.

A. The board has established fees for the following:

	Applied psychologists, Clinical psychologists, School psychologists	School psychologists-limited
1. Registration of residency (per residency request)	$50	- -
2. Add or change supervisor	$25	- -
3. Application processing and initial licensure	$200	$85
4. Annual renewal of active license	$140	$70
5. Annual renewal of inactive license	$70	$35
6. Late renewal	$50	$25
7. Verification of license to another jurisdiction	$25	$25
8. Duplicate license	$5	$5
9. Additional or replacement wall certificate	$15	$15
10. ~~Returned check~~ Handling	~~$35~~ $50	~~$35~~ $50

fee for returned check or dishonored credit card or debit card		
11. Reinstatement of a lapsed license	$270	$125
12. Reinstatement following revocation or suspension	$500	$500

B. Fees shall be made payable to the Treasurer of Virginia and forwarded to the board. All fees are nonrefundable.

C. Between May 1, 2020, and June 30, 2020, the following renewal fees shall be in effect:

1. For annual renewal of an active license as a clinical, applied, or school psychologist, it shall be $100. For an inactive license as a clinical, applied, or school psychologist, it shall be $50.

2. For annual renewal of an active license as a school psychologist-limited, it shall be $50. For an inactive license as a school psychologist-limited, it shall be $25.

18VAC125-30-20. Fees required by the board.

A. The board has established the following fees applicable to the certification of sex offender treatment providers:

Registration of supervision	$50
Add or change supervisor	$25
Application processing and initial certification fee	$90
Certification renewal	$75
Duplicate certificate	$5
Late renewal	$25
Reinstatement of an expired certificate	$125
Replacement of or additional wall certificate	$15
~~Returned check~~ Handling fee for returned check or dishonored credit card or debit card	~~$35~~ $50
Reinstatement following revocation or suspension	$500
One-time reduction in fee for renewal on June 30, 2020	$55

B. Fees shall be made payable to the Treasurer of Virginia. All fees are nonrefundable.

VA.R. Doc. No. R20-6172; Filed December 20, 2019, 1:21 p.m.

BOARD OF SOCIAL WORK

Fast-Track Regulation

Title of Regulation: **18VAC140-20. Regulations Governing the Practice of Social Work (amending 18VAC140-20-30, 18VAC140-20-45, 18VAC140-20-60).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

Agency Contact: Jaime Hoyle, Executive Director, Board of Social Work, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4406, FAX (804) 527-4435, or email jaime.hoyle@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Social Work the authority to promulgate regulations to administer the regulatory system.

Purpose: The less burdensome and costly pathway to licensure for a person with a bachelor's degree in social work resulting from the amendments may encourage individuals to seek licensure. And, more people working in the social work field, providing support services and casework, may increase access to mental health services to help protect the public health, safety, and welfare.

Rationale for Using Fast-Track Rulemaking Process: The regulatory action will make licensure as a licensed baccalaureate social worker (LBSW) considerably less burdensome, and since the change is consistent with 35 other states, it is not expected to be controversial.

Substance: The amendments will reduce the fee for initial licensure and for annual renewal of licensure for an LBSW. The application fee is reduced from $115 to $100, and the renewal fee is reduced from $65 to $55. The most significant reduction in regulatory burden is the elimination of the current requirement for an applicant with a baccalaureate degree to have 3,000 hours of supervised experience in order to qualify for licensure as an LBSW.

Issues: There are no primary advantages or disadvantages to the public. There may be more persons working as LBSWs, providing casework and related services, if the cost reduction and elimination of supervised experience leads to an increase in the number of licensed providers. There are no advantages or disadvantages to the agency. Only 13 people are currently licensed as LBSWs, so the $10 reduction in renewal fees will not affect the board's budget.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Social Work (Board) proposes to amend 18VAC140-20 Regulations Governing the Practice of Social Work (regulation) in order to reduce the fees and remove the supervised experience requirements for "licensed baccalaureate social workers" (LBSW). The application fee would be reduced from $115 to $100, and the renewal fee would be reduced from $65 to $55. LBSW candidates are currently required to undergo 3,000 hours of supervised experience in order to qualify for licensure; this requirement would be entirely eliminated.

Background. Chapter 451 of the 2018 Acts of Assembly divided the category of "licensed social worker" into two categories of "baccalaureate social workers" (BSW) and "master's social worker" (MSW) based on the education level of the applicants. In response to Chapter 451, the Board amended the regulation to create two categories of licensure by incorporating the definitions of BSW and MSW, and replacing "licensed social worker" with "LBSW and LMSW" in all of the existing fees and requirements for licensure. Apart from these changes, the Board did not revise the content of the requirements.[2]

Prior to the creation of two separate licenses, the regulatory requirements for licensed social workers were identical for applicants with bachelor's or master's degrees, except with respect to work experience. While applicants with a master's degree were not required to acquire any supervised work experience, those with a bachelor's degree were required to register for 3,000 hours of supervised experience with a licensed social worker. This difference in requirements was maintained when the Board amended the regulation in response to Chapter 451 to create two categories of licensure: LBSW applicants are required to provide documentation of having completed 3,000 hours of supervised experience whereas LMSW applicants face no such requirement.

The board now proposes to revise the content of the requirements. Per the Agency Background Document,[3] the Board is interested in increasing the workforce that is able to provide social work services by increasing the number of LBSWs. A survey of requirements in other states found that 32 states do not require supervised experience following the bachelor's degree and 12 states have no equivalent category of licensure. Virginia has required supervised experience for 30 years and is one of only 4 states that requires supervised experience. The Board estimates that it typically takes 18 months to 2 years for a candidate to complete 3,000 hours of supervised experience. Further, the category of BSW is defined as providing basic generalist services under the supervision of an MSW, including casework management, supportive services, consultation and education.[4] Hence, removing the supervised experience requirement does not change the capacity in which LBSWs perform their professional duties but allows them to become fully licensed more expeditiously upon completing a bachelor's degree in social work.

Finally, the Board also proposes a reduction in the first-time application fee and annual renewal fees for LBSWs; the application fee would be reduced from $115 to $100, and the renewal fee would be reduced from $65 to $55. This is a reduction of the current fees by $15 and $10 respectively and is intended to more clearly distinguish between the two levels of licensure.

Estimated Benefits and Costs. Institutions that hire social workers, such as hospitals, schools, and community services boards may find it easier to fill vacancies for social workers if the number of LBSWs increases. Further, to the extent that employers are able to substitute services provided by LMSWs with services provided by LBSWs, they may be able to lower their operating costs, assuming LBSWs are paid less than LMSWs. However, the ability of employers to substitute LMSWs with LBSWs is limited since LMSWs are required to supervise LBSWs.

Potential LBSWs may benefit from the removal of the 3,000-hour supervised experience requirement by being able to obtain a license and begin employment upon obtaining their degree to the extent that having the license in hand gives them greater flexibility and bargaining power in the labor market for social workers. However, unless there already is a shortage of social workers, such that employers cannot fill positions, an increase in the supply of social workers competing for positions would likely lead to a decline in average wages paid to them.

Potential LMSWs may be affected even though the proposed changes are not directly targeted at them. If the supervised experience requirement was burdensome (difficult to arrange, low-paying, and requiring nearly two years to complete), and ultimately provided the same benefits as obtaining a master's degree, it could have incentivized social work students to obtain a master's degree before applying for licensure altogether. This is indicated by the fact that the Board currently has only 13 LBSWs but 771 LMSWs.[5] This incentive was likely heightened to the extent that the burden of obtaining a master's degree decreased over the last thirty years as a result of increased access to student loans and the proliferation of online master's programs. Although these incentives will likely interact, the removal of the supervised experience requirement could diminish the perceived additional benefit of obtaining a master's degree in social work. As a result, some of the growth in the number of LBSWs could arise from slower growth, or even a reduction, in the number of LMSWs.

Finally, an overall increase in the supply of qualified and licensed social workers would support the expansion of mental health resources in a variety of institutional settings

from schools and hospitals to prisons and rehabilitation facilities. This could lead to increased public safety and well-being in general, although these benefits may be difficult to quantify in precise terms.

Businesses and Other Entities Affected. As mentioned, some social workers with bachelor's degrees may be encouraged to seek licensure. Mental health providers and entities that employ social workers, such as hospitals and nursing facilities, correctional facilities, and child placing agencies, may find it easier to fill vacancies for licensed social workers.

Localities[6] Affected.[7] The proposed amendments do not introduce new costs for local governments and are unlikely to affect any locality in particular.

Projected Impact on Employment. The proposed amendments are likely to increase the overall number of social workers that are licensed and employed in a variety of institutional settings, from schools and hospitals to prisons and rehabilitation facilities.

Effects on the Use and Value of Private Property. The proposed amendments are unlikely to affect the use and value of private property. Real estate development costs are not affected.

Adverse Effect on Small Businesses.[8] The proposed amendments are unlikely to have an adverse impact on any small business.

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[2]See https://townhall.virginia.gov/l/ViewStage.cfm?stageid=8344, effective August 8, 2019.

[3]See https://townhall.virginia.gov/l/GetFile.cfm?File=32\5389\8766\AgencyStatement_DHP_8766_v1.pdf

[4]Code of Virginia (§ 54.1-3700)

[5]The Department of Health Professions provided this information via email. Unfortunately, they could not provide information on the highest education level of licensed social workers prior to the separation of licensure levels.

[6]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[7]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[8]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."

Agency's Response to Economic Impact Analysis: The Board of Social Work concurs with the analysis of the Department of Planning and Budget.

Summary:

The amendments (i) reduce the fee for initial licensure to $100 and the fee for annual renewal of licensure to $55 for licensed baccalaureate social workers (LBSW) and (ii) eliminate the requirement for an applicant with a bachelor's degree to have 3,000 hours of supervised experience to qualify for licensure as an LBSW.

18VAC140-20-30. Fees.

A. The board has established fees for the following:

1. Registration of supervision	$50
2. Addition to or change in registration of supervision	$25
3. Application processing	
a. Licensed clinical social worker	$165
b. LBSW	~~$115~~ $100
c. LMSW	$115
4. Annual license renewal	
a. Registered social worker	$25
b. Associate social worker	$25
c. LBSW	~~$65~~ $55
d. LMSW	$65
e. Licensed clinical social worker	$90
5. Penalty for late renewal	
a. Registered social worker	$10
b. Associate social worker	$10
c. LBSW	$20
d. LMSW	$20
e. Licensed clinical social worker	$30
6. Verification of license to another jurisdiction	$25
7. Additional or replacement licenses	$15
8. Additional or replacement wall certificates	$25
9. Returned check	$35
10. Reinstatement following disciplinary action	$500

B. Fees shall be paid by check or money order made payable to the Treasurer of Virginia and forwarded to the board. All fees are nonrefundable.

C. Examination fees shall be paid directly to the examination service according to its requirements.

18VAC140-20-45. Requirements for licensure by endorsement.

A. Every applicant for licensure by endorsement shall submit in one package:

1. A completed application and the application fee prescribed in 18VAC140-20-30.

2. Documentation of active social work licensure in good standing obtained by standards required for licensure in another jurisdiction as verified by the out-of-state licensing agency. Licensure in the other jurisdiction shall be of a comparable type as the licensure that the applicant is seeking in Virginia.

3. Verification of a passing score on a board-approved national exam at the level for which the applicant is seeking licensure in Virginia.

4. Documentation of any other health or mental health licensure or certification, if applicable.

5. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB).

6. Verification of:

a. Active practice at the level for which the applicant is seeking licensure in another United States jurisdiction for 24 out of the past 60 months;

b. Active practice in an exempt setting at the level for which the applicant is seeking licensure for 24 out of the past 60 months; or

c. Evidence of supervised experience requirements substantially equivalent to those outlined in 18VAC140-20-50 A 2 and A 3 ~~and 18VAC140-20-60 C 2 and C 3~~.

7. Certification that the applicant is not the respondent in any pending or unresolved board action in another jurisdiction or in a malpractice claim.

B. If an applicant for licensure by endorsement has not passed a board-approved national examination at the level for which the applicant is seeking licensure in Virginia, the board may approve the applicant to sit for such examination.

18VAC140-20-60. Education ~~and experience~~ requirements for an LBSW or LMSW.

~~A. Education.~~ The applicant for licensure as an LBSW shall hold a bachelor's degree from an accredited school of social work. The applicant for licensure as an LMSW shall hold a master's degree from an accredited school of social work. Graduates of foreign institutions must establish the equivalency of their education to this requirement through the Foreign Equivalency Determination Service of the Council on Social Work Education.

~~B. Master's degree applicant. An applicant who holds a master's degree may apply for licensure as an LMSW without documentation of supervised experience.~~

~~C. Supervised experience requirement for bachelor's degree applicants. Supervised experience without prior written board approval will not be accepted toward licensure, except supervision obtained in another United States jurisdiction may be accepted if it met the requirements of that jurisdiction.~~

~~1. Registration. Prior to the onset of supervision, an individual who proposes to obtain supervised experience in Virginia shall:~~

~~a. Register on a form provided by the board and completed by the supervisor and the supervised individual; and~~

~~b. Pay the registration of supervision fee set forth in 18VAC140-20-30.~~

~~2. Hours. Bachelor's degree applicants shall have completed a minimum of 3,000 hours of supervised post-bachelor's degree experience in casework management and supportive services under supervision satisfactory to the board. A minimum of one hour and a maximum of four hours of face-to-face supervision shall be provided per 40 hours of work experience for a total of at least 100 hours.~~

~~3. Supervised experience shall be acquired in no less than two nor more than four consecutive years from the beginning of the supervised experience. An individual who does not complete the supervision requirement after four consecutive years of supervised experience may request an extension of up to 12 months. The request for an extension shall include evidence that demonstrates extenuating circumstances that prevented completion of the supervised experience within four consecutive years.~~

~~D. Requirements for supervisors.~~

~~1. The supervisor providing supervision shall hold an active, unrestricted license as a licensed social worker with a master's degree, or a licensed social worker with a bachelor's degree and at least three years of post licensure social work experience or a licensed clinical social worker in the jurisdiction in which the social work services are being rendered. If this requirement places an undue burden on the applicant due to geography or disability, the board may consider individuals with comparable qualifications.~~

~~2. The supervisor shall:~~

~~a. Be responsible for the social work practice of the prospective applicant once the supervisory arrangement is accepted by the board;~~

~~b. Review and approve the assessment and service plan of a representative sample of cases assigned to the applicant during the course of supervision. The sample should be representative of the variables of gender, age, assessment, length of service and casework method within the client population seen by the applicant. It is the applicant's responsibility to assure the representativeness of the sample that is presented to the supervisor. The supervisor shall be available to the applicant on a regularly scheduled basis for supervision.~~

~~The supervisor will maintain documentation, for five years post-supervision, of which clients were the subject of supervision;~~

~~c. Provide supervision only for those casework management and support services activities for which the supervisor has determined the applicant is competent to provide to clients;~~

~~d. Provide supervision only for those activities for which the supervisor is qualified;~~

~~e. Evaluate the supervisee in the areas of professional ethics and professional competency; and~~

~~f. Ensure that the board is notified of any change in supervision or if the supervision has ended or has been terminated by the supervisor.~~

~~3. The supervisor shall not provide supervision for a family member or provide supervision for anyone with whom the supervisor has a dual relationship.~~

VA.R. Doc. No. R20-6177; Filed December 17, 2019, 6:06 p.m.

BOARD OF VETERINARY MEDICINE

Fast-Track Regulation

Title of Regulation: **18VAC150-20. Regulations Governing the Practice of Veterinary Medicine (amending 18VAC150-20-100).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 19, 2020.

Effective Date: March 5, 2020.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Veterinary Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 597-4130, FAX (804) 527-4471, or email leslie.knachel@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Veterinary Medicine the authority to promulgate regulations to administer the regulatory system. The specific mandate for collection of a handling fee is found in § 2.2-4805 of the Virginia Debt Collection Act

Purpose: The rationale for the regulatory change is compliance with the Virginia Debt Collection Act (§ 2.2-4800 et seq.) of the Code of Virginia, in which the General Assembly has determined that the cost for handling returned checks or dishonored credit or debit cards is $50. The department and its regulatory boards license and discipline health care practitioners, and its mission of protecting the health and safety of the public must be supported by its licensing and miscellaneous fees.

Rationale for Using Fast-Track Rulemaking Process: The rulemaking is concurring with financial policy of the Commonwealth and is expected to be noncontroversial.

Substance: All board regulations are being amended to delete the returned check fee of $35 and replace it with a handling fee of $50 for a returned check, dishonored credit card, or dishonored debit card.

Issues: There are no primary advantages or disadvantages to the public. The primary advantage to the department is compliance with auditors from the Office of the Comptroller. There are no disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Veterinary Medicine (Board) proposes to amend 18VAC150-20 Regulations Governing the Practice of Veterinary Medicine to state that the handling fee for a returned check or dishonored credit card or debit card is $50, replacing a current $35 charge.

Background. Code of Virginia § 2.2-614.1 specifies that:

> If any check or other means of payment tendered to a public body in the course of its duties is not paid by the financial institution on which it is drawn, because of insufficient funds in the account of the drawer, no account is in the name of the drawer, or the account of the drawer is closed, and the check or other means of payment is returned to the public body unpaid, the amount thereof shall be charged to the person on whose account it was received, and his liability and that of his sureties, shall be as if he had never offered any such payment. A penalty of $35 or the amount of any costs, whichever is greater, shall be added to such amount.

Based on this Code provision, the current regulation includes a $35 returned check charge.

On the other hand, Code of Virginia § 2.2-4805 specifies that "Returned checks or dishonored credit card or debit card payments shall incur a handling fee of $50 unless a higher amount is authorized by statute to be added to the principal account balance." According to the Department of Health Professions (DHP), the Office of the Attorney General has advised that the handling fee of $50 in Virginia Code § 2.2-4805 governs.

Estimated Benefits and Costs. Based on the view of the Office of the Attorney General that Virginia Code § 2.2-4805 prevails, the fee by law for a returned check or dishonored credit card or debit card is $50. The Board's proposal therefore conforms the regulation to current law. DHP has indicated that in practice they will continue to charge the $35 fee until this proposed regulatory action becomes effective. The services provided by DHP are funded by the fees paid by

the regulated individuals and entities. To the extent that the $50 fee more accurately represents the cost incurred by DHP, the proposed change may be beneficial in that the cost would need not be subsidized by other regulants who did not cause the cost to be incurred.

Businesses and Other Entities Affected. The proposal pertains to fee-paying individuals and entities regulated by the Board. As of June 30, 2019, there were 24 equine dental technicians, 4,430 veterinarians, 1,151 veterinary establishments, 77 veterinary faculty, 58 veterinary intern/residents, and 2,327 veterinary technicians regulated by the Board.[2] If any of these individuals or entities have a check returned or a credit card or debit card dishonored, the proposal would increase their cost by $15.

Localities[3] Affected.[4] The proposal does not disproportionately affect any particular localities or introduce costs for local governments.

Projected Impact on Employment. The proposal does not affect employment.

Effects on the Use and Value of Private Property. The proposal does not substantially affect the use and value of private property or real estate development costs.

Adverse Effect on Small Businesses[5]:

Types and Estimated Number of Small Businesses Affected. The proposed amendment potentially affects the 1,151 veterinary establishments licensed in the Commonwealth, most or all of which likely qualify as small businesses.

Costs and Other Effects. If any of the veterinary establishments have a check returned or a credit card or debit card dishonored, the proposal would increase their cost by $15.

Alternative Method that Minimizes Adverse Impact. There are no clear alternative methods that both reduce adverse impact and meet the intended policy goals.

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[2]Data source: DHP

[3]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[4]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[5]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."

Agency's Response to Economic Impact Analysis: The Board of Veterinary Medicine concurs with the Analysis of the Department of Planning and Budget.

Summary:

The amendments replace the returned check fee of $35 with a fee of $50 for handling a returned check or dishonored credit card or debit card payment in compliance with § 2.2-4805 of the Code of Virginia.

18VAC150-20-100. Fees.

The following fees shall be in effect:

Veterinary application for licensure	$200
Veterinary application for faculty licensure	$100
Veterinary license renewal (active)	$175
Veterinary license renewal (inactive)	$85
Veterinary faculty license renewal	$75
Veterinary reinstatement of expired license	$255
Veterinary license late renewal	$60
Veterinary faculty license late renewal	$25
Veterinarian reinstatement after disciplinary action	$450
Veterinary intern/resident license -- initial or renewal	$25
Veterinary technician application for licensure	$65
Veterinary technician license renewal	$50
Veterinary technician license renewal (inactive)	$25
Veterinary technician license late renewal	$20
Veterinary technician reinstatement of expired license	$95
Veterinary technician reinstatement after disciplinary action	$125
Equine dental technician initial registration	$100
Equine dental technician registration renewal	$70
Equine dental technician late renewal	$25
Equine dental technician reinstatement	$120
Initial veterinary establishment registration	$300
Veterinary establishment renewal	$200
Veterinary establishment late renewal	$75
Veterinary establishment reinstatement	$75
Veterinary establishment reinspection	$300
Veterinary establishment -- change of location	$300

Veterinary establishment -- change of veterinarian-in-charge	$40
Duplicate license	$15
Duplicate wall certificate	$25
~~Returned check~~ Handling fee for returned check or dishonored credit card or debit card	~~$35~~ $50
Licensure verification to another jurisdiction	$25

VA.R. Doc. No. R20-6170; Filed December 20, 2019, 1:20 p.m.

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TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Proposed Regulation

Title of Regulation: **22VAC30-100. Adult Protective Services (amending 22VAC30-100-10, 22VAC30-100-20, 22VAC30-100-40 through 22VAC30-100-80; adding 22VAC30-100-45; repealing 22VAC30-100-30).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: March 20, 2020.

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.

Basis: Section 51.5-148 of the Code of Virginia gives the Department for Aging and Rehabilitative Services (DARS) the responsibility for the planning, administration, and implementation of adult protective services (APS) in the Commonwealth. In addition, § 51.5-148 establishes the provision of these services by local departments of social services (LDSSs) and subject to the regulations promulgated by the Commissioner of the Department for Aging and Rehabilitative Services. Finally, § 51.5-131 of the Code of Virginia authorizes the commissioner to promulgate regulations necessary to carry out the provisions of the laws of the Commonwealth administered by the department.

Purpose: This regulatory action amends and clarifies language describing LDSS actions during the provision of APS to vulnerable adults in the Commonwealth. The standards ensure that an adult's health and safety remain a primary focus when services are provided to victims of adult abuse, neglect, or exploitation.

The right to review process establishes requirements ensuring that alleged perpetrators are afforded the opportunity to dispute the investigative findings of the LDSS while also balancing the safety and welfare of adult victims.

This regulatory action ensures the regulation content is clear, which is essential to ensuring that the adult's health and safety needs are most appropriately met.

Substance: Proposed changes include clarifying definitions and other regulation text as well as amending content that is obsolete or inconsistent. The intention is also to review regulatory language to ensure requirements adequately address the safety of the adult who is receiving services, while also balancing the adult's right to self-determination.

The regulatory language explains the requirements regarding workers' case documentation, including entering the case record into the state database of record. DARS guidance has included this information for several years, but it is necessary to include it in regulation. This action also eliminates regulatory language that may be redundant or confusing to workers.

The section that addresses civil penalties provides a more detailed process for each step in imposing a civil penalty. The Office of the Attorney General (OAG) determined that the current language needs to be more precise.

A new section establishes a right to review process for alleged perpetrators of adult abuse, neglect, or exploitation. Guidance provided by the OAG stated that this process needed to be established.

Other revisions to the regulation content may also be proposed based on public comment.

Issues: The advantages to the public and the agency or Commonwealth include that:

1. The amendments to the regulations ensure that the needs of older adults and individuals with disabilities are met during APS investigations and service provision. With the exception of the addition of the right to review process, the amendments to the regulation clarify but do not increase LDSS staff responsibilities.

2. The majority of the regulatory content comports with current manual guidance and current LDSS practice. The increase in responsibilities regarding right to review are balanced by the need to ensure that an individual who the LDSS identifies as the alleged perpetrator of adult abuse, neglect, or exploitation is afforded the opportunity to address this issue with the LDSS. The right to review process does not undermine or conflict with any due process protections afforded the alleged perpetrator by other licensing, regulatory, or legal authorities.

3. Amendments to the section addressing civil penalties clarify the process and more thoroughly explain that the responsibilities of individuals involved in the imposition of a civil penalty when a mandated reporter fails to report. Most mandated reporters are regulated by other state agencies.

While the proposed regulation has the beneficial impact of providing a consistent framework during the provision of APS in Virginia, it does have the disadvantage of a fiscal impact (as it relates to the right to review process) on the Commonwealth and LDSS. There are no disadvantages to the public.

Small Business Impact Review Report of Findings: This proposed regulatory action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Department for Aging and Rehabilitative Services (DARS) proposes to incorporate the current policy on an alleged adult abuse, neglect, or exploitation perpetrator's right to review the actions taken by the local department of social services (LDSS) as well as to make clarifying changes to content that may be unclear, inconsistent, or obsolete.

Background. This regulation establishes standards for LDSS for the provision of Adult Protective Services (APS) investigations and post-investigation services.

Estimated Benefits and Costs. Currently, an alleged adult abuse, neglect, or exploitation perpetrator's right to review actions taken against him/her by LDSS are addressed in DARS policy manuals. However, the Attorney General has advised DARS to incorporate the current policy into regulation. The right to review is a process by which the alleged perpetrator can contest an adverse disposition. Although, the right to review has existed in DARS policy manuals, DARS expects that inclusion of the process in the regulation would significantly improve compliance because the standards would be in a regulation, which has the force of law, rather than policy documents, which do not. Consequently, promulgation of the right to review in regulation is anticipated to result in additional reviews and hence increased administrative costs for LDSS.

DARS estimates 427 right to reviews may be held annually pursuant to this regulation. It is estimated that a local APS worker would spend seven hours of staff time per review at $36/hour to prepare for and conduct a right to review. It is also estimated that a local director would spend three additional hours per review at $63/hour to conduct a right to review. If 427 reviews occur annually, statewide staff expenses would be $188,368. Postage costs are estimated at $5 per review for a total of $2,135 bringing the total costs to $190,503. Localities would fund $29,528 (15.5%) of this amount and the rest, $160,975 (84.5%), would be funded by the Department of Social Services.

On the other hand, this action confers a benefit by strengthening an individual's right to contest an adverse disposition and avoid the consequences that may follow such a finding, especially if the finding would be communicated to a licensing, regulatory, or legal authority. However, DARS cannot estimate the number of cases where an original disposition may be amended after the right to review process is invoked. Additionally, local departments of social services as well as the public would have ease of access to and clarity about the right to review, likely producing a more consistent application of this process throughout the state and conferring the other procedural benefits that result from promulgation of a regulation under the Administrative Process Act.

According to DARS, the remaining changes largely reflect and clarify practices already followed by LDSS, and they are therefore not expected to create any significant economic impact other than improving the clarity of the existing rules.

Businesses and Other Entities Affected. The proposed amendments to the regulation estimated to primarily affect 427 individuals who may invoke their right to review their dispositions.

Localities[2] Affected.[3] The proposed amendments should not affect any locality more than others. The proposed amendments are estimated to introduce $29,528 in administrative costs for local departments to conduct 427 right to reviews annually.

Projected Impact on Employment. The proposed amendments would require 4,270 hours of staff time statewide annually to implement the right to review process.

Effects on the Use and Value of Private Property. The proposed amendments would not affect the use and value of private property.

Adverse Effect on Small Businesses.[4] The proposed amendments do not appear to adversely affect small businesses.

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[2]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[3]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[4]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."

Agency's Response to Economic Impact Analysis: The Virginia Department for Aging and Rehabilitative Services concurs with the economic impact analysis performed by the Department of Planning and Budget.

Summary:

The proposed amendments update standards for local departments of social services (LDSSs) for the provision of adult protective services (APS) investigations and post-investigation services and provisions for the imposition of civil penalties on mandated reporters who fail to report suspected adult abuse, neglect, or exploitation, including (i) updating 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; (ii) clarifying the specific actions an APS worker must take; and (iii) establishing a process to afford certain alleged perpetrators of adult abuse, neglect, or exploitation the opportunity to review the actions taken by an LDSS.

22VAC30-100-10. Definitions.

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

"Abuse" means the willful infliction of physical pain, injury, or mental anguish or unreasonable confinement of an adult as defined in § 63.2-1603 of the Code of Virginia.

"Adult" means any person ~~in the Commonwealth who is abused, neglected, or exploited, or is at risk of being abused, neglected, or exploited; and is 18 years of age or older and incapacitated, or is~~ 60 years of age and older, or any person 18 years of age or older who is incapacitated and who resides in the Commonwealth; provided, however, "adult" may include qualifying nonresidents who are temporarily in the Commonwealth and who are in need of temporary or emergency protective services.

"Adult protective services" or "APS" means services provided by the local department that are necessary to protect an adult as defined in § 63.2-1603 of the Code of Virginia from abuse, neglect, or exploitation.

"APS case management information system" means the computer system that collects and maintains information on APS reports, investigations, and service provision. The system is the official state automated system for APS.

"Collateral" means a person whose personal or professional knowledge may help confirm or rebut the allegations of adult abuse, neglect, or exploitation or whose involvement may help ensure the safety of the adult.

"Commissioner" means the commissioner of the department.

"Conservator" means a person appointed by the court who is responsible for managing the estate and financial affairs of an incapacitated person, and where the context plainly indicates, includes a "limited conservator" or a "temporary conservator."

"Department" or "DARS" means the Virginia Department for Aging and Rehabilitative Services.

"Director" means the director or his ~~delegated~~ designated representative of the local department of social services of ~~the~~ any city or county in ~~which the adult resides or is found~~ the Commonwealth.

"Disposition" means the determination by the local department of whether or not adult abuse, neglect, or exploitation has occurred.

"Documentation" means information and materials, written or otherwise, concerning allegations, facts, and evidence.

"Exploitation" means the illegal, unauthorized, improper, or fraudulent use of an adult as defined in § 63.2-1603 of the Code of Virginia or ~~his~~ the adult's funds, property, benefits, resources, or other assets for another's profit, benefit, or advantage, including a caregiver or person serving in a fiduciary capacity, or that deprives the adult of his rightful use of or access to such funds, property, benefits, resources, or other assets. "Adult exploitation" includes (i) an intentional breach of a fiduciary obligation to an adult to his detriment or an intentional failure to use the financial resources of an adult in a manner that results in neglect of such adult; (ii) the acquisition, possession, or control of an adult's financial resources or property through the use of undue influence, coercion, or duress; and (iii) forcing or coercing an adult to pay for goods or services or perform services against his will for another's profit, benefit, or advantage if the adult did not agree, or was tricked, misled, or defrauded into agreeing, to pay for such goods or services or perform such services.

"Guardian" means a person ~~who has been legally invested with the authority and charged with the duty of taking care of the person and managing his property and protecting the rights of the person who has been declared by the circuit court to be incapacitated and incapable of administering his own affairs~~ appointed by the court who is responsible for the personal affairs of an incapacitated person, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, therapeutic treatment, and, if not inconsistent with an order of involuntary admission, residence. Where the context plainly indicates, the term includes a "limited guardian" or a "temporary guardian." The powers and duties of the guardian are defined by the court and are limited to matters within the areas ~~where~~ in which the person in need of a guardian has been determined to be incapacitated.

"Guardian ad litem" means an attorney appointed by the court to represent the interest of the adult for whom a guardian or conservator is requested. ~~On the hearing of the petition for appointment of a guardian or conservator, the guardian ad litem advocates for the adult who is the subject of the hearing, and his duties are usually concluded when the case is decided.~~

"Incapacitated person" means any adult who is impaired by reason of mental illness, intellectual disability, physical illness or disability, advanced age, or other causes to the extent that the adult lacks sufficient understanding or capacity to make, communicate, or carry out ~~reasonable~~ responsible decisions concerning his well-being. ~~This definition is~~ As used in this chapter for the purpose of establishing an adult's eligibility for ~~adult protective services and~~ APS, such adult may or may not have been ~~found~~ adjudicated incapacitated ~~through~~ by a court ~~procedures~~.

"Involuntary protective services" means those services authorized by the court for an adult who has been determined to need protective services and who has been adjudicated incapacitated and lacking the capacity to consent to receive the needed protective services.

"Lacks capacity to consent" means a preliminary judgment of a local department of social services ~~social worker~~ that an adult is unable to consent to receive needed services for reasons that relate to an emotional or psychiatric ~~problems~~ condition, intellectual disability, developmental ~~delay~~ disability, or other reasons ~~which~~ that impair the adult's ability to recognize a substantial risk of death or immediate and serious harm to himself. The lack of capacity to consent may be either permanent or temporary. The ~~worker must~~ local department shall make a preliminary judgment that the adult lacks capacity to consent before petitioning the court for authorization to provide protective services on an emergency basis pursuant to § 63.2-1609 of the Code of Virginia.

"Legally incapacitated" means that the person has been adjudicated incapacitated by a circuit court because of a mental or physical condition ~~which~~ that renders him, either wholly or partially, incapable of taking care of himself or his estate.

~~"Legally incompetent" means a person who has been adjudicated incompetent by a circuit court because of a mental condition which renders him incapable of taking care of his person or managing his estate.~~

"Legitimate interest" means a lawful, demonstrated ~~privilege~~ right to access the requested information ~~as defined in § 63.2-104~~ pursuant to § 51.5-122 of the Code of Virginia.

"Local department" means any local department of social services in the Commonwealth of Virginia.

"Mandated reporters" means those persons identified in § 63.2-1606 of the Code of Virginia who are required to report ~~pursuant to § 63.2-1606 of the Code of Virginia~~ to APS when such persons have reason to suspect that an adult is abused, neglected, or exploited or is at risk of ~~adult~~ abuse, neglect, or exploitation.

"Mental anguish" means a state of emotional pain or distress resulting from ~~activity (verbal or behavioral)~~ verbal or behavioral actions of ~~a~~ an alleged perpetrator. The intent of the ~~activity~~ action is to threaten or intimidate, cause sorrow or fear, humiliate, change behavior, or ridicule the adult. There must be observable or documented evidence that it is the alleged perpetrator's ~~activity~~ action that has caused the adult's ~~feelings of~~ emotional pain or distress.

"Neglect" means that an adult as defined in § 63.2-1603 of the Code of Virginia is living under such circumstances that he is not able to provide for himself or is not being provided such services as are necessary to maintain his physical and mental health and that the failure to receive such necessary services impairs or threatens to impair his well-being. However, no adult shall be considered neglected solely on the basis that such adult is receiving religious nonmedical treatment or religious nonmedical nursing care in lieu of medical care, provided that such treatment or care is performed in good faith and in accordance with the religious practices of the adult and there is written or oral expression of consent by that adult. Neglect includes the failure of a caregiver or another responsible person to provide for basic needs to maintain the adult's physical and mental health and well-being, and it includes the adult's neglect of self. Neglect includes:

1. The lack of clothing considered necessary to protect ~~a person's~~ an adult's health;

2. The lack of food necessary to prevent physical injury or to maintain life, including failure to receive appropriate food for adults with conditions requiring special diets;

3. Shelter that is not structurally safe; has rodents or other infestations ~~which~~ that may result in serious health problems; or does not have a safe and accessible water supply, safe heat source, or sewage disposal. Adequate shelter for an adult ~~will depend~~ depends on the impairments of ~~an~~ the adult; however, the adult must be protected from the elements that would seriously endanger his health (e.g., rain, cold, or heat) and could result in serious illness or debilitating conditions;

4. Inadequate supervision by a paid or unpaid caregiver ~~(paid or unpaid)~~ who ~~has been designated to provide~~ provides the supervision necessary to protect the safety and well-being of an adult in his care;

5. The failure of persons who are responsible for caregiving to seek needed medical care or to follow medically prescribed treatment for an adult, or the adult has failed to obtain such care for himself. The needed medical care is believed to be of such a nature as to result in physical or mental injury or illness if it is not provided;

6. Medical neglect includes the withholding of medication or aids needed by the adult ~~such as~~ including dentures, eye glasses, hearing aids, ~~walker, etc~~ or walkers. It also includes the unauthorized administration of prescription drugs, over-medicating or under-medicating, and the administration of drugs for other than ~~bona fide~~ medical

reasons, as determined by a licensed health care professional; ~~and~~ or

7. Self-neglect by an adult who is not meeting his own basic needs due to mental or physical impairments. Basic needs refer to such things as food, clothing, shelter, health, or medical care.

"Notification" means informing designated and appropriate individuals or agencies of the local department's action and the individual's rights.

"Preponderance of evidence" means the evidence as a whole shows that the facts are more probable and credible than not. It is evidence that is of greater weight or more convincing than the evidence offered in opposition.

"Report" means an allegation made in writing or orally by any person that an adult is ~~in need of protective services~~ suspected of being abused, neglected, or exploited or at risk of being abused, neglected, or exploited. ~~The term "report" shall refer to both reports and complaints of abuse, neglect, and exploitation of adults.~~ The report ~~may~~ shall be made ~~orally or in writing~~ to the local department or by calling the ~~Adult Protective Services~~ APS Hotline.

"Responsible person" means an individual who is authorized by state law to make decisions concerning the adult and to receive information about the adult.

"Service plan" means a written plan of action to address the service needs of an adult in order to protect the adult, to prevent future abuse, neglect, or exploitation, and to preserve the autonomy of the adult whenever possible.

"Unreasonable confinement" means the use of physical or chemical restraints ~~(physical or chemical)~~, isolation, or any other means of confinement ~~without medical orders,~~ when there is no emergency and for reasons other than the adult's safety or well-being or the safety of others.

"Valid report" means the local department ~~of social services~~ has evaluated the information and allegations of the report and determined that the local department shall conduct an investigation because all of the ~~following~~ elements of 22VAC30-100-20 C for a valid report are present~~:~~.

~~1. The alleged victim adult is 60 years of age or older or is 18 years of age or older and is incapacitated;~~

~~2. There is a specific adult with enough identifying information to locate the adult;~~

~~3. Circumstances allege abuse, neglect or exploitation or risk of abuse, neglect or exploitation; and~~

~~4. The local department receiving the report is a local department of jurisdiction as described in 22VAC30-100-20.~~

~~"Voluntary protective services" means those services provided to an adult who, after investigation by a local department, is determined to be in need of protective services and consents to receiving the services so as to prevent further abuse, neglect, and exploitation of an adult at risk of abuse, neglect and exploitation.~~

22VAC30-100-20. Adult protective services intake and investigation.

A. This section establishes the process for ~~the adult protective services~~ APS intake and investigation and provides priority to situations that are most critical.

B. ~~The validity of the report shall be determined. Investigations shall be initiated by the local department not later than 24 hours from the time a valid report was received in the local department.~~ All reports shall be entered into the APS case management information system within 48 hours of its receipt by the local department.

C. The local department shall determine if the report is valid by evaluating the information and allegations in the report. A report is valid if all of the following elements are present:

1. The alleged adult victim is 60 years of age or older or is 18 years of age or older and is incapacitated;

2. There is a specific adult with enough identifying information to locate the adult;

3. Circumstances allege abuse, neglect, or exploitation or risk of abuse, neglect, or exploitation; and

4. The local department receiving the report is the local department of jurisdiction as described in this section.

D. Within 24 hours after receiving a valid report, the local department shall initiate an investigation.

1. To initiate the investigation, the ~~social worker must~~ local department shall gather enough information concerning the report to determine ~~(i) if the report is valid and (ii)~~ if an immediate response is needed to ensure the safety of the alleged victim. Pertinent information may be obtained from the report, case record reviews, contact with the alleged victim, the reporter, friends ~~and~~, neighbors ~~and~~, service providers, or other sources of information.

2. When determining the need for an immediate response, the ~~social worker~~ local department shall consider the following factors:

a. The imminent danger to the adult or to others;

b. The severity of the alleged abuse, neglect, or exploitation;

c. The circumstances surrounding the alleged abuse, neglect, or exploitation; and

d. The physical and mental condition of the adult.

3. A face-to-face contact with the alleged victim shall be made as soon as possible but not later than five calendar

days after the date of the initiation of the investigation unless there are valid reasons that the contact could not be made. Those reasons shall be documented in the ~~Adult Protective Services Assessment Narrative as described in 22VAC30-100-40~~ APS case management information system. The timing of the interview with the alleged victim should occur in a reasonable amount of time ~~pursuant to~~ consistent with the local department's consideration of the circumstances in subdivision 2 of this subsection.

~~C. The report shall be reduced to writing within 72 hours of receiving the report on a form prescribed by the department.~~

~~D.~~ E. The purpose of the investigation is to determine whether the adult alleged to be abused, neglected, or exploited or at risk of abuse, neglect, or exploitation is in need of protective services and, if so, to identify those services ~~needed to provide the protection~~.

~~E.~~ F. The local department shall conduct a thorough investigation of the report.

~~F.~~ G. The investigation shall include a visit and private interview with the adult alleged to be abused, neglected, or exploited.

~~G.~~ H. The investigation shall include consultation with others ~~having~~ who may have knowledge ~~of the facts of~~ or information about the ~~particular case~~ report.

I. An APS assessment shall be required for all APS investigations and shall be entered into the APS case management information system. The APS assessment shall address the following:

1. Allegations in the report or circumstances discovered during the investigation that meet the definitions of adult abuse, neglect, or exploitation.

2. The extent to which the adult is physically, emotionally, and mentally capable of making and carrying out decisions concerning his health and well-being.

3. How the adult's environment, functional ability, physical and mental health, support system, and income and resources may be contributing factors in the abuse, neglect, or exploitation.

4. The risk of serious harm to the adult.

5. The need for an immediate response by the local department to a valid report.

6. The circumstances and information concerning an interview with the alleged victim, the alleged perpetrator (if known), and any collateral contacts having knowledge of the case.

~~H.~~ J. Primary responsibility for the investigation when more than one local department may have jurisdiction under § 63.2-1605 of the Code of Virginia shall be assumed by the local department:

1. Where the subject of the investigation resides when the place of residence is known and when the alleged abuse, neglect, or exploitation occurred in the city or county of residence;

2. Where the abuse, neglect, or exploitation is believed to have occurred when the report alleges that the incident occurred outside the city or county of residence;

3. Where the abuse, neglect, or exploitation was discovered if the incident did not occur in the city or county of residence or if the city or county of residence is unknown and the place where the abuse, neglect, or exploitation occurred is unknown; or

4. Where the abuse, neglect, or exploitation was discovered if the subject of the report is a nonresident who is temporarily in the Commonwealth.

K. An adult's residence is determined by the physical location of the residence. An adult's residence is not determined by the locality to which the adult may pay or previously paid taxes or by whether the adult currently or previously received services or public assistance from another local department.

L. A local department that may have previously provided a service to or conducted an APS investigation on an adult shall assist with the investigation at the request of the local department with primary responsibility for investigation.

~~I.~~ M. When an investigation extends ~~across city or county lines~~ into the jurisdiction of another local department, the local ~~departments~~ department in ~~those cities or counties~~ the other jurisdiction shall assist with the investigation at the request of the local department with primary responsibility for the investigation.

~~J.~~ N. When the local department receives information on suspicious deaths of adults, the local department ~~staff~~ shall immediately notify the appropriate medical examiner and law enforcement.

22VAC30-100-30. ~~Application for the provision of services.~~ (Repealed.)

~~A. Local departments are authorized to receive and investigate reports of suspected adult abuse, neglect and exploitation pursuant to Article 2 (§ 63.2-1603 et seq.) of Chapter 16 of Title 63.2 of the Code of Virginia.~~

~~B. Upon completion of the investigation and the determination that the adult is in need of protective services, the adult protective services worker must obtain an application signed by the adult in need of services or his representative prior to service provision.~~

~~C. The application process is designed to assure the prompt provision of needed adult protective services including services to adults who are not able to complete and sign a service application.~~

~~D. Persons who may complete and sign an application for adult protective services on behalf of an adult who needs the service include:~~

~~1. The adult who will receive the services or the adult's legally appointed guardian or conservator;~~

~~2. Someone authorized by the adult; or~~

~~3. The local department.~~

22VAC30-100-40. ~~Assessment narrative and~~ Adult protective services disposition.

~~A. An assessment narrative shall be required for all adult protective services investigations and shall be titled "Adult Protective Services Assessment Narrative." The narrative must address, but is not limited to, the following:~~

~~1. Allegations in the report or circumstances discovered during the investigation that meet the definitions of abuse, neglect or exploitation.~~

~~2. The extent to which the adult is physically, emotionally and mentally capable of making and carrying out decisions concerning his health and well-being.~~

~~3. The risk of serious harm to the adult.~~

~~4. The need for an immediate response by the adult protective services worker upon receipt of a valid report.~~

~~5. The ability to conduct a private interview with the alleged victim, the alleged perpetrator (if known) and any collateral contacts having knowledge of the case.~~

~~B.~~ A. After investigating the report, the ~~adult protective services worker must~~ local department shall review and evaluate the facts collected and make a disposition as to whether the adult is in need of protective services and, if so, what services are needed.

~~C.~~ B. The disposition that the adult needs protective services shall be based on the preponderance of evidence that abuse, neglect, or exploitation has occurred or that the adult is at risk of abuse, neglect, or exploitation. The local department may be unable to determine the identity of the alleged perpetrator but the inability to determine the identity of the alleged perpetrator shall not prohibit the local department from issuing a disposition reflecting the need for protective services.

~~D.~~ C. Possible dispositions.

1. Needs protective services and accepts. This disposition shall be used when:

a. A review of the facts shows a preponderance of evidence that adult abuse, neglect, or exploitation has occurred or is occurring; and

(1) The adult consents to receive services pursuant to § 63.2-1610 of the Code of Virginia; or

(2) Involuntary protective services are ordered by a court pursuant to § 63.2-1609 or Article 1 (§ 64.2-2000 et seq.) of Chapter 20 of Title 64.2 of the Code of Virginia; or

b. A review of the facts shows a preponderance of evidence that the adult is at risk of abuse, neglect, or exploitation and needs protective services in order to reduce that risk; and

~~c.~~ (1) The adult consents to receive services pursuant to § 63.2-1610 of the Code of Virginia; or

~~d.~~ (2) Involuntary protective services are ordered by ~~the~~ a court pursuant to § 63.2-1609 or Article 1 (§ 64.2-2000 et seq.) of Chapter 20 of Title 64.2 of the Code of Virginia.

2. Needs protective services and refuses. This disposition shall be used when:

a. A review of the facts shows a preponderance of evidence that adult abuse, neglect, or exploitation has occurred or is occurring or the adult is at risk of abuse, neglect, and exploitation; and

b. The adult refuses or withdraws consent to accept protective services pursuant to § 63.2-1610 of the Code of Virginia.

3. Need for protective services no longer exists. This disposition shall be used when the subject of the report no longer needs protective services. A review of the facts shows a preponderance of evidence that adult abuse, neglect, or exploitation has occurred. However, at the time the investigation is initiated or during the course of the investigation, the adult who is the subject of the report ceases to be at risk of further abuse, neglect, or exploitation due to the circumstances or actions that have occurred or have been initiated by the adult or an entity or person other than the local department.

4. Unfounded. This disposition shall be used when review of the facts does not show a preponderance of evidence that abuse, neglect, or exploitation occurred or that the adult is at risk of abuse, neglect, or exploitation.

5. Invalid. This disposition shall be used when, after initiating the investigation, it is determined that the report does not meet the criteria for a valid report.

~~E.~~ D. The investigation shall be completed and a disposition assigned by the local department within 45 calendar days of the date the report was received. If the investigation is not completed within 45 calendar days, the ~~record~~ local department shall document reasons for the delay. The disposition shall be entered into the APS case management information system no later than five working days of the conclusion of the investigation.

~~F. A notice~~ E. Notification of the completion of the investigation ~~must~~ shall be made in writing and shall be

mailed to the reporter within 10 working days of the completion of the investigation.

F. Written notification.

1. The local department shall provide written notification to the alleged perpetrator within 30 calendar days of the conclusion of the investigation when:

a. The disposition (i) is needs protective services and accepts, (ii) needs protective services and refuses, or (iii) need for protective services no longer exists; and

b. The local department notified a licensing, regulatory, or legal authority of the disposition pursuant to § 63.3-1605 D of the Code of Virginia.

2. The notification shall include a summary of the evidence and information used by the local department to support the findings of the investigation; inform the alleged perpetrator about his right to review; and if applicable, identify all licensing, regulatory, or legal authorities and the date these authorities were notified.

3. The local department may delay notification to the alleged perpetrator by an additional 30 calendar days at the request of a law-enforcement agency.

4. It is optional for the local department to provide such notification to an adult whom the local department determines to be self-neglecting and is therefore considered to be the alleged perpetrator.

G. The ~~Adult Protective Services Program~~ local department shall respect the rights of adults with capacity to consider options offered by the ~~program~~ local department and refuse services, even if those decisions do not appear to reasonably be in the best interests of the adult.

22VAC30-100-45. Right to review.

A. Right to review is the process by which the alleged perpetrator may request a hearing to amend the record when the investigation has resulted in a disposition that the local department has communicated to a licensing, regulatory, or legal authority.

B. A written request for an informal hearing with the local department must be received by the local department within 30 calendar days of the date of the local department's written notification that meets the requirements of 22VAC30-100-40 F to be deemed timely.

C. The local department shall conduct an informal hearing within 30 calendar days of receiving the written request for an informal hearing.

D. The director shall preside over the informal hearing. Except for the director, no person whose regular duties include substantial involvement with the local department's adult abuse, neglect, or exploitation investigations shall preside over the hearing.

E. The alleged perpetrator may be represented by counsel. The alleged perpetrator shall be entitled to present the testimony of witnesses, documents, factual data, arguments, or other submissions of proof.

F. The director shall have the authority to sustain, amend, or reverse the findings of the investigation or the disposition.

G. The director shall notify the alleged perpetrator, in writing, of the results of the informal hearing within 30 calendar days of the date of the hearing. The decision of the director shall be final. The results of the informal hearing shall be mailed, certified with return receipt, to the alleged perpetrator. A copy of the final decision shall be mailed to the appropriate licensing, regulatory, or legal authority.

H. If the director reverses the identification of the alleged perpetrator, the local department shall continue to offer services to the adult if the disposition remains needs protective services and accepts.

I. All written findings and actions of the local department or its director, including the decision of the director at the conclusion of the review, are final and shall not be (i) appealable to the Commissioner for Aging and Rehabilitative Services or (ii) considered a final agency action for purposes of judicial review pursuant to the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

22VAC30-100-50. Disclosure of adult protective services information.

A. This chapter describes the protection of confidential information including a description of when such information ~~must~~ shall be disclosed, when such disclosure of the information is at the discretion of the local department, what information may be disclosed, and the procedure for disclosing the information.

B. Department staff having legitimate interest shall have regular access to ~~adult protective services~~ APS records maintained by the local department.

C. The following agencies have licensing, regulatory, and legal authority for administrative action or criminal investigations, and they have a legitimate interest in confidential information when such information is relevant and reasonably necessary for the fulfillment of their licensing, regulatory, and legal responsibilities:

1. Department of Behavioral Health and Developmental Services;

2. disAbility Law Center of Virginia;

3. Office of the Attorney General, including the Medicaid Fraud Control Program;

4. Department for Aging and Rehabilitative Services;

5. Department of Health, including the Office of Licensure and Certification and the Office of the Chief Medical Examiner;

6. Department of Medical Assistance Services;

7. Department of Health Professions;

8. Department for the Blind and Vision Impaired;

9. Department of Social Services, including the Division of Licensing Programs;

10. The Office of the State Long-Term Care Ombudsman and local ombudsman;

11. Law-enforcement agencies;

12. Medical examiners;

13. Adult fatality review teams;

14. ~~Prosecutors~~ Commonwealth's attorneys; and

15. Any other entity deemed appropriate by the commissioner or ~~local department~~ director that demonstrates a legitimate interest.

D. The local department shall disclose all relevant information to representatives of the agencies identified in subsection C of this section except the identity of the person who reported the abuse, neglect, or exploitation unless the reporter authorizes the disclosure of his identity or the disclosure is ordered by the court.

E. The local department shall refer any appropriate matter and all relevant documentation to the appropriate licensing, regulatory, or legal authority for administrative action or criminal investigation.

F. Local departments may release information to the following persons when the local department has determined the person making the request has legitimate interest in accordance with ~~§ 63.2-104~~ § 51.5-122 of the Code of Virginia and the release of information is in the best interest of the adult:

1. Representatives of public and private agencies including community services boards, area agencies on aging, and local health departments requesting disclosure when the agency has legitimate interest;

2. A physician or other licensed health care professional who is treating an adult whom he reasonably suspects is abused, neglected, or exploited;

3. The adult's legally appointed guardian or conservator;

4. A guardian ad litem who has been appointed for an adult who is the subject of an ~~adult protective services~~ APS report;

5. A family member who is responsible for the welfare of an adult who is the subject of an ~~adult protective services~~ APS report;

6. An attorney representing a local department in an ~~adult protective services case~~ APS matter;

7. The Social Security Administration; or

8. Any other entity that demonstrates to the commissioner or ~~local department~~ director that legitimate interest is evident.

G. Local departments are required to disclose certain requested information under the following circumstances:

1. When disclosure is ordered by a court;

2. When a person has made an ~~adult protective services~~ APS report and an investigation has been completed; or

3. When a request for access to information is made pursuant to the Government Data Collection and Dissemination Practices Act (§ 2.2-3800 et seq. of the Code of Virginia).

H. Any or all of the following specific information may be disclosed at the discretion of the local department to agencies or persons specified in subsection F of this section:

1. Name, address, age, race, and gender of the adult who is the subject of the request for information;

2. Name, address, age, race, and gender of the person who is alleged to have perpetrated the abuse, neglect, or exploitation;

3. Description of the incident ~~or incidents~~ of abuse, neglect, or exploitation;

4. Description of the adult's medical ~~problems~~ conditions to the extent known;

5. Disposition of the ~~adult protective services~~ APS report; and

6. The protective service needs of the adult.

I. The identity of the person who reported the suspected abuse, neglect, or exploitation shall be held confidential unless the reporter authorizes the disclosure of his identity or disclosure is ordered by the court.

J. Agencies or persons who receive confidential information pursuant to subsection G of this section shall provide the following assurances to the local department:

1. The purpose for which information is requested is related to the protective services goal in the service plan for the adult;

2. The information will be used only for the purpose for which it is made available; and

3. The information will be held confidential by the department or individual receiving the information except to the extent that disclosure is required by law.

K. Methods of obtaining assurances. Any one of the following methods may be used to obtain assurances required in subsection J of this section:

1. Agreements between local departments and other community service agencies that provide blanket assurances required in subsection J of this section for all ~~adult protective services~~ APS cases; or

2. State-level agreements that provide blanket assurances required in subsection C of this section for all ~~adult protective services~~ APS cases.

L. Notification that information has been disclosed. When information has been disclosed pursuant to this ~~chapter~~ section, notice of the disclosure shall be given to the adult who is the subject of the information or to his legally appointed guardian. If the adult has given permission to release the information, further notification shall not be required.

22VAC30-100-60. Opening a case for service provision.

~~A~~ A. The local department shall offer a range of services ~~must be made available to any abused, neglected and exploited adult or to adults at risk of abuse, neglect or exploitation to protect the adult and to prevent any future abuse, neglect or exploitation~~ to the adult when the disposition is needs protective services and accepts as defined in 22VAC30-100-40.

~~1. Opening a case to adult protective services. Once a disposition of the report and an assessment of the adult's needs and strengths have been made, the department shall assess the adult's service needs.~~

B. Application for services.

1. The local department shall obtain an application when the disposition is needs protective services and accepts.

2. Representatives who may complete and sign an application on behalf of an adult who needs protective services include:

a. The adult's legally appointed guardian or conservator;

b. The adult's responsible person; or

c. The local department.

C. A case shall be opened for ~~adult~~ protective services when:

~~a.~~ 1. The service needs are identified;

~~b.~~ 2. The disposition is ~~that the adult~~ needs protective services and accepts; and

~~c.~~ 3. The adult or the adult's representative as identified in subdivision B 2 of this section agrees to accept protective services or protective services are ordered by the court.

~~2. Service planning.~~ D. A service plan ~~which~~ that is based on the investigative findings and ~~the assessment of~~ the adult's need for protective services shall be developed. The service plan is the basis for the activities that the ~~worker~~ local department, the adult, and other ~~persons~~ individuals will undertake to ~~provide the services necessary to~~ protect the adult. The service plan shall be documented in the APS case management information system.

~~3.~~ E. Implementation of the service plan. Implementation of the service plan is the delivery of the services necessary to provide adequate protection to the adult. The services may be delivered directly, through purchase of service, through informal support, or through referral. The continuous monitoring of the adult's progress and the system's response is a part of the implementation.

~~4.~~ F. Local departments are required to provide services beyond the investigation to the extent that federal or state matching funds are made available.

22VAC30-100-70. Civil penalty for nonreporting.

A. The ~~department~~ commissioner may impose civil penalties when it is determined that a mandated reporter failed to report suspected adult abuse, neglect, or exploitation pursuant to § 63.2-1606 of the Code of Virginia.

B. Civil penalties for ~~all mandated reporters except~~ law-enforcement officers shall be ~~imposed as described in 22VAC30-100-80~~ determined by a court of competent jurisdiction, at its discretion.

22VAC30-100-80. Imposition of civil penalty.

A. Local department review and recommendation.

1. ~~Based on a decision by the local department~~ When a director ~~or his designee~~ determines that a mandated reporter failed to report as required by § 63.2-1606 of the Code of Virginia, the ~~local~~ director shall prepare a written statement of fact on a form provided by the department concerning the mandated reporter's failure to report ~~and submit the statement of fact to the commissioner~~. The director also shall prepare a letter notifying the mandated reporter of the intent to request imposition of a civil penalty. The letter shall state the mandated reporter's right to submit a written statement to the commissioner concerning the mandated reporter's failure to report. The date of the director's notification shall be the date of the letter to the mandated reporter. Any supporting documentation that the director considered in requesting the imposition of a civil penalty shall be provided to the mandated reporter. The letter, statement of facts, and any supporting documentation that the director considered in requesting the imposition of a civil penalty shall be sent to

the mandated reporter by registered or certified mail, return receipt requested.

2. ~~The local director or his designee shall notify the mandated reporter in writing within 15 calendar days from the date of the determination of the intent to recommend that a civil penalty be imposed. The notification will include a copy of the local director's statement of fact concerning the mandated reporter's failure to report. The notification shall state the mandated reporter's right to submit a written statement to the commissioner concerning the mandated reporter's failure to report. The date of the notification is the postage date~~ At such time as the letter required under subdivision 1 of this subsection is sent, the director shall send a letter to the commissioner requesting the imposition of a civil penalty on the mandated reporter for failure to report. The statement of fact and the letter to the mandated reporter shall accompany the letter to the commissioner. Any supporting documentation that the director considered in requesting the imposition of a civil penalty shall be provided to the commissioner.

~~3. The mandated reporter's statement concerning his failure to report must be received by the commissioner within 45 days from the date of the local director's notification of intent to recommend the imposition of a civil penalty. A mandated reporter's statement received after the 45 days shall not be considered by the commissioner.~~

~~B. Review by the commissioner or his designee~~

~~1. The commissioner or his designee shall review the local director's written statement of fact concerning the mandated reporter's failure to report and the mandated reporter's written statement in determining whether to impose a civil penalty.~~

~~2. In the case of law enforcement officers who are alleged to have not reported as required, the commissioner or his designee shall forward the recommendation to a court of competent jurisdiction.~~

~~3. The commissioner or his designee shall impose a civil penalty upon a mandated reporter who is determined to have not reported as required pursuant to § 63.2-1606 of the Code of Virginia. Penalties shall be imposed as follows:~~

~~a. For first offenses of nonreporting pursuant to § 63.2-1606 H of the Code of Virginia, the penalty shall be not more than $500.~~

~~b. For second and subsequent offenses pursuant to § 63.2-1606 H of the Code of Virginia, the penalty shall be not less than $100 and not more than $1,000.~~

~~4. The commissioner or his designee shall notify the mandated reporter whether a civil penalty will be imposed and, if so, the amount of the penalty. This written notice shall describe the reasons for the imposition of the civil penalty. The date of notification shall be deemed to be the date the mandated reporter received written notice of the alleged violation. This notice shall include specifics of the violation charged and shall be sent by overnight express mail or by registered or certified mail, return receipt requested.~~

~~5. If a civil penalty is imposed, a copy of the notice to the mandated reporter shall be sent to the appropriate licensing, regulatory, or administrative agency and to the local director who recommended the imposition of the penalty.~~

B. Statement from mandated reporter. Within 45 calendar days from the date of the director's notification to the mandated reporter of intent to request the imposition of a civil penalty, the mandated reporter may submit a written statement concerning his failure to report to the commissioner. Statements received by the commissioner after 45 calendar days will be deemed untimely and will not be considered.

C. Review by the commissioner's designee.

1. The commissioner's designee shall review the director's statement of facts, the mandated reporter's written statement, and any supporting documentation provided by the director in determining whether to impose a civil penalty.

2. In the case of law-enforcement officers who are alleged not to have reported as required, the commissioner or the commissioner's designee shall forward a recommendation to the court of competent jurisdiction.

3. Within 30 calendar days after the deadline for the commissioner's receipt of the mandated reporter's written statement, the commissioner's designee shall issue a final decision to the mandated reporter in writing, addressing whether a civil penalty will be imposed. The final decision shall include specifics of the violation charged, the reasons for the imposition of the civil penalty, and the amount of the penalty. The date of the final decision is the date the final decision is sent to the mandated reporter. The commissioner's designee shall also send a copy of the final decision to the director who recommended the imposition of the civil penalty.

D. Reconsideration of a final decision imposing a civil penalty shall be conducted in accordance with § 2.2-4023.1 of the Code of Virginia. The commissioner's review on reconsideration shall not include testimony, statements, or documentary submissions that were not included in the director's intent to request imposition of a civil penalty or presented to the commissioner or the commissioner's designee prior to issuance of the final decision.

~~6.~~ E. Any mandated reporter has the right to appeal the decision to impose a civil penalty in accordance with § 2.2-

4026 of the Code of Virginia and pursuant to Part 2 A of the Rules of the Supreme Court of Virginia.

VA.R. Doc. No. R18-5270; Filed December 19, 2019, 9:02 a.m.

Proposed Regulation

Title of Regulation: **22VAC30-130. Adult Services Standards (adding 22VAC30-130-10 through 22VAC30-130-60).**

Statutory Authority: §§ 51.5-131 and 51.5-145 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: March 20, 2020.

Agency Contact: Paige McCleary, Adult Protective Services Division Director, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Henrico, VA 23229, telephone (804) 662-7605, FAX (804) 662-9531, TTY (800) 464-9950, or email paige.mccleary@dars.virginia.gov.

Basis: Section 51.5-145 of the Code of Virginia gives the Department for Aging and Rehabilitative Services (DARS) the responsibility for the planning and oversight of adult services (AS). These services are to be delivered by the local departments of social services (LDSSs) as set out in Article 1 (§ 63.2-1600 et seq.) of Chapter 16 of Title 63.2 of the Code of Virginia and pursuant to regulations and subject to the oversight of the Commissioner of the Department for Aging and Rehabilitative Services. Section 63.2-1600 of the Code of Virginia authorizes the provision of home-based services, including the eligibility for such services pursuant to regulations promulgated by the commissioner. In addition, § 51.5-131 of the Code of Virginia authorizes the commissioner to promulgate regulations necessary to carry out the provisions of the laws of the Commonwealth administered by the department.

Purpose: This regulation describes the provision of services to adults with impairment. Currently, no regulation specifically addresses this issue. Many services provided by LDSS AS workers ensure the safety of older adults and individuals with disabilities by helping prevent adult abuse, neglect, and exploitation from occurring or recurring.

These services also promote the well-being of adults by strengthening natural support systems, including family supports, that enable adults to live in community-based settings for as long as possible. The regulation provisions outline the principles and philosophy of AS and underscore the importance of an adult's right to self-determination and independence.

This regulation is clearly written. Clarity in regulation content is essential to ensuring that an individual's health and safety needs are most appropriately met.

Substance: This new regulation includes definitions of terms used in the regulation, the principles inherent in the provision of AS, intake services, individuals to be served, service eligibility determination, and types of services that may be provided.

In addition, the regulation clarifies the need for the development of service plans when services are provided to adults and the other responsibilities of LDSSs. Other revisions to regulation content may be made based on public comments received.

Issues: The advantages of the regulation to the public and the agency or Commonwealth include that the regulation describes service provision and ensures that LDSSs address the needs of older individuals and adults with an impairment. Additionally, the regulation content clarifies but does not increase LDSSs staff responsibilities. Much of the regulatory language in this regulation previously existed in a regulation that was repealed. Several sections directly refer to Code of Virginia requirements to which LDSSs currently adhere. Additionally, the standards addressed in this regulatory action have been part of DARS guidance for several years. Finally, the regulation describes assistance available to older adults and adults with an impairment, their families, and other support systems for adults.

The regulatory action poses no disadvantages to the public or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Department for Aging and Rehabilitative Services (DARS) proposes to establish a regulation for adult services standards reflecting the same policy and practices currently followed under guidance manuals.

Background. In 2012, the General Assembly transferred the oversight responsibility and the enforcement division for adult services from the Department of Social Services to DARS effective July 2013.[2] Since then, DARS guidance manuals have been the basis of the standards that local departments of social services follow in providing adult services.

Estimated Benefits and Costs. According to DARS, the proposed regulation does not introduce any change in policy or practice that have been followed since 2013 under agency manuals. Therefore, the primary impact of this action is a stronger enforcement capability for DARS because the standards would be in a regulation, which has the force of law, rather than guidance manuals, which do not. In addition, local departments of social services as well as the public would have ease of access to and clarity about the standards, as well as the procedural benefits resulting from the promulgation of a regulation under the Administrative Process Act.

Businesses and Other Entities Affected. The proposed regulation applies to 120 local departments of social services. In fiscal year 2017, local departments handled 3,800 home-based services cases, 15,000 preadmission screenings, 12,000 annual guardian report reviews, and 2,500 assisted living facility assessments. The proposed regulation does not appear to impose costs.

Localities[3] Affected.[4] The proposed regulation should not affect any locality more than others. The proposed regulation does not appear to introduce costs for local governments.

Projected Impact on Employment. The proposed regulation would not affect employment.

Effects on the Use and Value of Private Property. The proposed regulation would not affect the use and value of private property.

Adverse Effect on Small Businesses.[5] The proposed regulation does not adversely affect small businesses.

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[2]http://lis.virginia.gov/cgi-bin/legp604.exe?121+ful+CHAP0803

[3]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[4]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[5]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."

Agency's Response to Economic Impact Analysis: The Virginia Department for Aging and Rehabilitative Services concurs with the economic impact analysis performed by the Virginia Department of Planning and Budget.

Summary:

This proposed action establishes a new regulation, Adult Services Standards (22VAC30-130). Provisions proposed include definitions, principles inherent in the provision of adult services, the process for client intake and service delivery, descriptions of the types of services that may be provided, eligibility for services, and local department of social services responsibilities.

CHAPTER 130
ADULT SERVICES STANDARDS

22VAC30-130-10. Definitions.

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

"Activities of daily living" or "ADLs" means bathing, dressing, toileting, transferring, eating/feeding, and bowel and bladder continence.

"Adult" means any individual 18 years of age or older, or younger than 18 years of age if legally emancipated.

"Adult services" means services that are provided by local departments of social services to adults with an impairment.

"Adult with an impairment" means an adult whose physical or mental capacity is diminished to the extent that the adult needs counseling or supervisory assistance with ADLs or instrumental activities of daily living.

"Auxiliary Grants" or "AG" means cash payments made to certain aged, blind, or disabled individuals who receive benefits under Title XVI of the Social Security Act, as amended, or would be eligible to receive these benefits except for excess income.

"Chore services" means nonroutine, heavy home maintenance services provided to adults, including minor repair work on furniture and appliances in the adult's home; carrying coal, wood, or water; chopping wood; removing snow; yard maintenance; and painting.

"Companion services" means services to an adult, including light housekeeping, companionship, shopping, meal preparation, transportation, laundry, money management, and assistance with ADLs.

"Department" means the Department for Aging and Rehabilitative Services.

"Department-designated case management system" means the official state automated computer system for adult services that collects and maintains information on adult services provided by the local department.

"Eligibility based on income" means an eligibility category under which the adult's eligibility for services is based upon an income scale issued annually by the department.

"Home-based services" means companion, chore, and homemaker services that allow adults to attain or maintain self-care and are likely to prevent or reduce dependency.

"Homemaker services" means services that provide the adult instruction in or the performance of activities to maintain a household. Homemaker services may include personal care, home management, household maintenance, nutrition, and consumer or hygiene education.

"Income maintenance" means an eligibility category under which the adult is eligible for a service because the adult receives Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), or AG.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, money management, transportation, using the telephone, home maintenance, and laundry.

"Local board" means the local board of social services representing one or more counties or cities.

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

"Public assistance" means TANF, AG, medical assistance, energy assistance, supplemental nutritional assistance program, employment services, child care, and general relief.

"Responsible person" means an individual who is authorized under state or federal law to make decisions concerning the adult and to receive information about the adult.

"Service plan" means a written plan to address the needs of the adult.

"Social supports" means individuals or organizations who routinely provide assistance or support to the adult.

"Uniform Assessment Instrument" or "UAI" means the department-designated assessment form. It is used to record information about the adult's level of service needs.

"Universal access" means an eligibility category under which the adult is eligible for services without consideration of the adult's income.

22VAC30-130-20. Intake process.

A. Intake is designed to provide a timely, coordinated method for the adult to request services or assistance or to obtain sufficient information about other resources.

B. The local department shall be responsible for performing intake activities. These activities may include information and referral or initial assessment for assistance as indicated by the adult's situation.

22VAC30-130-30. Services and activities.

Local departments shall provide the following adult services:

1. Services provided under universal access.

a. Screening for long-term care services and supports pursuant to § 32.1-330 of the Code of Virginia.

b. Public pay assisted living facility assessment pursuant to § 63.2-1804 of the Code of Virginia.

c. Review of annual reports submitted by guardians pursuant to § 64.2-2020 of the Code of Virginia.

2. Home-based services provided under universal access, income maintenance, or eligibility based on income.

a. Home-based services shall be provided, to the extent that federal or state funding is available, as requested by an adult with an impairment who meets financial and functional eligibility criteria.

b. Local boards shall establish a local home-based services policy that includes the types of home-based services that are offered in the locality, the functional eligibility criteria, and the financial eligibility criteria as decided by the local board.

c. The local department, upon the decision of the local board, may choose to offer home-based services under universal access. If the local department does not offer home-based services under universal access, the adult shall be evaluated by the local department under the eligibility categories of income maintenance or eligibility based on income. Adults who are not eligible under universal access or income maintenance shall be evaluated by the local department under the eligibility based on income category.

22VAC30-130-40. Eligibility determination.

A. To request home-based services, the adult or the adult's responsible person shall submit a service application (Application for Adult Services Form) to the local department. The service application shall be on a form provided by the department. The local department shall document receipt of the application in the department-designated case management system. A service application shall not be required to request a screening for long-term care services and supports, for an assisted living facility assessment, or for review of an annual guardian report.

B. Determinations for functional eligibility and financial eligibility are separate processes but shall be pursued simultaneously. Functional and financial eligibility shall be determined as promptly as possible. The local department shall notify the adult of its eligibility determination decision no later than 45 days from the date the application is received by the local department.

C. The local department shall determine the adult's functional eligibility for home-based services. Home-based services shall not be available to adults who reside in an institutional setting including a nursing facility, assisted living facility, or hospital. The local department shall assess the adult using the UAI, the department-designated form, including evaluating the adult's degree of independence or need for assistance with performing ADLs and IADLs.

D. The local department shall determine the adult's financial eligibility for home-based services.

1. If the local department chooses to offer home-based services under universal access, the adult is financially eligible for home-based services without consideration of the adult's income.

2. If the local department chooses to offer home-based services under income maintenance, the local department shall verify and document the adult's source of income in the department-designated case management system, and document whether the adult is eligible for an Auxiliary Grant, Temporary Assistance for Needy Families, or Supplemental Security Income. Adults who receive an

Auxiliary Grant, Temporary Assistance for Needy Families, or Supplemental Security Income meet the financial eligibility requirement for home-based services offered under the income maintenance category.

3. If the local department chooses to offer home-based services under eligibility based on income, each local board shall select a threshold percentage of the median income to evaluate financial eligibility for adults. The department shall provide a scale of the median income for a family of four in Virginia as updated periodically in the Federal Register by the U.S. Department of Health and Human Services annually to local departments to use to determine financial eligibility. The adult's income, not resources, shall be counted when determining the adult's financial eligibility. The local department shall verify and document the adult's income in the department-designated case management system. Income from the following resources shall be disregarded when determining financial eligibility for home-based services in eligibility based on income category:

a. Home produce utilized by the adult for his own consumption;

b. The value of food benefits under the Supplemental Nutrition Assistance Program;

c. The value of supplemental food assistance received under the Child Nutrition Act of 1966 (42 USC §§ 1771 through 1789). This includes all school meals programs; the Women, Infants and Children program; and the Child Care Food program;

d. The value of foods donated under the U.S. Department of Agriculture Commodity Distribution Program, including those foods furnished through the school meal programs;

e. Benefits received under Nutrition Program for the Elderly, Title VII of the Older Americans Act of 1965, as amended (42 USC §§ 3001 et seq.);

f. Grants or loans to any undergraduate students for educational purposes made or insured under any program administered by the U.S. Secretary of Education;

g. A scholarship or grant obtained and used under conditions that preclude its use for current living costs;

h. Training allowance provided by the department for persons participating in rehabilitative services programs;

i. Payments to VISTA volunteers;

j. The Veterans Administration educational amount for the caretaker 18 years of age or older when used specifically for educational purposes. Any additional money included in the benefit amount for dependents is to be counted as income;

k. Income tax refunds including earned income tax credit advance payments and refunds;

l. Payments made under the Energy Assistance Program;

m. All federal, state, and local government rent and housing subsidies and utility payments;

n. Funds distributed to or held in trust for members of any Indian tribe under Public Laws 92-254, 93-134, 94-540, 97-458, 98-64, 98-123, or 98-124. Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income;

o. All bona fide loans. The loan may be for any purpose and may be from a private individual as well as from a commercial institution. The amount disregarded is limited to the principal of the loan;

p. Monetary gifts for special occasions such as the adult's birthday, holidays, or graduations;

q. Withdrawals of bank deposits;

r. Payments to vendors for services provided to the adult; and

s. Lump sum insurance payments.

22VAC30-130-50. Service planning.

A. A variety of interventions including referral to public assistance and other resources, case management, and other programs may be provided depending on the adult's needs.

B. The services or activities may be provided directly by local department staff or volunteers, purchased from local department approved providers or contracted vendors, or provided through referral to other community resources.

C. If an adult is determined eligible for home-based services, the local department shall develop a service plan, enter the plan into the department-designated case management system, and review the plan at least annually. A service plan shall not be required when the only intervention or activity provided by the local department is screening for long-term services and supports, public pay assisted living facility annual assessment, or review of an annual guardian report. The local department, the adult and the adult's family, the responsible person, or other social supports, if applicable, shall collaborate to evaluate progress toward meeting the goals and objectives of the service plan. The local department shall document progress toward meeting service plan goals and objectives at least quarterly in the department-designated case management system.

D. For any services for which a payment is made on behalf of an adult, the service, service provider, and payment authorization shall be documented in the service plan. Any local department hard copy records documenting the provision of adult services shall be made available to the department upon request.

22VAC30-130-60. Responsibilities of local department.

A. The local department shall comply with all laws, regulations, and department guidance regarding the provision of adult services.

B. The local department shall notify the adult on a form approved by the department when the local department takes an action regarding home-based services pursuant to § 51.5-147 of the Code of Virginia.

C. The local department shall close the adult's case in the department-designated case management system in the following circumstances, including:

1. When the adult dies;

2. When the adult with capacity or the adult's responsible person requests closure;

3. When the local department is unable to locate the adult and attempts to contact the adult are unsuccessful;

4. When the adult is no longer functionally or financially eligible for the service;

5. When the local department has no funding to provide home-based services;

6. When the service or activity identified on the service plan is complete; or

7. With exception of annual guardian report reviews, when the adult relocates to another state.

NOTICE: Forms used in administering the regulation have been filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (22VAC30-130)

Application for Adult Services Form, 032-26-0001-01-eng, (rev. 5/2017)

Virginia Uniform Assessment Instrument, UAI, (eff. 1994)

VA.R. Doc. No. R18-5230; Filed December 19, 2019, 9:02 a.m.

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TITLE 24. TRANSPORTATION AND MOTOR VEHICLES

COMMONWEATH TRANSPORTATION BOARD

Final Regulation

REGISTRAR'S NOTICE: The Commonwealth Transportation Board is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 B 11 of the Code of Virginia, which exempts regulations relating to traffic signs, markers, or control devices.

Title of Regulation: **24VAC30-530. Roadway and Structure Lighting (repealing 24VAC30-530-10).**

Statutory Authority: § 33.1-210 of the Code of Virginia.

Effective Date: February 20, 2020.

Agency Contact: Jo Anne P. Maxwell, Regulatory Coordinator, Policy Division, Department of Transportation, 11th Floor, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-1830, or email joanne.maxwell@vdot.virginia.gov.

Small Business Impact Review Report of Findings: This final regulatory action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Summary:

The chapter references by description a Commonwealth Transportation Board Policy from 1995, contains no additional substantive obligations, and was recommended for repeal by the Attorney General's Regulatory Reduction Task Force in 2009. Therefore, the chapter is repealed.

VA.R. Doc. No. R20-6259; Filed December 20, 2019, 11:26 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Commonwealth Transportation Board is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 B 2 of the Code of Virginia, which exempts regulations relating to the award or denial of state contracts, as well as decisions regarding compliance therewith.

Title of Regulation: **24VAC30-580. Guidelines for Considering Requests for Restricting Through Trucks on Primary and Secondary Highways (amending 24VAC30-580-20).**

Statutory Authority: § 46.2-809 of the Code of Virginia.

Effective Date: February 20, 2020.

Agency Contact: Jo Anne P. Maxwell, Regulatory Coordinator, Policy Division, Department of Transportation, 11th Floor, 1401 East Broad Street, Richmond, VA 23219,

telephone (804) 786-1830, or email joanne.maxwell@vdot.virginia.gov.

Small Business Impact Review Report of Findings: This final regulatory action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Summary:

The amendment permits a Department of Transportation district administrator or district engineer for the applicable construction district to deny a request for a restriction on through truck traffic on a secondary highway when the request clearly and objectively does not meet the required regulatory criteria.

24VAC30-580-20. Authority to restrict truck traffic on primary and secondary highways.

The Commonwealth Transportation Board delegates the authority to restrict through truck traffic on secondary highways to the Commissioner of the Virginia Department of Transportation. Such restrictions can apply to any truck, truck and trailer or semitrailer combination, or any combination of those classifications. Consideration of all such restrictions by the commissioner is subject to this chapter as adopted by the board. Any request for such restrictions that fails to objectively satisfy the required criteria found in 24VAC30-580-40 may be rejected by the Virginia Department of Transportation District Administrator or District Engineer for the Construction District in which the restriction is requested prior to presentation to the commissioner. The board shall retain authority to restrict through truck traffic on primary highways.

VA.R. Doc. No. R20-6262; Filed December 20, 2019, 12:00 p.m.

Final Regulation

REGISTRAR'S NOTICE: The Commonwealth Transportation Board is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 B 11 of the Code of Virginia, which exempts regulations relating to traffic signs, markers, or control devices.

Title of Regulation: **24VAC30-590. Policies and Procedures for Control of Residential and Non-Residential Cut-Through Traffic (repealing 24VAC30-590-10).**

Statutory Authority: § 33.2-210 of the Code of Virginia.

Effective Date: February 20, 2020.

Agency Contact: Jo Anne P. Maxwell, Regulatory Coordinator, Policy Division, Department of Transportation, 11th Floor, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-1830, or email joanne.maxwell@vdot.virginia.gov.

Small Business Impact Review Report of Findings: This final regulatory action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Summary:

The chapter references by description a Commonwealth Transportation Board policy and contains no additional substantive obligations. Therefore, the chapter is repealed.

VA.R. Doc. No. R20-6260; Filed December 20, 2019, 11:32 a.m.

GUIDANCE DOCUMENTS

PUBLIC COMMENT OPPORTUNITY

Pursuant to § 2.2-4002.1 of the Code of Virginia, a certified guidance document is subject to a 30-day public comment period after publication in the Virginia Register of Regulations and prior to the guidance document's effective date. During the public comment period, comments may be made through the Virginia Regulatory Town Hall website (http://www.townhall.virginia.gov) or sent to the agency contact. Under subsection C of § 2.2-4002.1, the effective date of the guidance document may be delayed for an additional period. The guidance document may also be withdrawn.

The following guidance documents have been submitted for publication by the listed agencies for a public comment period. Online users of this issue of the Virginia Register of Regulations may click on the name of a guidance document to access it. Guidance documents are also available on the Virginia Regulatory Town Hall (http://www.townhall.virginia.gov) or from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, Richmond, Virginia 23219.

BOARD OF AGRICULTURE AND CONSUMER SERVICES

Titles of Documents:

Comprehensive Animal Care Law and Related Regulations Civil Penalty Matrix Guidelines for Enforcement.

Virginia Livestock and Poultry Law and Related Regulations Civil Penalty Matrix Guidelines for Enforcement.

Public Comment Deadline: February 19, 2020.

Effective Date: February 20, 2020.

Agency Contact: Dr. Carolynn Bissett, Program Manager, Office of Veterinary Services, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-2483, or email carolynn.bissett@vdacs.virginia.gov.

STATE BOARD OF EDUCATION

Title of Document: Guidelines for Working with Students Who Are Deaf and Hard of Hearing in Virginia Public Schools.

Public Comment Deadline: February 19, 2020.

Effective Date: February 20, 2020.

Agency Contact: Wanda Council, Education Specialist, Office of Special Education Instructional Services, Department of Education, 101 North 14th Street, Richmond, VA 23219, telephone (804) 271-4059, or email wanda.council@doe.virginia.gov.

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Title of Document: VAAP Participation Criteria and the Determination of Significant Cognitive Disabilities.

Public Comment Deadline: February 19, 2020.

Effective Date: February 20, 2020.

Agency Contact: Deborah Johnson, Education Specialist, Office of Special Education Instructional Services, Department of Education, 101 North 14th Street, Richmond, VA 23219, telephone (804) 371-2725, or email deborah.johnson@doe.virginia.gov.

STATE BOARD OF HEALTH

Title of Document: Adverse Events - Guidelines for Non-Long Term Care Healthcare Facilities.

Public Comment Deadline: February 19, 2020.

Effective Date: February 20, 2020.

Agency Contact: Mylam Ly, Policy Analyst and Project Coordinator, Virginia Department of Health, James Madison Building, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7263, or email mylam.ly@vdh.virginia.gov.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Draft Temporary Detention Order Supplement for Stakeholder Input

The draft Temporary Detention Order (TDO) Supplement is available on the Department of Medical Assistance Services website at http://www.dmas.virginia.gov/#/manualdraft.

Updates include (i) claims processing requirements for crisis stabilization units that admit individuals ages 21 through 64 under TDOs; (ii) coverage information for individuals enrolled in Medicaid's managed care programs; and (iii) clarifying the Federal Managed Care Rule for individuals ages 21 through 64 enrolled in Medicaid managed care receiving services in an institution for mental disease.

The updated information can be found on pages 1 through 4 of the draft supplement. Once finalized, the supplement will be housed in the hospital, physician-practitioner, and psychiatric services provider manuals.

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

Amendment of Water Quality Management Planning Regulation

Notice of action: The State Water Control Board is considering the amendment of the regulation on water quality management planning in accordance with the public participation procedures for water quality management planning. A regulation is a general rule governing people's rights or conduct that is upheld by a state agency.

Purpose of notice: The board is seeking comments through the Department of Environmental Quality (DEQ) on the proposed amendment. The purpose of the amendment to the state's Water Quality Management Planning Regulation (9VAC25-720) is to adopt 11 new total maximum daily load (TMDL) wasteload allocations.

Public comment period: January 20, 2020, through February 19, 2020.

Description of proposed action: DEQ staff will propose amendments of the state's Water Quality Management Planning Regulation for the Potomac-Shenandoah River Basin (9VAC25-720-50 A) and James River Basin (9VAC25-720-60 A). Statutory authority for promulgating these amendments can be found in § 62.1-44.15 of the Code of Virginia.

Staff intends to recommend (i) that the board approve the two TMDL reports as the plan for the pollutant reductions necessary for attainment of water quality goals in the impaired segments, (ii) that the board authorize inclusion of the two TMDL reports in the appropriate water quality management plan, and (iii) that the board adopt 11 new TMDL wasteload allocations (WLAs) as part of the state's Water Quality Management Planning Regulation in accordance with § 2.2-4006 A 14 and B of the Code of Virginia.

The TMDL reports were developed in accordance with federal regulations (40 CFR 130.7) and are exempt from the provisions of Article 2 (§ 2.2-4006 et seq.) of the Virginia Administrative Process Act. The reports were subject to the TMDL public participation process contained in DEQ's public participation procedures for water quality management planning. The public comment process provides the affected stakeholders an opportunity for public appeal of the TMDL.

As of July 1, 2014, TMDL WLAs can receive State Water Control Board approval prior to Environmental Protection Agency (EPA) approval due to amendments outlined in § 2.2-4006 A 14 of the Code of Virginia. The two TMDL reports in this public notice have been reviewed by the EPA for required TMDL elements, but remain in draft form awaiting State Water Control Board approval. The draft reports can be found at http://www.deq.virginia.gov/Programs/Water/WaterQualityInformationTMDLs/TMDL/TMDLDevelopment/DraftTMDLReports.aspx.

Affected waterbodies and localities for the 11 new TMDL wasteload allocations:

Potomac-Shenandoah River Basin (9VAC25-720-50 A): "A TMDL and Watershed Management Plan to address Sediment in North Fork Catoctin Creek Located in Loudoun County, Virginia"

- The North Fork Catoctin Creek TMDL, located in Loudoun County, proposes sediment reductions for the North Fork Catoctin Creek watershed and provides a new sediment wasteload allocation of 99.1 tons/year.

James River Basin (9VAC25-720-60 A): "Benthic TMDL Development for the North Fork Rivanna River Watershed and Tributaries Located in Albemarle, Greene, and Orange Counties"

- The North Fork Rivanna River and tributaries TMDL, located in Albemarle, Greene, and Orange Counties, proposes sediment reductions for the Blue Run, Marsh Run, Preddy Creek, Preedy Creek North Branch, Quarter Creek, Standardsville Run, Swift Run, and an unnamed Tributary to Flat Branch watersheds and provides new sediment wasteload allocations of 20,750 lbs/year, 5,210 lbs/year, 105,600 lbs/year, 47,940 lbs/year, 11,020

lbs/year, 6,105 lbs/year, 89,130 lbs/year, and 27,890 lbs/year.

• The North Fork Rivanna River and tributaries TMDL, located in Albemarle, Greene, and Orange Counties, proposes total phosphorus reductions for the Blue Run and Standardsville Run watersheds and provides new total phosphorus wasteload allocations of 21.8 lbs/year and 4.6 lbs/year.

How to comment: DEQ accepts written comments by email, fax, and postal mail. All written comments must include the full name, address, and telephone number of the person commenting and be received by DEQ by 5 p.m. on the last day of the comment period.

How a decision is made: After comments have been considered, the board will make the final decision. Citizens who submit statements during the comment period may address the board members during the board meeting at which a final decision is made on the proposal.

To review documents: The TMDL reports are available on the DEQ website at http://www.deq.virginia.gov/Programs/Water/WaterQualityInformationTMDLs/TMDL/TMDLDevelopment/DraftTMDLReports.aspx and by contacting the DEQ representative listed for any report. The electronic copies are in PDF or Word format and may be read online or downloaded.

Contact for public comments, document requests, and additional information: Kelly Meadows, Department of Environmental Quality, 1111 East Main Street, Suite 1400, Richmond, VA 23219, telephone (804) 698-4291, FAX: (804) 698-4032, or email kelly.meadows@deq.virginia.gov.

Proposed Consent Special Order for Lakeside Real Estate LLC

An enforcement action is being proposed for Lakeside Real Estate LLC for alleged violations regarding financial assurance mechanisms used to demonstrate financial responsibility, corrective action requirements that occurred at 5301 Lakeside Avenue, Richmond, Virginia 23228. The State Water Control Board proposes to issue a consent special order to Lakeside Real Estate LLC to address the noncompliance. A description of the proposed action is available at the Department of Environmental Quality office listed or online at www.deq.virginia.gov. Natalie Womack will accept comments by email at natalie.womack@deq.virginia.gov or by postal mail at Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23219, from January 20, 2020, to February 20, 2020.

Proposed Consent Order for Reston RELAC LLC

An enforcement action has been proposed for Reston RELAC LLC for violations of the State Water Control Law and regulations at Reston Lake Anne Air Conditioning located in Reston, Virginia. The State Water Control Board proposes to issue a consent order to resolve violations associated with Reston Lake Anne Air Conditioning. A description of the proposed action is available at the Department of Environmental Quality office listed or online at www.deq.virginia.gov. Benjamin Holland will accept comments by email at benjamin.holland@deq.virginia.gov or by postal mail at Department of Environmental Quality, Northern Regional Office, 13901 Crown Court, Woodbridge, VA 22193, from January 21, 2020, through February 20, 2020.

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/cumultab.pdf.

Filing Material for Publication in the *Virginia Register of Regulations*: Agencies use the Regulation Information System (RIS) to file regulations and related items for publication in the *Virginia Register of Regulations*. The Registrar's office works closely with the Department of Planning and Budget (DPB) to coordinate the system with the Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.

ERRATA

VIRGINIA BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

Title of Regulation: **18VAC15-20. Virginia Asbestos Licensing Regulations.**

Publication: 36:9 VA.R. 1073-1075 December 23, 2019.

Correction to Final Regulation:

Page 1074, FORMS, replace "Asbestos - Experience Verification Application, A506-33AEXP-v4 (rev. 8/2015)" with "Asbestos - Experience Verification Application, A506-33AEXP-v5 (rev. 3/2019)"

VA.R. Doc. No. R20-6213; Filed December 26 2019, 3:40 p.m.

Title of Regulation: **18VAC15-30. Virginia Lead-Based Paint Activities Regulations.**

Publication: 36:9 VA.R. 1075-1076 December 23, 2019.

Correction to Final Regulation:

Page 1076, FORMS, column 2, replace "~~Contractor - Asbestos & Lead License Renewal Form, A506-33CONREN-v4 (rev. 2/2018)~~" with "~~Contractor - Asbestos & Lead License Renewal Form, A506-33CONREN-v5 (rev. 9/2019)~~"

VA.R. Doc. No. R20-6214; Filed December 26, 2019, 4:17 p.m.

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

Publication: 36:9 VA.R. 1076-1077, December 23, 2019.

Correction to Final Regulation:

Page 1077, FORMS, replace "Home Inspector - Course Approval Application, Prelicense Education Course/NRS Training Module/NRS CPE, A506-3331HICRS-v1 (eff. 4/2017)" with "Home Inspector - Course Approval Application, Prelicense Education Course/NRS Training Module/NRS CPE, A506-3331HICRS-v2 (eff. 8/2019)"

VA.R. Doc. No. R20-6215; Filed December 26, 2019, 4:17 p.m.