VIRGINIA REGISTER OF REGULATIONS

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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

Unless exempted by law, an agency wishing to adopt, amend, or repeal regulations must follow the procedures in the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). Typically, this includes first publishing 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 proposed regulation 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 of Regulations 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 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 the final regulation contains changes made after publication of the proposed regulation that 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*. Pursuant to § 2.2-4007.06 of the Code of Virginia, any person may request that the agency solicit additional public comment on certain changes made after publication of the proposed regulation. The agency shall suspend the regulatory process for 30 days upon such request from 25 or more individuals, 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 alternative to the standard process set forth in the Administrative Process Act for regulations deemed by the Governor to be noncontroversial. To use this process, the Governor's concurrence is required and advance notice must be provided to certain legislative committees. Fast-track regulations become effective on the date noted in the regulatory action if fewer than 10 persons object to using the process in accordance with § 2.2-4012.1.

EMERGENCY REGULATIONS

Pursuant to § 2.2-4011 of the Code of Virginia, an agency may adopt emergency regulations if necessitated by an emergency situation or when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or fewer from its enactment. In either situation, approval of the Governor is required. The emergency regulation is effective upon its filing with the Registrar of Regulations, unless a later date is specified per § 2.2-4012 of the Code of Virginia. Emergency regulations are limited to no more than 18 months in duration; however, may be extended for six months under the circumstances noted in § 2.2-4011 D. Emergency regulations are published as soon as possible in the *Virginia Register* and are on the Register of Regulations website at register.dls.virgina.gov.

During the time the emergency regulation is in effect, the agency may proceed with the adoption of permanent regulations in accordance with the Administrative Process Act. 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 2022 through February 2023

Volume: Issue	Material Submitted By Noon*	Will Be Published On
38:13	January 26, 2022	February 14, 2022
38:14	February 9, 2022	February 28, 2022
38:15	February 23, 2022	March 14, 2022
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39:6	October 19, 2022	November 7, 2022
39:7	November 2, 2022	November 21, 2022
39:8	November 14, 2022 **(Monday)**	December 5, 2022
39:9	November 30, 2022	December 19, 2022
39:10	December 14, 2022	January 2, 2023
39:11	December 27, 2022 **(Tuesday)**	January 16, 2023
39:12	January 11, 2023	January 30, 2023
39:13	January 25, 2023	February 13, 2023
39:14	February 8, 2023	February 27, 2023

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF NURSING

Initial Agency Notice

Title of Regulation: **18VAC90-26. Regulations for Nurse Aide Education Programs.**

Statutory Authority: § 54.1-3005 of the Code of Virginia.

Name of Petitioner: Gary Bahena.

Nature of Petitioner's Request: To amend regulations to allow for the following: (i) the use of licensed hospitals for clinical education rather than nursing homes; (ii) the elimination of requirement that RNs and LPNs serving as clinical instructors have experience working in nursing homes; and (iii) an allowance for clinical instructors to be on site and to perform their regular work at the same time but reduce the ratio from 10 to one to four to one for students to instructor.

Agency Plan for Disposition of Request: In accordance with Virginia law, the petition will be published on January 31, 2022, in the Virginia Register of Regulations and also posted on the Virginia Regulatory Town Hall at www.townhall.virginia.gov to receive public comment ending February 20, 2022.

Following receipt of all comments on the petition to amend regulations, the board will decide whether to make any changes to the regulatory language. This matter will be on the board's agenda for its first meeting after the comment period, which is scheduled for March 22, 2022. The board will inform the petitioner of its decision after that meeting.

Public Comment Deadline: February 20, 2022.

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.

VA.R. Doc. No. PFR22-16; Filed January 10, 2022, 2:20 p.m.

PERIODIC REVIEWS AND SMALL BUSINESS IMPACT REVIEWS

TITLE 1. ADMINISTRATION

DEPARTMENT OF GENERAL SERVICES

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of General Services conducted a periodic review and a small business impact review of **1VAC30-11, Public Participation Guidelines**, and determined that this regulation should be amended. The department is publishing its report of findings dated January 6, 2022, to support this decision.

This regulatory change is necessary for the Department of General Services (DGS) to comply with § 2.2- 4007.02 B of the Administrative Process Act that requires of an agency, "pursuant to its public participation guidelines shall afford interested persons an opportunity to…be accompanied by and represented by counsel or other representative" when an agency formulates a regulation. This regulatory change is essential to protect the health, safety, or welfare of citizens by requiring the department to provide an opportunity for the public to be represented by counsel or other representatives when the department promulgates a regulatory action.

DGS will amend this regulation to conform with 1VAC30-11, Public Participation Guidelines to Chapter 795 of the 2012 Acts of Assembly, which amended § 2.2-4007.02 B on public participation guidelines. The regulation has no impact on small business.

Contact Information: Rhonda Bishton, Director's Executive Administrative Assistant, Department of General Services, 1100 Bank Street, Suite 420, Richmond, VA 23219, telephone (804) 786-3311.

TITLE 6. CRIMINAL JUSTICE AND CORRECTIONS

CRIMINAL JUSTICE SERVICES BOARD

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 and a small business impact review: **6VAC20-230, Regulations Relating to Special Conservator of the Peace**.

The Notice of Intended Regulatory Action to amend 6VAC20-230, which is published in this issue of the Virginia Register, serves as the agency notice of the review.

Public comment period begins January 31, 2022, and ends March 2, 2022.

Contact Information: Kristi Shalton, Law Enforcement Program Coordinator, Department of Criminal Justice Services, 1100 Bank Street, Richmond, VA 23219, telephone (804) 786-7801, or email kristi.shalton@dcjs.virginia.gov.

TITLE 9. ENVIRONMENT

DEPARTMENT OF ENVIRONMENTAL QUALITY

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality conducted a periodic review and a small business impact review of **9VAC15-30, Regulations for the Certification of Recycling Machinery and Equipment for Local Tax Exemption Purposes**, and determined that this regulation should be retained as is. The department is publishing its report of findings dated January 3, 2022, to support this decision.

Section 58.1-3661 of the Code of Virginia specifies that recycling machinery and equipment certified by the Department of Environmental Quality may be eligible for a local property tax exemption. Section 58.1-3661 of the Code of Virginia allows the governing body of any county, city, or town to exempt or partially exempt qualifying machinery or equipment from local taxation. This regulation promulgated by the Department of Environmental Quality establishes the procedure and rules for the certification to avoid confusion concerning equipment that is eligible for reduced tax rates. The regulation has been effective in protecting public health and welfare with the least possible cost and intrusiveness to the citizens and businesses of the Commonwealth, ensuring that certified recycling equipment is eligible for reduced tax rates.

The department has determined that the regulation is clearly written and easily understandable by the individuals and entities affected. It is written so as to permit only one reasonable interpretation, is written to adequately identify the affected entity, and, insofar as possible, is written in nontechnical language.

This regulation satisfies the provisions of state law and is effective in meeting its goals; therefore, the regulation is being retained without amendment. This regulation continues to be needed. It provides recycling facilities with criteria concerning equipment that is eligible for reduced tax rates. No complaints or comments were received concerning the regulation from the public during the comment period. The regulation's level of complexity is appropriate to ensure that the regulated entities are able to provide the necessary information for the department to review recycling equipment and certify it is eligible for reduced tax rates. This regulation does not overlap, duplicate, or conflict with any state law or other state regulation. This regulation provides a means for persons

(businesses) to claim a unique tax exemption for costs incurred for recycling equipment. This regulation was last reviewed in 2017. Technology, economic conditions, and other factors have not changed in ways that would make this regulation less efficient and cost-effective in terms of protecting human health and the environment or meeting legal mandates.

The department, through examination of the regulation, has determined that the regulatory requirements currently minimize the economic impact of this regulation on small businesses and thereby minimize the impact on existing and potential Virginia employers and those employers' ability to maintain and increase the number of jobs in the Commonwealth. If a small business purchases eligible recycling equipment, that business's tax rates assessed by the governing body of any county, city, or town may be reduced.

Contact Information: Melissa Porterfield, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238.

VIRGINIA WASTE MANAGEMENT BOARD

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Virginia Waste Management Board conducted a periodic review and a small business impact review of **9VAC20-120, Regulated Medical Waste Management Regulations**, and determined that this regulation should be amended.

The proposed regulatory action to repeal 9VAC20-120 and replace it with newly promulgated 9VAC20-121, which is published in this issue of the Virginia Register, serves as the report of findings.

Contact Information: Priscilla D. Rohrer, Guidance and Regulation Coordinator, Department of Environmental Quality, P.O. Box 3000, Harrisonburg, VA 22801, telephone (540) 574-7852, FAX (804) 698-4178, or email priscilla.rohrer@deq.virginia.gov.

STATE WATER CONTROL BOARD

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the State Water Control Board conducted a periodic review and a small business impact review of **9VAC25-880, General VPDES Permit for Discharges of Stormwater from Construction Activities**, and determined that this regulation should be amended. The department is publishing its report of findings dated October 26, 2021, to support this decision.

This regulation continues to be needed. This regulation is necessary for the protection of public health, safety, and welfare. The regulation is clearly written and easily understandable. The general permit is scheduled to expire on June 30, 2024. This regulation will be amended to reissue the general permit.

The general permit regulates stormwater discharges from construction activities. The term "construction activity" is defined in 9VAC25-870-10 as "…any clearing, grading or excavation associated with large construction activity or associated with small construction activity." This general permit authorizes discharges of stormwater from regulated construction activities to surface waters within the boundaries of the Commonwealth of Virginia and includes enhanced criteria for impaired and exceptional waters. Construction activities that disturb one acre or greater or less than one acre but part of a common plan of development are required to obtain coverage under this general permit prior to commencing land disturbing activities. If this regulation were repealed, individual permits would be required to conduct these activities.

No public comments were received during the periodic review. This regulation establishes procedures for obtaining coverage under this general permit, and portions of the regulation may be viewed as complex due to the technical requirements included in the regulation. This regulation is clearly written and easily understandable. The regulation does not overlap, duplicate, or conflict with federal or state law or regulation as the State Water Control Board is the delegated authority to regulate point source discharges to surface water. The State Water Control Board last reissued this regulation in 2019. This regulation is evaluated and necessary changes are made to the regulation when the permit is reissued.

The reissuance of the general VPDES permit accomplishes the objectives of applicable law, minimizes the costs to a small business owner and simplifies the application process. Without the general permit, a small business owner would be required to obtain an individual permit, which would increase the complexity of a permit application and the costs to obtain permit coverage.

Contact Information: Melissa Porterfield, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the State Board of Health conducted a periodic review and a small business impact review of **12VAC5-600,**

Waterworks Operation Fee, and determined that this regulation should be amended.

The Notice of Intended Regulatory Action to amend 12VAC5-600, which is published in this issue of the Virginia Register, serves as the report of findings.

Contact Information: Nelson Daniel, Policy and Program Director, Office of Drinking Water, Virginia Department of Health, 109 Governor Street, 6th Floor, Richmond, VA 23219, telephone (804) 864-7210, FAX (804) 864-7521, or email nelson.daniel@vdh.virginia.gov.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF COUNSELING

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board of Counseling conducted a periodic review and a small business impact review of **18VAC115-20, Regulations Governing the Practice of Professional Counseling; 18VAC115-50, Regulations Governing the Practice of Marriage and Family Therapy; and 18VAC115-60, Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners**, and determined that these regulations should be amended.

The proposed regulatory action to amend 18VAC115-20, 18VAC115-50, and 18VAC115-60, which is published in this issue of the Virginia Register, serves as the report of findings.

Contact Information: 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.

TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department for Aging and Rehabilitative Services conducted a periodic review and a small business impact review of **22VAC30-70, The Virginia Public Guardian and Conservator Program**, and determined that this regulation should be amended.

The Notice of Intended Regulatory Action to amend 22VAC30-70, which is published in this issue of the Virginia Register, serves as the report of findings.

Contact Information: Charlotte Arbogast, Policy Advisor, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7093, FAX (804) 662-7663, TDD (800) 464-9950, or email charlotte.arbogast@dars.virginia.gov.

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department for Aging and Rehabilitative Services conducted a periodic review and a small business impact review of **22VAC30-120, Adult Services Approved Providers**, and determined that this regulation should be amended.

The proposed regulatory action to amend 22VAC30-120, which is published in this issue of the Virginia Register, serves as the report of findings.

Contact Information: 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.

STATE BOARD OF SOCIAL SERVICES

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the State Board of Social Services conducted a periodic review and a small business impact review of **22VAC40-901, Community Services Block Grant Program**, and determined that this regulation should be amended.

The fast-track regulatory action to amend 22VAC40-901, which is published in this issue of the Virginia Register, serves as the report of findings.

Contact Information: Matt Fitzgerald, Community Service Program Manager, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7088, FAX (800) 726-7088, or email matt.fitzgerald@dss.virgnia.gov.

TITLE 24. TRANSPORTATION AND MOTOR VEHICLES

COMMONWEALTH TRANSPORTATION BOARD

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Commonwealth Transportation Board conducted a periodic review and a small business impact review of **24VAC30-451, Airport Access Fund Policy**, and determined that this regulation should be repealed.

The final regulatory action to repeal 24VAC30-451, which is published in this issue of the Virginia Register, serves as the report of findings.

Contact Information: Jo Anne P. Maxwell, Regulator Coordinator, Policy Division, Department of Transportation, 1401 East Broad Street, 11th Floor, Richmond, VA 23219, telephone (804) 786-1830, FAX (804) 225-4700, or email joanne.maxwell@vdot.virginia.gov.

TITLE 6. CRIMINAL JUSTICE AND CORRECTIONS

CRIMINAL JUSTICE SERVICES BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Criminal Justice Services Board intends to consider amending **6VAC20-230, Regulations Relating to Special Conservator of the Peace**. The purpose of the proposed action is to amend and revise the compulsory minimum training standards, make technical amendments, and increase the number of training hours required. Training requirements are established in § 9.1-150.2 of the Code of Virginia, and this action's goal is to simplify the regulation by repealing sections and replacing them with a document incorporated by reference that houses the various categories of training that must be met by all special conservators of the peace (SPOCs) in the Commonwealth. All amendments will reflect newly-revised compulsory minimum training standards for law-enforcement officers so that the two professions have consistency across all regulations.

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 this regulation to determine whether this regulation should be terminated, 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 does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 9.1-150.2 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Kristi Shalton, Law Enforcement Program Coordinator, Department of Criminal Justice Services, 1100 Bank Street, Richmond, VA 23219, telephone (804) 786-7801, or email kristi.shalton@dcjs.virginia.gov.

VA.R. Doc. No. R22-7064; Filed January 6, 2022, 2:09 p.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 repealing **8VAC20-770, Background Checks for Child Day Programs and Family Day Systems** and promulgating **8VAC20-771, Background Checks for Child Day Programs and Family Day Systems**. The purpose of the proposed action is to repeal and replace the current chapter in order to (i) ensure that the regulation aligns with federal and state laws and (ii) clarify and update the regulatory requirements. By repealing the current chapter and promulgating a new chapter in its place, the board anticipates greater flexibility in aligning the regulatory structure to federal and state law, which has changed since the current chapter became effective. The board also anticipates changes to format and language.

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

Statutory Authority: §§ 22.1-16 and 22.1-289.046 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Tatanishia Armstrong, Legislative Consultant, Department of Education, James Monroe Building, 101 North 14th Street, 16th Floor, Richmond, VA 23219, telephone (804) 382-5047, or email tatanishia.armstrong@doe.virginia.gov.

VA.R. Doc. No. R22-7027; Filed December 29, 2021, 1:14 p.m.

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 repealing **8VAC20-820, General Procedures and Information for Licensure**, and promulgating **8VAC20-821, General Procedures and Information for Licensure**. The purpose of the proposed action is to repeal the current chapter and promulgate a new chapter in order to implement statutory requirements, clarify existing regulatory requirements, and update practices and procedures. The General Procedures and Information for Licensure applies to child day centers, family day homes, and family day systems that are licensed by the State Board of Education. The chapter sets out requirements and procedures for the licensure process, including the application process, license maintenance, inspections, and enforcement of violations. The current regulation was originally promulgated by the Virginia Department of Social Services in 1984 and adopted by the board in 2021.

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

Statutory Authority: §§ 22.1-16 and 22.1-289.046 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Tatanishia Armstrong, Legislative Consultant, Department of Education, James Monroe Building, 101 North 14th Street, 16th Floor, Richmond, VA 23219, telephone (804) 382-5047, or email tatanishia.armstrong@doe.virginia.gov.

VA.R. Doc. No. R22-7028; Filed December 29, 2021, 1:15 p.m.

TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Notice of Intended Regulatory Action

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 **9VAC25-190, Virginia Pollutant Discharge Elimination System (VPDES) General Permit Regulation for Nonmetallic Mineral Mining**. The purpose of the proposed action is to amend and reissue the existing VPDES general permit regulation that addresses wastewater and stormwater discharges from nonmetallic mineral mines. The existing general permit will expire June 30, 2024, and this action will reissue the general permit for another five-year term. In addition, any updates or necessary changes will be made to the general permit. Amendments may be identified following the submittal of public comments on this notice and by the technical advisory committee during deliberations on this general permit regulation. Some issues that may need to be addressed include (i) effluent limitations and monitoring requirements; (ii) electronic reporting, once this is made available for this industry; (iii) total maximum daily load requirements; (iv) special conditions to ensure they are updated and protective of water quality; (v) conforming changes based on the U.S. Environmental Protection Agency's most recent National Pollutant Discharge Elimination System Multi-Sector General Permit; and (vi) clarifying other aspects of the permit, regulation, forms, or instructions, as needed.

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; § 402 of the Clean Water Act; 40 CFR Parts 122, 123, and 124.

Public Comment Deadline: March 2, 2022.

Agency Contact: Peter Sherman, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4044, FAX (804) 698-4178, or email peter.sherman@deq.virginia.gov.

VA.R. Doc. No. R22-7006; Filed January 10, 2022, 1:26 p.m.

Notice of Intended Regulatory Action

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 **9VAC25-210, Virginia Water Protection Permit Regulation**, and **9VAC25-610, Ground Water Withdrawal Regulations**. The purpose of the proposed action is to require that any application for a permit to withdraw surface water (9VAC25-210) or groundwater (9VAC25-610) include (i) a water auditing plan and (ii) a leak detection and repair plan. This regulatory proposal will establish requirements for such plans as required by Chapter 100 of the 2021 Acts of Assembly, Special Session I.

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; § 401 of the Clean Water Act (33 USC § 1251 et seq.).

Public Comment Deadline: March 2, 2022.

Agency Contact: Joseph Grist, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4031, FAX (804) 698-4178, or email joseph.grist@deq.virginia.gov.

VA.R. Doc. No. R22-6942; Filed January 10, 2022, 2:47 p.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

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 Health intends to consider amending **12VAC5-600, Waterworks Operation Fee**. The purpose of the proposed action is to review (i) how the Virginia Department of Health (VDH) provides technical and regulatory assistance to different types and sizes of waterworks, including those serving disadvantaged communities and (ii) how waterworks support that assistance through operation fees. VDH will also consider equity and environmental justice issues as they relate to the operation fees waterworks pay. VDH intends to amend fees so that they more accurately reflect the benefit members of the regulated community receive from the agency through technical and regulatory assistance. The intended amendments are a result of the periodic review.

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

Statutory Authority: §§ 32.1-12 and 32.1-170 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Nelson Daniel, Policy and Program Director, Office of Drinking Water, Virginia Department of Health, 109 Governor Street, 6th Floor, Richmond, VA 23219, telephone (804) 864-7210, FAX (804) 864-7521, or email nelson.daniel@vdh.virginia.gov.

VA.R. Doc. No. R22-7059; Filed December 29, 2021, 4:39 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD FOR ARCHITECTS, PROFESSIONAL ENGINEERS, LAND SURVEYORS, CERTIFIED INTERIOR DESIGNERS AND LANDSCAPE ARCHITECTS

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 Architects, Professional Engineers, Land Surveyors, Certified Interior Designers, and Landscape Architects intends to consider amending **18VAC10-20, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers, and Landscape Architects Regulations**. The purpose of the proposed action is to adjust its licensing fee structure. The board must establish fees adequate to support the costs of board operations and pay a proportionate share of the Department of Professional and Occupational Regulation operations. By the close of the next biennium, fees will not provide adequate revenue for those costs. The board has no other source of revenue from which to fund its operations.

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

Statutory Authority: §§ 54.1-201 and 54.1-404 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Kathleen R. Nosbisch, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers, and Landscape Architects, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8514, FAX (866) 465-6206, or email apelscidla@dpor.virginia.gov.

VA.R. Doc. No. R22-6512; Filed December 29, 2021, 2:31 p.m.

AUCTIONEERS BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Auctioneers Board intends to consider amending **18VAC25-21, Rules and Regulations of the Virginia Auctioneers Board**. The purpose of the proposed action is to adjust the board's licensing fee structure. The board must establish fees adequate to support the costs of board operations and pay a proportionate share of the Department of Professional and Occupational Regulation operations. By the close of the next biennium, fees will not provide adequate revenue for those costs. The board has no other source of revenue from which to fund its operations.

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

Statutory Authority: §§ 54.1-201 and 54.1-602 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Kathleen R. Nosbisch, Executive Director, Auctioneers Board, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8514, FAX (866) 465-6206, or email auctioneers@dpor.virginia.gov.

VA.R. Doc. No. R22-6589; Filed December 29, 2021, 2:38 p.m.

BOARD OF DENTISTRY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending **18VAC60-30, Regulations Governing the Practice of Dental Assistants**. The purpose of the proposed action is to eliminate the practice of pulp capping from the practices for which a dental assistant II can be trained and delegated to perform in a dental office. Pulp capping is the covering of an exposed dental pulp with some material to provide protection against external influences and to encourage healing. The board's intent is to delete pulp capping from the procedures for which a dental assistant II can be trained and certified to perform.

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

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

Public Comment Deadline: March 2, 2022.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

VA.R. Doc. No. R22-7061; Filed December 30, 2021, 1:32 p.m.

REAL ESTATE BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Real Estate Board intends to consider amending **18VAC135-20, Virginia Real Estate Board Licensing Regulations**. The purpose of the proposed action is to adjust license application, renewal, and reinstatement fees for real estate licenses. The board must establish fees adequate to support the costs of its operations and pay a proportionate share of the Department of Professional and Occupational Regulation operations. By the close of the next biennium, fees will not provide adequate revenue for those costs. The board has no other source of revenue from which to fund its operations.

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

Statutory Authority: §§ 54.1-201 and 54.1-2105 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Christine Martine, Executive Director, Real Estate Board, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8552, FAX (804) 527-4299, or email reboard@dpor.virginia.gov.

VA.R. Doc. No. R22-6767; Filed December 29, 2021, 2:35 p.m.

BOARD FOR PROFESSIONAL SOIL SCIENTISTS, WETLAND PROFESSIONALS, AND GEOLOGISTS

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 Professional Soil Scientists, Wetland Professionals, and Geologists intends to consider amending **18VAC145-20, Board for Professional Soil Scientists Regulations**; **18VAC145-30, Wetland Delineators Certification Regulations**; and **18VAC145-40, Regulations for the Geology Certification Program**. The purpose of the proposed action is to adjust the board's licensing fee structure. The board must establish fees adequate to support the costs of board operations and pay a proportionate share of the Department of Professional and Occupational Regulation operations. By the close of the next biennium, fees will not provide adequate revenue for those costs. The board has no other source of revenue from which to fund its operations.

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

Public Comment Deadline: March 2, 2022.

Agency Contact: Kathleen R. Nosbisch, Executive Director, Board for Professional Soil Scientists, Wetland Professionals, and Geologists, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8514, FAX (804) 527-4294, or email soilscientist@dpor.virginia.gov.

VA.R. Doc. No. R22-7058; Filed December 29, 2021, 2:32 p.m.

BOARD FOR WASTE MANAGEMENT FACILITY OPERATORS

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 Waste Management Facility Operators intends to consider amending **18VAC155-20, Waste Management Facility Operators Regulations**. The purpose of the proposed action is to increase licensing fees for regulants of the Board for Waste Management Facility Operators. The board must establish fees adequate to support the costs of board operations and pay a proportionate share of the Department of Professional and Occupational Regulation operations. By close of the next biennium, the current fee structure will not provide adequate revenue for those costs. The Board for Waste Management Facility Operators has no other source of revenue from which to fund its operations.

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

Statutory Authority: §§ 54.1-201 and 54.1-2211 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Marjorie King, Administrator, Board for Waste Management Facility Operators, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-2785, FAX (866) 430-1033, TDD (804) 527-4290, or email contractors@dpor.virginia.gov.

VA.R. Doc. No. R22-6804; Filed December 29, 2021, 2:34 p.m.

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS AND ONSITE SEWAGE SYSTEM PROFESSIONALS

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 Waterworks and Wastewater Works Operators and Onsite Sewage System Professionals intends to consider amending **18VAC160-30, Waterworks and Wastewater Works Operators Licensing Regulations**. The purpose of the proposed action is to adjust license application, renewal, and reinstatement fees for waterworks and wastewater works operator licenses. The board must establish fees adequate to support the costs of board operations and pay a proportionate share of the Department of Professional and Occupational Regulation operations. By the close of the next biennium, fees will not provide adequate revenue for those costs. The board has no other source of revenue from which to fund its operations.

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

Statutory Authority: §§ 54.1-113 and 54.1-201 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Trisha L. Lindsey, Executive Director, Board for Waterworks and Wastewater Works Operators and Onsite Sewage System Professionals, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8595, FAX (866) 350-5354, or email waterwasteoper@dpor.virginia.gov.

VA.R. Doc. No. R22-6627; Filed December 29, 2021, 2:40 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board for Waterworks and Wastewater Works Operators and Onsite Sewage System Professionals intends to consider amending **18VAC160-40, Onsite Sewage System Professionals Licensing Regulations**. The purpose of the proposed action is to adjust license application, renewal, and reinstatement fees for onsite sewage system operator, onsite sewage system installer, and onsite soil evaluator licenses. The board must establish fees

adequate to support the costs of board operations and pay a proportionate share of the Department of Professional and Occupational Regulation operations. By the close of the next biennium, fees will not provide adequate revenue for those costs. The board has no other source of revenue from which to fund its operations.

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

Statutory Authority: §§ 54.1-201 and 54.1-2301 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Trisha L. Lindsey, Executive Director, Board for Waterworks and Wastewater Works Operators and Onsite Sewage System Professionals, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8595, FAX (866) 350-5354, or email waterwasteoper@dpor.virginia.gov.

VA.R. Doc. No. R22-6628; Filed December 29, 2021, 2:36 p.m.

TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Notice of Intended Regulatory Action

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Department for Aging and Rehabilitative Services (DARS) intends to consider amending **22VAC30-70, The Virginia Public Guardian and Conservator Program**. The Virginia Public Guardian and Conservator Program provides public guardian and conservator services for adults who are incapacitated, indigent, and for whom no other proper or suitable person can be identified who is willing and able to serve as the individual's guardian, or conservator, or both, as applicable. The program has capacity to provide public guardianship services, public conservatorship services, or both to 1,049 incapacitated adult residents of Virginia who are found by a Virginia circuit court to be (i) incapacitated, and (ii) who meet the criteria for public guardianship as set forth in § 64.2-2010 of the Code of Virginia. These services are provided by 13 local public guardian programs, which are operated by local public guardian program contractors under contract with the department.

The proposed regulatory action is prompted by a periodic review. The purpose of the proposed action is a comprehensive review of the chapter. Revision to all areas of the regulation will be considered. DARS intends to amend sections that may be determined to be outdated or inconsistent with policy and practice. Other revisions to the regulation content may also be proposed based on public comment or from discussions with the Virginia Public Guardian and Conservator Advisory Board, the 13 public guardian program contractors, and other stakeholders and advocates.

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

Statutory Authority: § 51.5-131 of the Code of Virginia.

Public Comment Deadline: March 2, 2022.

Agency Contact: Charlotte Arbogast, Policy Advisor, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7093, FAX (804) 662-7663, TDD (800) 464-9950, or email charlotte.arbogast@dars.virginia.gov.

VA.R. Doc. No. R22-7060; Filed December 30, 2021, 10:25 a.m.

TITLE 1. ADMINISTRATION

DEPARTMENT OF GENERAL SERVICES

Final Regulation

Titles of Regulations: **1VAC30-45. Certification for Noncommercial Environmental Laboratories (amending 1VAC30-45-40, 1VAC30-45-95, 1VAC30-45-100, 1VAC30-45-130, 1VAC30-45-520, 1VAC30-45-650, 1VAC30-45-730, 1VAC30-45-750, 1VAC30-45-760, 1VAC30-45-771).**

1VAC30-46. Accreditation for Commercial Environmental Laboratories (amending 1VAC30-46-15, 1VAC30-46-40, 1VAC30-46-70, 1VAC30-46-95, 1VAC30-46-100, 1VAC30-46-140, 1VAC30-46-150, 1VAC30-46-200, 1VAC30-46-210, 1VAC30-46-220).

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

Effective Date: April 1, 2022.

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.

Summary:

The amendments update the regulations to the 2016 TNI standards, including adding (i) as a cause for suspension, laboratory failure to submit an acceptable corrective action plan after two opportunities; (ii) as a reason to withdraw accreditation or certification, laboratory failure to correct the causes for suspension within the term of suspension; (iii) as a reason to withdraw accreditation in part or in total, when a laboratory fails three consecutive proficiency testing (PT) studies; (iv) as a reason to withdraw accreditation or certification, when a laboratory fails to meet the provisions concerning communicating with other laboratories with regard to proficiency testing; (v) a statement that the agency will regularly review its budget to determine if the fees charged under the program offset its costs; and (vi) a provision requiring a laboratory to pay the cost of compliance determination when the agency has suspended accreditation or certification in total and the laboratory wishes to demonstrate that reasons for suspension have been resolved.

In 1VAC30-45, the amendments revise the time between PT supplemental studies, delete the requirement for an access log to archived records, require a successful performance of the demonstration of capability procedure when the laboratory has not performed this procedure within 12 months, and conform to the U.S. Environmental Protection Agency's 2017 Methods Update Rule.

Changes since the proposed regulation (i) clarify decertification and withdrawal of accreditation when a laboratory has failed PT studies three times in succession and (ii) make technical edits to make the regulation more understandable.

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.

1VAC30-45-40. Definitions.

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

"Acceptance criteria" means specified limits placed on characteristics of an item, process, or service defined in requirement documents.

"Accuracy" means the degree of agreement between an observed value and an accepted reference value. Accuracy includes a combination of random error (precision) and systematic error (bias) components that are due to sampling and analytical operations. Accuracy is an indicator of data quality.

"Algae" means simple single-celled, colonial, or multicelled, mostly aquatic plants, containing chlorophyll and lacking roots, stems and leaves that are either suspended in water (phytoplankton) or attached to rocks and other substrates (periphyton).

"Aliquot" means a portion of a sample taken for analysis.

"Analyte" means the substance ~~or physical property to be determined in samples examined~~, organism, physical parameter, or chemical constituent for which an environmental sample is being analyzed.

"Analytical method" means a technical procedure for providing analysis of a sample, defined by a body such as the Environmental Protection Agency or the American Society for Testing and Materials [~~,~~] that may not include the sample preparation method.

"Assessment" means the evaluation process used to measure or establish the performance, effectiveness, and conformance of an organization and its systems or both to defined criteria

(i.e., to the standards and requirements of laboratory certification).

"Assessor" means the person assigned by DCLS to perform, alone or as part of an assessment team, an assessment of an environmental laboratory.

"Audit" means a systematic evaluation to determine the conformance to quantitative and qualitative specifications of some operational function or activity.

"Authority" means, in the context of a governmental body or local government, an authority created under the provisions of the Virginia Water and Waste Authorities Act, Chapter 51 (§ 15.2-5100 et seq.) of Title 15.2 of the Code of Virginia.

"Batch" means environmental samples that are prepared together or analyzed together or both with the same process and personnel, using the same lot or lots of reagents. "Analytical batch" means a batch composed of prepared environmental samples (extracts, digestates, or concentrates) that are analyzed together as a group. An analytical batch can include prepared samples originating from various environmental matrices and can exceed 20 samples. "Preparation batch" means a batch composed of one to 20 environmental samples of the same matrix that meets the criteria in this definition for "batch" and with a maximum time between the start of processing of the first and last sample in the batch to be 24 hours.

"Benthic macroinvertebrates" means bottom dwelling animals without backbones that live at least part of their life cycles within or upon available substrates within a body of water.

"Blank" means a sample that has not been exposed to the analyzed sample stream in order to monitor contamination during sampling, transport, storage or analysis. The blank is subjected to the usual analytical and measurement process to establish a zero baseline or background value and is sometimes used to adjust or correct routine analytical results. Blanks include the following types:

1. Field blank. A blank prepared in the field by filling a clean container with pure deionized water and appropriate preservative, if any, for the specific sampling activity being undertaken.

2. Method blank. A sample of a matrix similar to the batch of associated samples (when available) that is free from the analytes of interest and is processed simultaneously with and under the same conditions as samples through all steps of the analytical procedures, and in which no target analytes or interferences are present at concentrations that impact the analytical results for sample analyses.

"Calibration" means to determine, by measurement or comparison with a standard, the correct value of each scale reading on a meter, instrument or other device. The levels of the applied calibration standard should bracket the range of planned or expected sample measurements.

"Calibration curve" means the graphical relationship between the known values, such as concentrations, of a series of calibration standards and their instrument response.

"Calibration standard" means a substance or reference material used to calibrate an instrument.

"Certified reference material" means a reference material one or more of whose property values are certified by a technically valid procedure, accompanied by or traceable to a certificate or other documentation that is issued by a certifying body.

"Client" or "customer" means the Department of Environmental Quality (DEQ) when used in the context of quality assurance and specific quality control provisions.

"Commercial environmental laboratory" means an environmental laboratory where environmental analysis is performed for another person.

"Corrective action" means the action taken to eliminate the causes of an existing nonconformity, defect or other undesirable situation in order to prevent recurrence.

"DCLS" means the Division of Consolidated Laboratory Services of the Department of General Services.

"Demonstration of capability" means the procedure to establish the ability of the analyst to generate data of acceptable accuracy and precision.

"Detection limit" means the lowest concentration or amount of the target analyte that can be determined to be different from zero by a single measurement at a stated degree of confidence.

"Environmental analysis" or "environmental analyses" means any test, analysis, measurement, or monitoring used for the purposes of the Virginia Air Pollution Control Law, the Virginia Waste Management Act or the State Water Control Law (§ 10.1-1300 et seq., § 10.1-1400 et seq., and § 62.1-44.2 et seq., respectively, of the Code of Virginia). For the purposes of these regulations, any test, analysis, measurement, or monitoring required pursuant to the regulations promulgated under these three laws, or by any permit or order issued under the authority of any of these laws or regulations is "used for the purposes" of these laws. The term shall not include the following:

1. Sampling of water, solid and chemical materials, biological tissue, or air and emissions.

2. Field testing and measurement of water, solid and chemical materials, biological tissue, or air and emissions, except when performed in an environmental laboratory rather than at the site where the sample was taken.

3. Taxonomic identification of samples for which there is no national accreditation standard such as algae, benthic

macroinvertebrates, macrophytes, vertebrates, and zooplankton.

4. Protocols used pursuant to § 10.1-104.2 of the Code of Virginia to determine soil fertility, animal manure nutrient content, or plant tissue nutrient uptake for the purposes of nutrient management.

5. Geochemical and permeability testing for solid waste compliance.

6. Materials specification for air quality compliance when product certifications specify the data required by an air permit such as fuel type, Btu content, sulfur content, or VOC content.

"Environmental laboratory" or "laboratory" means a facility or a defined area within a facility where environmental analysis is performed. A structure built solely to shelter field personnel and equipment from inclement weather shall not be considered an environmental laboratory.

"Establishment date" means the date set for the accreditation program under 1VAC30-46 and the certification program to be established under this chapter.

"Establishment of certification program" or "established program" means that DCLS has completed the initial accreditation of environmental laboratories covered by 1VAC30-46 and the initial certification of environmental laboratories covered by 1VAC30-45.

"Facility" means something that is built or installed to serve a particular function.

"Field of certification" or "FoC" means those matrix, technology/method, and analyte combinations for which DCLS offers certification.

"Field of proficiency testing" or "FoPT" means ~~analytes for which a laboratory is required to successfully analyze a PT sample in order to obtain or maintain certification, collectively defined as~~ the matrix, technology/method, and analyte combinations for which the composition spike concentration ranges and acceptance criteria have been established by the Proficiency Testing Program Executive Committee of TNI.

"Field testing and measurement" means any of the following:

1. Any test for parameters under 40 CFR Part 136 for which the holding time indicated for the sample requires immediate analysis; or

2. Any test defined as a field test in federal regulation.

The following is a limited list of currently recognized field tests or measures that is not intended to be inclusive: continuous emissions monitoring; online monitoring; flow monitoring; tests for pH, residual chlorine, temperature and dissolved oxygen; and field analysis for soil gas.

"Finding" means an assessment conclusion referenced to a laboratory certification standard and supported by objective evidence that identifies a deviation from a laboratory certification standard requirement.

"Governmental body" means any department, agency, bureau, authority, or district of the United States government, of the government of the Commonwealth of Virginia, or of any local government within the Commonwealth of Virginia.

"Holding time" means the maximum time that can elapse between two specified activities.

"International System of Units (SI)" means the coherent system of units adopted and recommended by the General Conference on Weights and Measures.

"Laboratory control sample" or "LCS" means a sample matrix, free from the analytes of interest, spiked with verified known amounts of analytes or a material containing known and verified amounts of analytes. It is generally used to establish intra-laboratory or analyst specific precision and bias or to assess the performance of all or a portion of the measurement system. "Laboratory control sample" or "LCS" may also be named laboratory fortified blank, spiked blank, or QC check sample.

"Laboratory manager" means the person who has overall responsibility for the technical operation of the environmental laboratory and who exercises actual day-to-day supervision of laboratory operation for the appropriate fields of testing and reporting of results. The title of this person may include ~~but is not limited to~~ laboratory director, technical director, laboratory supervisor, or laboratory manager.

"Legal entity" means an entity, other than a natural person, ~~who~~ that has sufficient existence in legal contemplation that it can function legally, be sued or sue, and make decisions through agents as in the case of corporations.

"Limit of detection" or "LOD" means an estimate of the minimum amount of a substance that an analytical process can reliably detect. An LOD is analyte and matrix specific and may be laboratory dependent.

"Limit of quantitation" or "LOQ" means the minimum levels, concentrations, or quantities of a target variable (e.g., target analyte) that can be reported with a specified degree of confidence.

"Local government" means a municipality (city or town), county, sanitation district, or authority.

"Macrophytes" means any aquatic or terrestrial plant species that can be identified and observed with the eye, unaided by magnification.

"Matrix" means the component or substrate that may contain the analyte of interest. A matrix can be a field of certification matrix or a quality system matrix.

1. Field of certification matrix. These matrix definitions shall be used when certifying a laboratory.

a. Nonpotable water. Any aqueous sample that has not been designated a potable or potential potable water source. Includes surface water, groundwater, effluents, water treatment chemicals, and TCLP or other extracts.

b. Solid and chemical materials. Includes soils, sediments, sludges, products, and byproducts of an industrial process that results in a matrix not previously defined.

c. Biological tissue. Any sample of a biological origin such as fish tissue, shellfish, or plant material. Such samples shall be grouped according to origin.

d. Air and emissions. Whole gas or vapor samples including those contained in flexible or rigid wall containers and the extracted concentrated analytes of interest from a gas or vapor that are collected with a sorbent tube, impinger solution, filter or other device.

2. Quality system matrix. For purposes of batch and quality control requirement determinations, the following matrix types shall be used:

a. Drinking water. Any aqueous sample that has been designated a potable or potential potable water source.

b. Aqueous. Any aqueous sample excluded from the definition of drinking water matrix or saline/estuarine source. Includes surface water, groundwater, effluents, and TCLP or other extracts.

c. Saline/estuarine. Any aqueous sample from an ocean or estuary, or other salt water source.

d. Nonaqueous liquid. Any organic liquid with less than 15% settleable solids.

e. Biological tissue. Any sample of a biological origin such as fish tissue, shellfish, or plant material. Such samples shall be grouped according to origin.

f. Solids. Includes soils, sediments, sludges, and other matrices with more than 15% settleable solids.

g. Chemical waste. A product or byproduct of an industrial process that results in a matrix not previously defined.

h. Air and emissions. Whole gas or vapor samples including those contained in flexible or rigid wall containers and the extracted concentrated analytes of interest from a gas or vapor that are collected with a sorbent tube, impinger solution, filter, or other device.

"Matrix spike (spiked sample or fortified sample)" means a sample prepared by adding a known mass of target analyte to a specified amount of matrix sample for which an independent estimate of target analyte concentration is available. Matrix spikes are used, for example, to determine the effect of the matrix on a method's recovery efficiency.

"Matrix spike duplicate (spiked sample or fortified sample duplicate)" means a second replicate matrix spike prepared in the laboratory and analyzed to obtain a measure of the precision of the recovery for each analyte.

"National Environmental Laboratory Accreditation Conference ~~(NELAC)~~" or "NELAC" means a voluntary organization of state and federal environmental officials and interest groups with the primary purpose to establish mutually acceptable standards for accrediting environmental laboratories. NELAC preceded the formation of The NELAC Institute or TNI.

"National Institute of Standards and Technology" or "NIST" means an agency of the U.S. Department of Commerce's Technology Administration that is working with EPA, states, NELAC, and other public and commercial entities to establish a system under which private sector companies and interested states can be certified by NIST to provide NIST-traceable proficiency testing (PT) samples.

"Negative control" means measures taken to ensure that a test, its components, or the environment do not cause undesired effects, or produce incorrect test results.

"Noncommercial environmental laboratory" means either of the following:

1. An environmental laboratory where environmental analysis is performed solely for the owner of the laboratory.

2. An environmental laboratory where the only performance of environmental analysis for another person is one of the following:

a. Environmental analysis performed by an environmental laboratory owned by a local government for an owner of a small wastewater treatment system treating domestic sewage at a flow rate of less than or equal to 1,000 gallons per day.

b. Environmental analysis performed by an environmental laboratory operated by a corporation as part of a general contract issued by a local government to operate and maintain a wastewater treatment system or a waterworks.

c. Environmental analysis performed by an environmental laboratory owned by a corporation as part of the prequalification process or to confirm the identity or characteristics of material supplied by a potential or existing customer or generator as required by a hazardous waste management permit under 9VAC20-60.

d. Environmental analysis performed by an environmental laboratory owned by a Publicly Owned Treatment Works (POTW) for an industrial source of wastewater under a permit issued by the POTW to the industrial source as part of the requirements of a pretreatment program under Part VII (9VAC25-31-730 et seq.) of 9VAC25-31.

e. Environmental analysis performed by an environmental laboratory owned by a county authority for any municipality within the county's geographic jurisdiction

when the environmental analysis pertains solely to the purpose for which the authority was created.

f. Environmental analysis performed by an environmental laboratory owned by an authority or a sanitation district for any participating local government of the authority or sanitation district when the environmental analysis pertains solely to the purpose for which the authority or sanitation district was created.

"Owner" means any person who owns, operates, leases, or controls an environmental laboratory.

"Person" means an individual, corporation, partnership, association, company, business, trust, joint venture, or other legal entity.

"Physical," for the purposes of fee test categories, means the tests to determine the physical properties of a sample. Tests for solids, turbidity, and color are examples of physical tests.

"Positive control" means measures taken to ensure that a test or its components are working properly and producing correct or expected results from positive test subjects.

"Precision" means the degree to which a set of observations or measurements of the same property, obtained under similar conditions, conform to themselves. Precision is an indicator of data quality. Precision is expressed usually as standard deviation, variance, or range, in either absolute or relative terms.

"Primary accreditation body" means the accreditation body responsible for assessing a laboratory's total quality system, on-site assessment, and PT performance tracking for fields of accreditation.

"Proficiency test or testing ~~(PT)~~" or "PT" means ~~evaluating~~ a process to evaluate a laboratory's performance under controlled conditions relative to a given set of criteria through analysis of unknown samples provided by an external source.

"Proficiency test (PT) sample" means a sample, the composition of which is unknown to the laboratory and is provided to test whether the laboratory can produce analytical results within specified acceptance criteria.

"Proficiency testing (PT) program" means the aggregate of providing rigorously controlled and standardized environmental samples to a laboratory for analysis, reporting of results, statistical evaluation of the results, and the collective demographics and results summary of all participating laboratories.

"Program," in the context of a regulatory program, means the relevant U.S. Environmental Protection Agency program such as the water program under the Clean Water Act (CWA), the air program under the Clean Air Act (CAA), the waste program under the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA or Superfund), or the waste program under the Resource Conservation and Recovery Act (RCRA).

"Publicly Owned Treatment Works ~~(POTW)~~" or "POTW" means a treatment works as defined by § 212 of the CWA, which is owned by a state or municipality (as defined by § 502(4) of the CWA). This definition includes any devices and systems used in the storage, treatment, recycling, and reclamation of municipal sewage or industrial wastes of a liquid nature. It also includes sewers, pipes, and other conveyances only if they convey wastewater to a POTW treatment plant. The term also means the municipality as defined in § 502(4) of the CWA, which has jurisdiction over the indirect discharges to and the discharges from such a treatment works.

"Quality assurance" or "QA" means an integrated system of management activities involving planning, implementation, assessment, reporting, and quality improvement to ensure that a process, item, or service is of the type and quality needed and expected by the client.

"Quality assurance officer" means the person who has responsibility for the quality system and its implementation. Where staffing is limited, the quality assurance officer may also be the laboratory manager.

"Quality control" or "QC" means the overall system of technical activities that measures the attributes and performance of a process, item, or service against defined standards to verify that they meet the stated requirements established by the customer; operational techniques and activities that are used to fulfill requirements for quality; and also the system of activities and checks used to ensure that measurement systems are maintained within prescribed limits, providing protection against "out of control" conditions and ensuring that the results are of acceptable quality.

"Quality manual" means a document stating the management policies, objectives, principles, organizational structure and authority, responsibilities, accountability, and implementation of an agency, organization, or laboratory, to ensure the quality of its product and the utility of its product to its users.

"Quality system" means a structured and documented management system describing the policies, objectives, principles, organizational authority, responsibilities, accountability, and implementation plan of an organization for ensuring quality in its work processes, products (items), and services. The quality system provides the framework for planning, implementing, and assessing work performed by the organization and for carrying out required quality assurance and quality control activities.

"Range" means the difference between the minimum and maximum of a set of values.

"Reference material" means a material or substance one or more properties of which are sufficiently well established to be

used for the calibration of an apparatus, the assessment of a measurement test method, or for assigning values to materials.

"Reference standard" means a standard, generally of the highest metrological quality available at a given location, from which measurements made at that location are derived.

"Responsible official" means one of the following, as appropriate:

1. If the laboratory is owned or operated by a private corporation, "responsible official" means (i) a president, secretary, treasurer, or a vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy-making or decision-making functions for the corporation or (ii) the manager of one or more manufacturing, production, or operating facilities employing more than 250 persons or having gross annual sales or expenditures exceeding $25 million (in second-quarter 1980 dollars), if authority to sign documents has been assigned or delegated in accordance with corporate procedures.

2. If the laboratory is owned or operated by a partnership, association, or a sole proprietor, "responsible official" means a general partner, officer of the association, or the proprietor, respectively.

3. If the laboratory is owned or operated by a governmental body, "responsible official" means a director or highest official appointed or designated to oversee the operation and performance of the activities of the environmental laboratory.

4. Any person designated as the responsible official by an individual described in subdivision 1, 2, or 3 of this definition, provided the designation is in writing, the designation specifies an individual or position with responsibility for the overall operation of the environmental laboratory, and the designation is submitted to DCLS.

"Sampling" means ~~the act of collection for the purpose of analysis~~ an activity related to obtaining a representative sample of the object of conformity assessment, according to a procedure.

"Sanitation district" means a sanitation district created under the provisions of Chapters 3 (§ 21-141 et seq.) through 5 (§ 21-291 et seq.) of Title 21 of the Code of Virginia.

"Selectivity" means the ability to analyze, distinguish, and determine a specific analyte from another component that may be a potential interferent or that may behave similarly to the target analyte within the measurement system.

"Sewage" means the water-carried human wastes from residences, buildings, industrial establishments, or other places together with such industrial wastes and underground, surface, storm, or other water as may be present.

"Simple test procedures" or "STP" means any of the following:

1. Field testing and measurement performed in an environmental laboratory.

2. The test procedures to determine:

a. Biochemical oxygen demand (BOD) or carbonaceous BOD (CBOD);

b. Fecal coliform;

c. Total coliform;

d. Fecal streptococci;

e. E. coli;

f. Enterococci;

g. Settleable solids (SS);

h. Total dissolved solids (TDS);

i. Total solids (TS);

j. Total suspended solids (TSS);

k. Total volatile solids (TVS); and

l. Total volatile suspended solids (TVSS).

"Standard operating procedure" or "SOP" means a written document that details the method for an operation, analysis, or action with thoroughly prescribed techniques and steps. An SOP is officially approved as the method for performing certain routine or repetitive tasks.

"Standardized reference material" or "SRM" means a certified reference material produced by the U.S. National Institute of Standards and Technology or other equivalent organization and characterized for absolute content, independent of analytical method.

"System laboratory" means a noncommercial laboratory that analyzes samples from multiple facilities having the same owner.

"Test" means a technical operation that consists of the determination of one or more characteristics or performance of a given product, material, equipment, organism, physical phenomenon, process, or service according to a specified procedure.

"Test, analysis, measurement or monitoring required pursuant to the Virginia Air Pollution Control Law" means any method of analysis required by the Virginia Air Pollution Control Law (§ 10.1-1300 et seq.); by the regulations promulgated under this law (9VAC5) including any method of analysis listed either in the definition of "reference method" in 9VAC5-10-20, or listed or adopted by reference in 9VAC5; or by any permit or order issued under and in accordance with this law and these regulations.

"Test, analysis, measurement or monitoring required pursuant to the Virginia Waste Management Act" means any method of analysis required by the Virginia Waste Management Act

(§ 10.1-1400 et seq.); by the regulations promulgated under this law (9VAC20), including any method of analysis listed or adopted by reference in 9VAC20; or by any permit or order issued under and in accordance with this law and these regulations.

"Test, analysis, measurement or monitoring required pursuant to the Virginia Water Control Law" means any method of analysis required by the Virginia Water Control Law (§ 62.1-44.2 et seq.); by the regulations promulgated under this law (9VAC25), including any method of analysis listed or adopted by reference in 9VAC25; or by any permit or order issued under and in accordance with this law and these regulations.

"Test method" means an adoption of a scientific technique for performing a specific measurement as documented in a laboratory standard operating procedure or as published by a recognized authority.

"The NELAC Institute" or "TNI" means the organization whose standards environmental laboratories must meet to become accredited under 1VAC30-46, the regulation governing commercial environmental laboratories in Virginia.

"Toxicity characteristic leachate procedure" or "TCLP" means Test Method 1311 in "Test Methods for Evaluating Solid Waste, Physical/Chemical Methods," EPA Publication SW-846, as incorporated by reference in 40 CFR 260.11. This method is used to determine whether a solid waste exhibits the characteristic of toxicity (see 40 CFR 261.24).

"Traceability" means the property of a result of a measurement whereby it can be related to appropriate standards, generally international or national standards, through an unbroken chain of comparisons.

"U.S. Environmental Protection Agency" or "EPA" means the federal government agency with responsibility for protecting, safeguarding, and improving the natural environment (i.e., air, water, and land) upon which human life depends.

"Virginia Air Pollution Control Law" means Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 of the Code of Virginia, which is titled "Air Pollution Control Board."

"Virginia Environmental Laboratory Accreditation Program" or "VELAP" means the program DCLS operates to certify environmental laboratories under this chapter.

"Wastewater" means liquid and water-carried industrial wastes and domestic sewage from residential dwellings, commercial buildings, industrial and manufacturing facilities, and institutions.

"Waterworks" means each system of structures and appliances used in connection with the collection, storage, purification, and treatment of water for drinking or domestic use and the distribution thereof to the public, except distribution piping.

"Zooplankton" means microscopic animals that float freely with voluntary movement in a body of water.

1VAC30-45-95. Suspension of certification.

A. DCLS may suspend certification from an environmental laboratory in total or in part to allow the laboratory time to correct the reason for which DCLS may withdraw certification. Suspension is limited to the reasons listed in subsection B of this section.

B. DCLS may suspend certification from an environmental laboratory in part or in total when the laboratory has failed to do any of the following:

1. Participate in the proficiency testing program as required by Article 3 (1VAC30-45-500 et seq.) of Part II of this chapter.

2. Satisfactorily complete proficiency testing studies as required by Article 3 (1VAC30-45-500 et seq.) of Part II of this chapter.

3. Submit an acceptable corrective action plan after two opportunities as specified in 1VAC30-45-390.

4. Maintain a quality system as defined in Article 4 (1VAC30-45-600 et seq.) of Part II of this chapter.

~~4.~~ 5. Employ staff that meets the personnel qualifications of Article 1 (1VAC30-45-200 et seq.) of Part II of this chapter.

~~5.~~ 6. Notify DCLS of any changes in key certification criteria as set forth in 1VAC30-45-90.

C. Process to suspend certification.

1. When DCLS becomes aware of a cause to suspend a laboratory, the agency shall send notification to the responsible official and the laboratory manager stating it appears to DCLS that the laboratory has failed to meet the 1VAC30-45 standards for one or more of the reasons listed in subsection B of this section. DCLS shall send the notification by certified mail.

2. The DCLS notification shall do the following:

a. Require the laboratory to provide DCLS with documentation of the corrective action already taken with regard to its failure to meet a standard under subsection B of this section.

b. State the corrective action the laboratory must take and the time allowed for this corrective action to be completed in order to retain certification.

3. The environmental laboratory may proceed to correct the deficiencies for which DCLS may suspend the laboratory's certification.

4. Alternatively the laboratory may state in writing that DCLS is incorrect in its observations regarding potential suspension and give specific reasons why the laboratory believes DCLS should not suspend certification. The

laboratory has the right to due process as set forth in 1VAC30-45-110, the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia), and Part 2A of the Rules of the Supreme Court of Virginia.

5. With the exception of subdivision B 4 of this section, DCLS may allow the laboratory up to 60 days to correct the problem for which it may have its certification suspended.

6. DCLS shall set a date for suspension that follows the period provided under subdivision 5 of this subsection to restore certification.

7. If the laboratory does not correct its deficiencies within the time period allowed or pursue options under subdivision 4 of this subsection, DCLS may suspend a laboratory in part or in total.

8. DCLS shall notify the laboratory by letter if the laboratory's certification is suspended in part or in total. DCLS shall send the notification by certified mail. DCLS shall also notify the pertinent Virginia state agency of the laboratory's suspension status.

9. The laboratory may provide information demonstrating why suspension is not warranted in accordance with subdivision 4 of this subsection.

D. Responsibilities of the environmental laboratory and DCLS when certification has been suspended.

1. The term of suspension shall be limited to six months or the period of certification whichever is longer.

2. The environmental laboratory shall not continue to analyze samples or report analysis for the fields of certification for which DCLS has suspended certification.

3. The environmental laboratory shall retain certification for the fields of certification, methods, and analytes where it continues to meet the requirements of this chapter.

4. The laboratory's suspended certification status shall change to certified when the laboratory demonstrates to DCLS that the laboratory has corrected the deficiency or deficiencies for which its certification was suspended.

5. An environmental laboratory with suspended certification shall not have to reapply for certification if the cause or causes for suspension are corrected within the term of suspension.

6. An environmental laboratory that DCLS has suspended in total shall pay the cost of any necessary follow-up on-site assessments or data review or both to determine compliance. This cost shall be calculated under the provisions of 1VAC30-45-130 F and G.

7. If the laboratory fails to correct the causes of suspension within the term of suspension, DCLS shall decertify the laboratory in total or in part.

1VAC30-45-100. Decertification.

A. DCLS shall decertify an environmental laboratory in total if the laboratory is found to be falsifying any data or providing false information to support certification.

B. DCLS may decertify an environmental laboratory in part or in total when the laboratory has failed to do any of the following:

1. Participate in the proficiency testing program as required by Article 3 (1VAC30-45-500 et seq.) of Part II of this chapter.

2. Satisfactorily complete proficiency testing studies as required by Article 3 (1VAC30-45-500 et seq.) of Part II of this chapter.

[~~3. Successfully complete three consecutive PT studies, either by failure to participate in the required PT study or by failure to obtain acceptable results for the same field of certification.~~]

[~~4.~~ 3.] Maintain a quality system as defined in Article 4 (1VAC30-45-600 et seq.) of Part II of this chapter.

[4. ~~5.~~] Employ staff that meets the personnel qualifications in Article 1 (1VAC30-45-200 et seq.) of Part II of this chapter.

[5. ~~6.~~] Submit an acceptable corrective action plan after two opportunities as specified in 1VAC30-45-390.

[6. ~~7.~~] Implement corrective action specified in the laboratory's corrective action plan as set out under 1VAC30-45-390.

[7. ~~8.~~] Correct the causes of suspension within the term of suspension.

[~~9.~~ 8.] Notify DCLS of any changes in key certification criteria as set forth in 1VAC30-45-90.

[~~8. 10.~~ 9.] Use accurate references to the laboratory's certification status in the laboratory's documentation.

[~~9. 11.~~ 10.] Allow a DCLS assessment team entry during normal business hours to conduct an on-site assessment required by Article 2 (1VAC30-45-300 et seq.) of Part II of this chapter.

[~~10. 12.~~ 11.] Pay the required fees specified in 1VAC30-45-130.

[~~13.~~ 12.] Meet the provisions regarding communication with others in 1VAC30-45-510 C.

C. [DCLS may decertify an environmental laboratory in part or in total when the laboratory has failed three consecutive proficiency testing studies for the same field of certification either by failure to participate in the proficiency testing study or by failure to obtain acceptable results.

D.] DCLS shall follow the process specified in 1VAC30-45-110 when decertifying an environmental laboratory.

[~~D.~~ E.] Responsibilities of the environmental laboratory and DCLS when certification has been withdrawn.

1. Laboratories that lose their certification in full shall return their certificate to DCLS.

2. If a laboratory loses certification in part, DCLS shall issue a revised certificate to the laboratory.

3. When the environmental laboratory has lost certification in full or in part, the laboratory shall not continue to analyze samples or report analyses for the fields of certification that DCLS has decertified.

[~~E.~~ F.] After correcting the reason or cause for decertification under subsection A or B of this section, the laboratory owner may reapply for certification under 1VAC30-45-70.

1VAC30-45-130. Fees.

A. General.

1. Environmental laboratories shall pay a fee with all applications, including reapplications, for certification. DCLS shall not designate an application as complete until it receives payment of the fee.

2. Each certified environmental laboratory shall pay an annual fee to maintain its certification. DCLS shall send an invoice to the certified environmental laboratory.

3. Fees shall be nonrefundable.

4. DCLS, as part of its regular budgetary review of the program, shall determine whether the fees charged under this section offset the program costs as required under § 2.2-1105 of the Code of Virginia.

B. Environmental laboratories performing only simple test procedures shall pay an annual fee of $690.

C. Fee computation for general environmental laboratories.

1. Fees shall be applied on an annual basis.

2. Environmental laboratories shall pay the total of the base fee and the test category fees set out in subsections D and E of this section.

D. Base fees for general environmental laboratories.

1. DCLS determines the base fee for a laboratory by taking into account both the total number of methods and the total number of field of certification matrices for which the laboratory would be certified.

2. DCLS shall charge the base fees set out in Table 1. The base fee for a laboratory is located by first finding the row for the total number of methods to be certified and then finding the box on that row located in the column headed by the total number of matrices to be certified. For example, DCLS charges a base fee of $1495 to a laboratory performing a total of eight methods for one matrix.

TABLE 1: BASE FEES

Number of Methods	1 Matrix	2 Matrices
1 - 9	$1495	$1645
10 - 29	$1610	$1811
30 - 99	$1783	$2099

E. Test category fees for general environmental laboratories.

1. The test category fees cover the types of testing for which a laboratory may be certified as specified in the laboratory's application or as certified at the time of annual billing.

2. Fees shall be charged for each category of tests to be certified.

3. Fees shall be charged for the total number of field of certification matrices to be certified under the specific test category. For example, if a laboratory is performing inorganic chemistry for both nonpotable water and solid and chemical materials matrices, the fee for this test category would be found in the column for two matrices.

4. The fee for each category includes one or more analytical methods unless otherwise specified.

5. DCLS shall charge the test category fees set out in Table 2. The test category fees for a laboratory are located by first finding the row with the total number of test methods for the test category to be certified. The fee to be charged for the test category will be found on that row in the column headed by the total number of matrices to be certified. A laboratory performing four test methods for inorganic chemistry in nonpotable water and solid and chemical materials (two matrices) would be charged a test category fee of $431.

6. Noncommercial environmental laboratories that perform toxicity, radiochemical, or asbestos testing shall pay the test category fees established for these types of testing in 1VAC30-46-150.

TABLE 2: TEST CATEGORY FEES

Test Category	Fees by Number of Matrices	
	One	Two
Oxygen demand	$259	$385
Bacteriology, 1 - 3 total methods	$201	$305
Bacteriology, 4 or more total methods	$253	$380
Physical, 1 - 5 total methods	$201	$305

Physical, 6 - 10 total methods	$253	$380
Inorganic chemistry, 1 - 10 total methods	$288	$431
Inorganic chemistry, 11 - 20 total methods	$362	$546
Inorganic chemistry, 21 - 49 total methods	$453	$679
Chemistry metals, 1 - 5 total methods	$374	$564
Chemistry metals, 6 - 20 total methods	$472	$707
Organic chemistry, 1 - 5 total methods	$460	$690
Organic chemistry, 6 - 20 total methods	$575	$863

7. Fee examples. Three examples are provided.

a. Example 1:

Base Fee	One matrix and four test methods	$1495
Test Category Fees		
One Matrix		
Nonpotable Water	Bacteriology (2 methods)	$201
Nonpotable Water	Oxygen demand (1 method)	$259
Nonpotable Water	Physical (1)	$201
TOTAL		$2156

b. Example 2:

Base Fee	One matrix and 15 test methods	$1610
Test Category Fees		
One Matrix		
Nonpotable Water	Bacteriology (2 methods)	$201
Nonpotable Water	Inorganic chemistry (9 methods)	$288
Nonpotable Water	Chemistry metals (2 methods)	$374
Nonpotable Water	Oxygen demand (1 method)	$259
Nonpotable Water	Physical (1)	$201
TOTAL		$2933

c. Example 3:

Base Fee	Two matrices and 27 test methods	$1811
Test Category Fees		
One Matrix		
Nonpotable Water	Bacteriology (4 methods)	$253
Nonpotable Water	Oxygen demand (1 method)	$259
Solid and Chemical Materials	Chemistry metals (1 method)	$374
Two Matrices		
Nonpotable Water and Solid and Chemical Materials	Inorganic chemistry (13 methods)	$546
Nonpotable Water and Solid and Chemical Materials	Physical (7 methods)	$380
TOTAL		$3623

F. Additional fees. Additional fees shall be charged to laboratories applying for the following: (i) modification to scope of certification under 1VAC30-45-90 B, (ii) transfer of ownership under 1VAC30-45-90 C, (iii) review of compliance following total suspension, (iv) exemption under 1VAC30-45-120, or ~~(iv)~~ (v) petition for a variance under 1VAC30-45-140.

1. For any certified environmental laboratory that applies to modify its scope of certification as specified under 1VAC30-45-90 B, DCLS shall assess a fee determined by the method in subsection G of this section.

2. Under 1VAC30-45-90 C, DCLS may charge a transfer fee to a certified laboratory that transfers ownership. A fee shall be charged if DCLS (i) needs to review documentation sent by the laboratory about the transfer of ownership or (ii) determines that an on-site assessment is necessary to evaluate the effect of the transfer of ownership. DCLS shall assess a fee determined by the method in subsection G of this section. If, under 1VAC30-45-90 C, DCLS determines that the change of ownership or location of laboratory requires recertification of or reapplication by the laboratory, the laboratory shall pay the application fees required under this section.

3. Under 1VAC30-45-95 D 6, an environmental laboratory that DCLS has suspended in total shall be charged the cost of any necessary follow-up on-site assessments or data review or both to determine compliance. This charge shall be calculated under the method specified in subsection G of this section.

4. General environmental laboratories applying for an exemption under 1VAC30-45-120 shall pay an initial application fee of $700 plus an additional fee based on the actual time needed for DCLS to assess the exemption request. The total fee shall not exceed the actual time DCLS takes to assess the exemption request. Laboratories performing only simple test procedures applying for an exemption under 1VAC30-45-120 shall pay an initial application fee of $300 plus an additional fee based on the actual time needed for DCLS to assess the exemption request. The total fee shall not exceed the actual time DCLS takes to assess the exemption request. The fee assessed shall be calculated using the method in subsection G of this section.

~~4.~~ 5. Under 1VAC30-45-140, any person regulated by this chapter may petition the director to grant a variance from any requirement of this chapter. DCLS shall charge an initial fee of $700 plus an additional fee based on the actual time needed for DCLS to review the petition, including any on-site assessment required. The total fee shall not exceed the actual time DCLS takes to review and make a determination on the request for a variance. The fee shall be determined by the method specified in subsection G of this section.

G. Fee determination.

1. The fee shall be the sum of the total hourly charges for all reviewers plus any on-site review costs incurred.

2. An hourly charge per reviewer shall be determined by (i) obtaining a yearly cost by multiplying the reviewer's annual salary by 1.35 (accounts for overhead such as taxes and insurance) and then (ii) dividing the yearly cost by 1,642 (number of annual hours established by Fiscal Services, the Department of General Services, for billing purposes).

3. The charge per reviewer shall be determined by multiplying the number of hours expended in the review by the reviewer's hourly charge.

4. If an on-site review is required, travel time and on-site review time shall be charged at the same hourly charge per reviewer, and any travel expenses shall be added.

H. Out-of-state laboratories - travel costs. The owner of an environmental laboratory located in another state who applies for certification under this chapter shall also pay a fee equal to the reasonable travel costs associated with conducting an on-site assessment at the laboratory. Reasonable travel costs include transportation, lodging, per diem, and telephone and duplication charges.

I. DCLS shall derive the travel costs charged under subsections G and H of this section from the Commonwealth of Virginia reimbursement allowances and rates for lodging, per diem, and mileage.

1VAC30-45-520. PT criteria for laboratory certification.

A. Result categories.

1. The criteria described in this section apply individually to each FoPT, as defined by the laboratory seeking to obtain or maintain certification in its certification request. These criteria apply only to the PT portion of the overall certification standard.

2. There are two PT result categories: "acceptable" and "not acceptable."

B. Initial and continuing certification.

1. A laboratory seeking to obtain or maintain certification shall successfully complete one PT study for each requested FoC.

2. Once a laboratory has been granted certification status, it shall continue to complete PT studies for each FoPT and maintain a history of at least one acceptable PT study each calendar year. The laboratory shall complete its PT studies by September 30 of each calendar year.

3. When the PT sample used for initial certification was analyzed by the laboratory prior to the date of application, the analysis date of the PT sample shall be no more than 12 months prior to the application date of certification.

4. For a laboratory performing supplemental testing, the PT studies shall be at least ~~15~~ seven calendar days apart from the closing date of one study to the ~~shipment~~ opening date of another study for the same FoPT.

5. When the PT study result is reported by the PT provider as "acceptable" the environmental laboratory has satisfied the PT requirement.

6. When the PT study result is "not acceptable," the environmental laboratory shall follow the procedure in subsection C of this section.

7. DCLS shall consider a laboratory's analytical result for a FoPT not acceptable when the laboratory makes any reporting error or omission that results in a nonspecific match between the analytical result for the FoPT and any criterion that identifies the laboratory or the field of certification for which the PT sample was analyzed for the purpose of initial or continued certification.

C. Procedure and requirements for "not acceptable" PT study results.

1. When a laboratory receives a PT study result of "not acceptable," the laboratory shall determine the cause for the failure and perform and document corrective action. The corrective action documentation shall be completed within 30 days of receiving the "not acceptable" PT study result and be submitted to DCLS upon request. DCLS may extend the time for corrective action and documentation.

2. Upon completion of the corrective action the laboratory shall perform another PT study for each FoPT that had a "not acceptable" result.

3. If the laboratory successfully completes the makeup PT study by receiving an "acceptable" result before December 31, DCLS shall not suspend the laboratory's certification for the pertinent FoC.

4. If the laboratory receives a "not acceptable" result on the makeup PT study, DCLS shall notify the laboratory that there is cause to suspend the laboratory's certification for the FoC for which the PT study was "not acceptable."

5. DCLS shall not extend the period for annual PT study completion beyond December 31 each year. Failure to satisfactorily complete a PT study, including any corrective action and makeup PT study, by December 31 shall result in suspension of certification in total or in part.

6. If the laboratory receives a "not acceptable" result on three successive PT studies, DCLS shall decertify the laboratory for the pertinent FoC until such time that the laboratory:

a. Completes corrective action for all failed studies and submits its corrective action report to DCLS;

b. Obtains an "acceptable" result for the PT studies; and

c. Applies for a change to its scope of certification and pays applicable fees required by 1VAC30-45-90 B and 1VAC30-45-130 F.

7. DCLS shall follow the provisions of 1VAC30-45-110 in decertifying the laboratory.

D. Withdrawal from PT studies. A laboratory may withdraw from a PT study for any FoPT on or before the close date of the study. Withdrawing from a study shall not exempt the laboratory from meeting the annual analysis requirements necessary for continued certification.

1VAC30-45-650. Records management and storage.

A. The laboratory shall keep all records, certificates, and reports as required by applicable state and federal recordkeeping laws and regulations. The laboratory shall safely store these records and hold them secure.

B. The laboratory shall retain all records for a minimum of three years from generation of the last entry in the records, or longer, if required by an applicable regulatory program, whichever is greater. The laboratory shall maintain all information necessary for the historical reconstruction of data, including all original observations, calculations and derived data, calibration records and a copy of the test report.

C. Records that are stored only on electronic media shall be supported by the hardware and software necessary for their retrieval. Records that are stored or generated by computers or personal computers shall have hard copy or write-protected backup copies.

D. The laboratory shall establish a record management system for control of laboratory notebooks, instrument logbooks, standards logbooks, and records for data reduction, validation storage and reporting.

E. ~~Access to archived information shall be documented with an access log.~~ The laboratory shall protect these records against fire, theft, loss, environmental deterioration, vermin and, in the case of electronic records, electronic or magnetic sources.

F. The laboratory shall have a plan to ensure that the records are maintained or transferred in the event that a laboratory transfers ownership or goes out of business. In addition, in cases of bankruptcy, the laboratory shall follow appropriate regulatory and state legal requirements concerning laboratory records.

1VAC30-45-730. Test methods and standard operating procedures.

A. Methods documentation.

1. The laboratory shall have documented instructions on the use and operation of all relevant equipment, on the handling and preparation of samples, and for calibration or testing, where the absence of such instructions could jeopardize the calibrations or tests.

2. All instructions, standards, manuals, and reference data relevant to the work of the laboratory shall be maintained up to date and be readily available to the staff.

B. Standard operating procedures (SOPs).

1. Laboratories shall maintain SOPs that accurately reflect all phases of current laboratory activities such as assessing data integrity, corrective actions, handling customer complaints, and all test methods. These documents, for

example, may be equipment manuals provided by the manufacturer or internally written documents. The test methods may be copies of published methods as long as any changes or selected options in the methods are documented and included in the laboratory methods manual.

2. The SOPs shall be organized. Each SOP shall clearly indicate the effective date of the document, the revision number, and the signature or signatures of the responsible laboratory manager or managers.

3. Copies of all SOPs shall be accessible to all personnel.

C. SOPs for laboratory methods.

1. The laboratory shall have and maintain an SOP for each certified analyte or test method.

2. This SOP may be a copy of a published or referenced method or may be written by the laboratory. In cases where modifications to the published method have been made by the laboratory or where the referenced test method is ambiguous or provides insufficient detail, these changes or clarifications shall be clearly described. Each test method shall include or reference where applicable:

a. Identification of the test method;

b. Applicable matrix or matrices;

c. Limits of detection or quantitation;

d. Scope and application, including parameters to be analyzed;

e. Summary of the test method;

f. Definitions;

g. Interferences;

h. Safety;

i. Equipment and supplies;

j. Reagents and standards;

k. Sample collection, preservation, shipment, and storage;

l. Quality control;

m. Calibration and standardization;

n. Procedure;

o. Data analysis and calculations;

p. Method performance;

q. Pollution prevention;

r. Data assessment and acceptance criteria for quality control measures;

s. Corrective actions for out-of-control data;

t. Contingencies for handling out-of-control or unacceptable data;

u. Waste management;

v. References; and

w. Any tables, diagrams, flowcharts, and validation data.

D. Test methods.

1. Laboratories shall use (i) promulgated test methods in accordance with the Code of Federal Regulations; (ii) test methods stated in any current permit issued by the State Air Pollution Control Board, the Virginia Waste Management Board, or the State Water Control Board; or (iii) alternate test procedures approved by the board issuing the permit or the Department of Environmental Quality, including applicable quality assurance requirements, and sample preservation, container, storage, and holding time requirements.

2. The laboratory shall use appropriate test methods and procedures for all tests and related activities within its responsibility (including sample handling, transport and storage, preparation, and analysis). The method and procedures shall be consistent with the accuracy required and with any standard specifications relevant to the calibrations or tests concerned.

3. When the use of reference test methods for a sample analysis is mandated, only those methods shall be used.

4. Where test methods are employed that are not required, as in the Performance Based Measurement System approach, the methods shall be fully documented and validated (see subsection E of this section).

E. Demonstration of capability.

1. Prior to acceptance and institution of any test method, satisfactory initial demonstration of method capability is required. In general, this demonstration does not test the performance of the method in real world samples, but in the applicable and available clean quality system matrix sample (a quality system matrix in which no target analytes or interferences are present at concentrations that impact the results of a specific test method), for example, drinking water, solids, biological tissue, and air. Laboratories shall follow the procedure in subsection F of this section to demonstrate capability.

2. Thereafter, ongoing demonstration of method performance, such as laboratory control samples, is required.

3. In cases where a laboratory analyzes samples using a test method that has been in use by the laboratory for at least one year prior to applying for certification, and there have been no significant changes in instrument type, personnel or test method, the continuing demonstration of method performance and the analyst's documentation of continued proficiency shall be acceptable. The laboratory shall have records on file to demonstrate that an initial demonstration of capability is not required.

4. In cases where a laboratory analyzes samples using a test method that has not been in use by an individual in the laboratory for at least one 12-month period, another successful demonstration of capability in accordance with

subsection F of this section shall be required for that individual to resume testing by the method.

5. In all cases, the laboratory shall document each demonstration of capability as required by subsection G of this section.

~~5.~~ 6. The laboratory shall complete a demonstration of capability each time there is a change in instrument type, personnel or test method, including the addition of an analyte to a certified test method.

F. Procedure for demonstration of capability. The following steps shall be performed for mandated test methods. However, before any results are reported using this method, actual sample spike results may be used to meet this standard (i.e., at least four consecutive matrix spikes within the last 12 months). For analytes that do not lend themselves to spiking (e.g., TSS) the demonstration of capability may be performed using quality control samples. The laboratory may document that other approaches to demonstration of capability are adequate. This documentation shall be included in the laboratory's quality manual:

1. A quality control (QC) sample may be obtained from an outside source or may be prepared by the laboratory using alternate source stock standards that are prepared independently from those used in instrument calibration.

2. The analyte or analytes shall be diluted in a volume of clean quality system matrix sufficient to prepare four aliquots at the concentration specified, or if unspecified, to a concentration of 1-4 times the limit of quantitation.

3. At least four aliquots shall be prepared and analyzed according to the test method either concurrently or over a period of days.

4. Using all of the results, calculate the mean recovery in the appropriate reporting units (such as g/L) and the standard deviations of the population sample (n-1) (in the same units) for each parameter of interest. When it is not possible to determine mean and standard deviations, such as for presence or absence of the analyte and logarithmic values, the laboratory shall assess performance against established and documented criteria.

5. Compare the information from subdivision 4 of this subsection to the corresponding acceptance criteria for precision and accuracy in the test method (if applicable) or in laboratory-generated acceptance criteria (if there are not established mandatory criteria). If all parameters meet the acceptance criteria, the analysis of actual samples may begin. If any one of the parameters do not meet the acceptance criteria, the performance is unacceptable for that parameter.

6. When one or more of the tested parameters fail at least one of the acceptance criteria, the analyst shall proceed according to either subdivision 6 a or 6 b of this subsection.

a. Locate and correct the source of the problem and repeat the test for all parameters of interest beginning with subdivision 3 of this subsection.

b. Beginning with subdivision 3 of this subsection, repeat the test for all parameters that failed to meet criteria. Repeated failure, however, confirms a general problem with the measurement system. If this occurs, locate and correct the source of the problem and repeat the test for all compounds of interest beginning with subdivision 3 of this subsection.

G. Documentation of demonstration of capability. The laboratory shall document each demonstration of capability so that the following information shall be readily available for each employee:

1. Analyst or analysts involved in preparation and analysis.

2. Matrix.

3. Analytes, class of analytes, measured parameters, or organisms.

4. Identification of methods performed.

5. Identification of laboratory-specific SOP used for analysis, including revision number.

6. Date ~~or dates~~ of analysis.

7. All raw data necessary to reconstruct and validate the analyses.

8. Data evaluation required by subsection F of this section.

H. Sample aliquots. Where sampling (as in obtaining sample aliquots from a submitted sample) is carried out as part of the test method, the laboratory shall use documented procedures and appropriate techniques to obtain representative subsamples.

I. Data verification. Calculations and data transfers shall be subject to appropriate checks. The laboratory shall establish standard operating procedures to ensure that (i) the reported data are free from transcription and calculation errors and (ii) all quality control measures are reviewed and evaluated before data are reported. The laboratory also shall establish standard operating procedures addressing manual calculations including manual integrations.

J. Documentation and labeling of standards and reagents. Documented procedures shall exist for the reception and storage of consumable materials used for the technical operations of the laboratory.

1. The laboratory shall retain records for all standards, reagents, reference materials, and media including the manufacturer/vendor, the manufacturer's Certificate of Analysis or purity (if available), the date of receipt, recommended storage conditions, and an expiration date

after which the material shall not be used unless its reliability is verified by the laboratory.

2. Original containers (such as provided by the manufacturer or vendor) shall be labeled with an expiration date if this date is provided by the manufacturer or vendor.

3. Records shall be maintained on standard and reference material preparation. These records shall indicate traceability to purchased stocks or neat compounds, reference to the method of preparation, date of preparation, expiration date and preparer's initials.

4. Sufficient identification of containers of prepared reagents and standards shall be provided to ensure proper performance of tests.

K. Computers and electronic data related requirements. Where computers, automated equipment or microprocessors are used for the capture, processing, manipulation, recording, reporting, storage or retrieval of test data, the laboratory shall ensure the following:

1. Computer software developed by the user is documented in sufficient detail and is suitably validated as being adequate for use.

2. Procedures are established and implemented for protecting the integrity of data, such as integrity of data entry or capture, data storage, data transmission and data processing.

3. Computer and automated equipment are maintained to ensure proper functioning and provided with the environmental and operating conditions necessary to maintain the integrity of calibration and test data.

4. Appropriate procedures are established and implemented for the maintenance of security of data including the prevention of unauthorized access to, and the unauthorized amendment of, computer records.

1VAC30-45-750. Quality assurance.

A. General. The laboratory shall have quality control procedures for monitoring the validity of environmental tests undertaken. The resulting data shall be recorded in such a way that trends are detectable and, where practicable, statistical techniques shall be applied to the reviewing of the results. This monitoring shall be planned and reviewed and may include, but not be limited to, the following:

1. Regular use of certified reference materials or internal quality control using secondary reference materials or both.

2. Participation in interlaboratory comparison or proficiency testing program.

3. Replicate tests using the same or different methods.

4. Retesting of retained samples.

5. Correlation of results for different characteristics of a sample (e.g., total phosphate should be greater than or equal to orthophosphate).

B. Essential quality control procedures. The general quality control principles in subsection C of this section shall apply, where applicable, to all environmental laboratories. The manner in which they are implemented is dependent on the types of tests performed by the laboratory. 1VAC30-45-770 through 1VAC30-45-775, 1VAC30-45-790 through 1VAC30-45-798, and 1VAC30-45-810 through 1VAC30-45-818 specify quality control requirements for chemical testing, microbiological testing, and air testing, respectively. Noncommercial environmental laboratories that analyze environmental samples using ~~other types of testing such as~~ toxicity, radiochemical, or asbestos testing shall meet the quality control standards for the specific method and the specific type of testing in ~~the 2009~~ Modules 3, 6, and 7 of Volume 1 of the 2016 TNI Standards for Environmental Laboratories. The standards for any given test type shall assure that the applicable principles are addressed.

C. All laboratories shall have detailed written protocols in place to monitor the following quality controls:

1. Positive and negative controls to monitor tests such as blanks, spikes, reference toxicants.

2. Tests to define the variability or repeatability of the laboratory results or both such as replicates.

3. Measures to assure the accuracy of the test method including calibration or continuing calibrations or both, use of certified reference materials, proficiency test samples, or other measures.

4. Measures to evaluate test method capability, such as method detection limits and quantitation limits or range of applicability such as linearity.

5. Selection of appropriate formulae to reduce raw data to final results such as regression analysis, comparison to internal and external standard calculations, and statistical analyses.

6. Selection and use of reagents and standards of appropriate quality.

7. Measures to assure the selectivity of the test for its intended purpose.

8. Measures to assure constant and consistent test conditions (both instrumental and environmental) where required by the test method such as temperature, humidity, light, or specific instrument conditions.

1VAC30-45-760. Quality control requirements.

A. General.

1. The quality control protocols specified by the laboratory's SOPs shall be followed (1VAC30-45-730 C). The laboratory

shall ensure that either the (i) applicable essential standards outlined in this section through 1VAC30-45-775, 1VAC30-45-790 through 1VAC30-45-798, and 1VAC30-45-810 through 1VAC30-45-818 or (ii) mandated methods or regulations, whichever are more stringent, are incorporated into their method SOPs. When it is not apparent which is more stringent, the quality controls in the mandated method or regulations are to be followed.

2. All quality control measures shall be assessed and evaluated on an ongoing basis and quality control acceptance criteria shall be used to determine the validity of the data. The laboratory shall have procedures for the development of acceptance/rejection criteria where no method or regulatory criteria exists.

B. Initial test method evaluation. For all test methods other than microbiology, the requirements of subdivisions 1 and 2 of this subsection apply. For microbiology testing, the initial test method evaluation requirements are contained in 1VAC30-45-790 through 1VAC30-45-798. For the evaluation of precision and bias (subdivision 3 of this subsection), the requirements of subdivision 3 a of this subsection apply to standard methods. The requirements of subdivision 3 b of this subsection apply to the methods referenced in that subdivision.

1. Limit of detection (LOD).

a. The laboratory shall determine the LOD for the method for each target analyte of concern in the quality system matrices~~. All~~ when the testing is [~~done in accordance with the federal Clean Water Act~~ conducted] using approved methods listed in 40 CFR Part 136 [for a program under the federal Clean Water Act], except when the procedure for Determination of Method Detection Limit at 40 CFR Part 136 Appendix B states the procedure is not applicable to a measurement.

b. The laboratory shall determine the LOD for the method for each target analyte of concern in the quality system matrices when test results are to be reported to the LOD (versus the limit of quantitation or working range of instrument calibration), according to 1VAC30-45-771 and 1VAC30-45-814. Where an LOD study is not performed, the laboratory may not report a value below the limit of quantitation.

c. When the LOD is required under subdivision 1 a or 1 b of this subsection, all sample processing steps of the analytical method shall be included in the determination of the LOD.

~~b.~~ d. The validity of the LOD shall be confirmed as described in 40 CFR Part 136 Appendix B as applicable, or by qualitative identification of the analyte or analytes in a quality control sample in each quality system matrix containing the analyte at no more than two to three times the LOD for single analyte tests and one to four times the LOD for multiple analyte tests. This verification shall be performed on every instrument that is to be used for analysis of samples and reporting of data.

~~c. An LOD study is not required for any component for which spiking solutions or quality control samples are not available such as temperature, or, when test results are not to be reported to the LOD (versus the limit of quantitation or working range of instrument calibration), according to 1VAC30-45-771 and 1VAC30-45-814. Where an LOD study is not performed, the laboratory may not report a value below the limit of quantitation.~~

2. Limit of quantitation (LOQ).

a. The laboratory shall determine the LOQ for each analyte of concern according to a defined, documented procedure.

b. The LOQ study is not required for any component or property for which spiking solutions or quality control samples are not commercially available or otherwise inappropriate (e.g., pH).

c. The validity of the LOQ shall be confirmed by successful analysis of a QC sample containing the analytes of concern in each quality system matrix ~~one to~~ at a concentration at or below the LOQ or no more than two times the concentration of the claimed LOQ. A successful analysis is one where the recovery of each analyte is within the established test method acceptance criteria or client data quality objectives for accuracy. This single analysis is not required if the bias and precision of the measurement system is evaluated at the LOQ.

3. Evaluation of precision and bias.

a. Standard methods. The laboratory shall evaluate the precision and bias of a standard method for each analyte of concern for each quality system matrix according to either of the following:

(1) The single-concentration four-replicate recovery study procedures in 1VAC30-45-730 F; or

(2) An alternate procedure documented in the quality manual when the analyte cannot be spiked into the sample matrix and quality control samples are not commercially available.

b. Nonstandard methods.

(1) For laboratory-developed test methods or nonstandard test methods that were not in use by the laboratory before July 2003, the laboratory shall have a documented procedure to evaluate precision and bias. The laboratory shall also compare results of the precision and bias measurements with criteria given in the reference method or criteria established by the laboratory.

(2) Precision and bias measurements shall evaluate the method across the analytical calibration range of the method. The laboratory shall also evaluate precision and bias in the relevant quality system matrices and shall process the samples through the entire measurement system for each analyte of interest.

(3) The following are examples of a systematic approach to evaluate precision and bias:

(a) Example 1. Analyze QC samples in triplicate containing the analytes of concern at or near the limit of quantitation, at the upper-range of the calibration (upper 20%) and at a mid-range concentration. Process these samples on different days as three sets of samples through the entire measurement system for each analyte of interest. Each day one QC sample at each concentration is analyzed. A separate method blank shall be subjected to the analytical method along with the QC samples on each of the three days. (Note that the three samples at the LOQ concentration can demonstrate sensitivity as well.) For each analyte, calculate the mean recovery for each day, for each level over days, and for all nine samples. Calculate the relative standard deviation for each of the separate means obtained. Compare the standard deviations for the different days and the standard deviations for the different concentrations. If the different standard deviations are all statistically insignificant (e.g., F-test), then compare the overall mean and standard deviation with the established criteria from above.

(b) Example 2. A validation protocol such as the Tier I, Tier II, and Tier III requirements in U.S. EPA Office of Water's Alternate Test Procedure (ATP) approval process.

4. Evaluation of selectivity. The laboratory shall evaluate selectivity by following the checks established within the method. These checks may include mass spectral tuning, second column confirmation, ICP inter-element interference checks, chromatography retention time windows, sample blanks, spectrochemical absorption or fluorescence profiles, co-precipitation evaluations, and electrode response factors.

1VAC30-45-771. Chemical testing: limit of detection and limit of quantitation.

A. General. All procedures used shall be documented. Documentation shall include the quality system matrix type. All supporting data shall be retained.

B. Limit of detection (LOD). The laboratory shall utilize a test method that provides an LOD that is appropriate and relevant for the intended use of the data. ~~An LOD is not required for a test method when test results are not reported outside of the calibration range.~~ LOD determination and validation are required as specified by 1VAC3045-760 B 1. LODs shall be determined by the protocol in the mandated test method or applicable regulation. If the protocol for determining LODs is not specified, the selection of the procedure shall reflect instrument limitations and the intended application of the test method.

1. The LOD shall be initially determined for the compounds of interest in each test method in a quality system matrix in which there are no target analytes or interferences at a concentration that would impact the results. Alternatively the LOD shall be determined in the quality system matrix of interest (see definition of matrix).

2. LODs shall be determined each time there is a change in the test method that affects how the test is performed, or when a change in instrumentation occurs that affects the sensitivity of the analysis.

3. The LOD shall be verified annually for each quality system matrix, method and analyte according to the procedure as specified in 1VAC30-45-760 B 1.

C. Limit of quantitation (LOQ).

1. Any established LOQ shall be above the LOD.

2. The LOQ shall be verified annually for each quality system matrix, method and analyte according to the procedure specified in 1VAC30-45-760 B 2. Alternatively, the annual LOQ verification is not required if the LOD is reevaluated or verified according to subdivision B 3 of this section.

NOTICE: The following forms used in administering the regulation have been filed by the agency. Amended or added forms are reflected in the listing and are published following the listing. Online users of this issue of the Virginia Register of Regulations may also click on the name to access a form. The forms are also available from the agency contact or may be viewed at the Office of Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (1VAC30-45)

~~Application for Certification of Environmental Laboratories DGS 21-156 (eff. 1/2009) (Application for Certification~~ Laboratories applying for certification under 1VAC30-45 must ~~be obtained~~ obtain the application from DCLS program staff at Lab_Cert@dgs.virginia.gov~~)~~

DOCUMENTS INCORPORATED BY REFERENCE (1VAC30-45)

The Standards for Environmental Laboratories and Accreditation Bodies, ~~2009~~ 2016, The NELAC Institute (TNI), P.O. Box 2439, Weatherford, TX 76086; www.nelac-institute.org:

~~Volume 1: Management and Technical Requirements for Laboratories Performing Environmental Analysis (EL-V1-2009)~~

~~Volume 2: General Requirements for Accreditation Bodies Accrediting Environmental Laboratories (EL-V2-2009)~~

Volume 1: Management and Technical Requirements for Laboratories Performing Environmental Analysis (EL-V1-2016, rev. 2.1). Modules 3, 6, and 7 only

1VAC30-46-15. Standards for accreditation transition.

A. Commercial environmental laboratories are accredited under the standards of ~~the National Environmental Laboratory~~

~~Accreditation Conference (NELAC), now~~ The NELAC Institute (TNI).

B. DCLS shall accredit commercial environmental laboratories under the ~~2003 NELAC~~ 2009 TNI Standards as specified by the provisions of this chapter that became effective on ~~January 1, 2009~~ November 1, 2015, for the first ~~10~~ six months following ~~November 1, 2015~~ [~~(insert the effective date of this chapter)~~ April 1, 2022].

C. DCLS shall accredit commercial environmental laboratories under the ~~2009~~ 2016 TNI Standards as specified by the provisions of this chapter effective ~~on November 1, 2015~~ [~~(insert the effective date of this chapter)~~ April 1, 2022], beginning on the first day of the ~~11th~~ seventh month following ~~November 1, 2015~~ [~~(insert the effective date of this chapter)~~ April 1, 2022].

1VAC30-46-40. Definitions.

A. The definitions contained in the ~~2009~~ 2016 TNI Standards are incorporated by reference into this section. Some of these definitions are included in this section because the terms are used throughout this chapter.

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

"Acceptance criteria" means specified limits placed on characteristics of an item, process, or service defined in requirement documents.

"Accreditation" means the process by which an agency or organization evaluates and recognizes a laboratory as meeting certain predetermined qualifications or standards, thereby accrediting the laboratory. "Accreditation" is the term used as a substitute for the term "certification" under this chapter.

"Accreditation body" or "AB" means the territorial, state, or federal agency having responsibility and accountability for environmental laboratory accreditation and which grants accreditation.

"Algae" means simple single-celled, colonial, or multicelled, mostly aquatic plants, containing chlorophyll and lacking roots, stems and leaves that are either suspended in water (phytoplankton) or attached to rocks and other substrates (periphyton).

"Analyte" means the substance ~~or physical property to be determined in samples examined~~, organism, physical parameter, or chemical constituent for which an environmental sample is being analyzed.

"Analytical method" means a technical procedure for providing analysis of a sample, defined by a body such as the Environmental Protection Agency or the American Society for Testing and Materials, that may not include the sample preparation method.

"Assessment" means the evaluation process used to measure or establish the performance, effectiveness, and conformance of an organization and its systems or both to defined criteria (i.e., to the standards and requirements of laboratory accreditation).

"Assessor" means the person assigned by DCLS to perform, alone or as part of an assessment team, an assessment of an environmental laboratory.

"Authority" means, in the context of a governmental body or local government, an authority created under the provisions of the Virginia Water and Waste Authorities Act, Chapter 51 (§ 15.2-5100 et seq.) of Title 15.2 of the Code of Virginia.

"Benthic macroinvertebrates" means bottom dwelling animals without backbones that live at least part of their life cycles within or upon available substrates within a body of water.

"Commercial environmental laboratory" means an environmental laboratory where environmental analysis is performed for another person.

"Corrective action" means the action taken to eliminate the causes of an existing nonconformity, defect or other undesirable situation in order to prevent recurrence.

"DCLS" means the Division of Consolidated Laboratory Services of the Department of General Services.

"Environmental analysis" or "environmental analyses" means any test, analysis, measurement, or monitoring used for the purposes of the Virginia Air Pollution Control Law, the Virginia Waste Management Act or the State Water Control Law (§ 10.1-1300 et seq., § 10.1-1400 et seq., and § 62.1-44.2 et seq., respectively, of the Code of Virginia). For the purposes of these regulations, any test, analysis, measurement, or monitoring required pursuant to the regulations promulgated under these three laws, or by any permit or order issued under the authority of any of these laws or regulations is "used for the purposes" of these laws. The term shall not include the following:

1. Sampling of water, solid and chemical materials, biological tissue, or air and emissions.

2. Field testing and measurement of water, solid and chemical materials, biological tissue, or air and emissions, except when performed in an environmental laboratory rather than at the site where the sample was taken.

3. Taxonomic identification of samples for which there is no national accreditation standard such as algae, benthic macroinvertebrates, macrophytes, vertebrates, and zooplankton.

4. Protocols used pursuant to § 10.1-104.2 of the Code of Virginia to determine soil fertility, animal manure nutrient content, or plant tissue nutrient uptake for the purposes of nutrient management.

5. Geochemical and permeability testing for solid waste compliance.

6. Materials specification for air quality compliance when product certifications specify the data required by an air permit such as fuel type, Btu content, sulfur content, or volatile organic chemical (VOC) content.

"Environmental laboratory" or "laboratory" means a facility or a defined area within a facility where environmental analysis is performed. A structure built solely to shelter field personnel and equipment from inclement weather shall not be considered an environmental laboratory.

"Establishment date" means the date set for the accreditation program under this chapter and the certification program under 1VAC30-45 to be established.

"Establishment of accreditation program" or "established program" means that DCLS has completed the initial accreditation of environmental laboratories covered by this chapter and the initial certification of environmental laboratories covered by 1VAC30-45.

"Facility" means something that is built or installed to serve a particular function.

"Field of accreditation" means those matrix, technology/method, and analyte combinations for which DCLS offers accreditation.

"Field of accreditation matrix" means the following when accrediting a laboratory:

1. Drinking water. Any aqueous sample that has been designated a potable or potential potable water source.

2. Nonpotable water. Any aqueous sample excluded from the definition of drinking water matrix. Includes surface water, groundwater, effluents, water treatment chemicals, and TCLP or other extracts.

3. Solid and chemical materials. Includes soils, sediments, sludges, products and byproducts of an industrial process that results in a matrix not previously defined.

4. Biological tissue. Any sample of a biological origin such as fish tissue, shellfish, or plant material. Such samples shall be grouped according to origin (i.e., by species).

5. Air and emissions. Whole gas or vapor samples including those contained in flexible or rigid wall containers and the extracted concentrated analytes of interest from a gas or vapor that are collected with a sorbent tube, impinger solution, filter or other device.

"Field of proficiency testing" or "FoPT" means ~~analytes for which a laboratory is required to successfully analyze a PT sample in order to obtain or maintain accreditation, collectively defined as:~~ the matrix, technology/method, and analyte combinations for which the composition spike concentration ranges and acceptance criteria have been established by the Proficiency Testing Program Executive Committee of TNI.

"Field testing and measurement" means any of the following:

1. Any test for parameters under 40 CFR Part 136 for which the holding time indicated for the sample requires immediate analysis; or

2. Any test defined as a field test in federal regulation.

The following is a limited list of currently recognized field tests or measures that is not intended to be inclusive: continuous emissions monitoring; online monitoring; flow monitoring; tests for pH, residual chlorine, temperature and dissolved oxygen; and field analysis for soil gas.

"Finding" means an assessment conclusion referenced to a laboratory accreditation standard incorporated by reference or contained in this chapter and supported by objective evidence that identifies a deviation from a laboratory accreditation standard requirement.

"Governmental body" means any department, agency, bureau, authority, or district of the United States government, of the government of the Commonwealth of Virginia, or of any local government within the Commonwealth of Virginia.

"Holding time" means the maximum time that can elapse between two specified activities.

"Legal entity" means an entity, other than a natural person, who has sufficient existence in legal contemplation that it can function legally, be sued or sue and make decisions through agents as in the case of corporations.

"Local government" means a municipality (city or town), county, sanitation district, or authority.

"Macrophytes" means any aquatic or terrestrial plant species that can be identified and observed with the eye, unaided by magnification.

"Matrix" means the substrate of a test sample.

"National Environmental Laboratory Accreditation Conference ~~(NELAC)~~" or "NELAC" means a voluntary organization of state and federal environmental officials and interest groups with the primary purpose to establish mutually acceptable standards for accrediting environmental laboratories. NELAC preceded the formation of The NELAC Institute or TNI.

"National Environmental Laboratory Accreditation Program" or "NELAP" means the program under TNI the purpose of which is to establish and implement a program for the accreditation of environmental laboratories. This program is comprised in part of NELAP Accreditation Bodies which are recognized and approved under the program to implement the TNI standards. The NELAP accreditation bodies currently are state programs such as the one in Virginia.

"Noncommercial environmental laboratory" means either of the following:

1. An environmental laboratory where environmental analysis is performed solely for the owner of the laboratory.

2. An environmental laboratory where the only performance of environmental analysis for another person is one of the following:

a. Environmental analysis performed by an environmental laboratory owned by a local government for an owner of a small wastewater treatment system treating domestic sewage at a flow rate of less than or equal to 1,000 gallons per day.

b. Environmental analysis performed by an environmental laboratory operated by a corporation as part of a general contract issued by a local government to operate and maintain a wastewater treatment system or a waterworks.

c. Environmental analysis performed by an environmental laboratory owned by a corporation as part of the prequalification process or to confirm the identity or characteristics of material supplied by a potential or existing customer or generator as required by a hazardous waste management permit under 9VAC20-60.

d. Environmental analysis performed by an environmental laboratory owned by a Publicly Owned Treatment Works (POTW) for an industrial source of wastewater under a permit issued by the POTW to the industrial source as part of the requirements of a pretreatment program under Part VII (9VAC25-31-730 et seq.) of 9VAC25-31.

e. Environmental analysis performed by an environmental laboratory owned by a county authority for any municipality within the county's geographic jurisdiction when the environmental analysis pertains solely to the purpose for which the authority was created.

f. Environmental analysis performed by an environmental laboratory owned by an authority or a sanitation district for any participating local government of the authority or sanitation district when the environmental analysis pertains solely to the purpose for which the authority or sanitation district was created.

"Owner" means any person who owns, operates, leases, or controls an environmental laboratory.

"Person" means an individual, corporation, partnership, association, company, business, trust, joint venture or other legal entity.

"Physical," for the purposes of fee test categories, means the tests to determine the physical properties of a sample. Tests for solids, turbidity, and color are examples of physical tests.

"Pretreatment requirements" means any requirements arising under Part VII (9VAC25-31-730 et seq.) of 9VAC25-31 including the duty to allow or carry out inspections, entry, or monitoring activities; any rules, regulations, or orders issued by the owner of a POTW; or any reporting requirements imposed by the owner of a POTW or by the regulations of the State Water Control Board. Pretreatment requirements do not include the requirements of a national pretreatment standard.

"Primary accreditation body" or "primary AB" means the accreditation body responsible for assessing a laboratory's total quality system, on-site assessment, and PT performance tracking for fields of accreditation.

"Proficiency test," "proficiency testing," or "PT" means ~~evaluating~~ a process to evaluate a laboratory's performance under controlled conditions relative to a given set of criteria through analysis of unknown samples provided by an external source.

"Proficiency test sample" or "PT sample" means a sample, the composition of which is unknown to the laboratory and is provided to test whether the laboratory can produce analytical results within specified acceptance criteria.

"Proficiency testing program" or "PT program" means the aggregate of providing rigorously controlled and standardized environmental samples to a laboratory for analysis, reporting of results, statistical evaluation of the results and the collective demographics and results summary of all participating laboratories.

"Publicly Owned Treatment Works" or "POTW" means a treatment works as defined by § 212 of the CWA, which is owned by a state or municipality (as defined by § 502(4) of the CWA). This definition includes any devices and systems used in the storage, treatment, recycling, and reclamation of municipal sewage or industrial wastes of a liquid nature. It also includes sewers, pipes, and other conveyances only if they convey wastewater to a POTW treatment plant. The term also means the municipality as defined in § 502(4) of the CWA, which has jurisdiction over the indirect discharges to and the discharges from such a treatment works.

"Quality assurance" or "QA" means an integrated system of management activities involving planning, implementation, assessment, reporting, and quality improvement to ensure that a process, item, or service is of the type and quality needed and expected by the client.

"Quality assurance officer" means the person who has responsibility for the quality system and its implementation. Where staffing is limited, the quality assurance officer may also be the technical manager.

"Quality control" or "QC" means the (i) overall system of technical activities that measures the attributes and performance of a process, item, or service against defined standards to verify that they meet the stated requirements established by the customer; (ii) operational techniques and activities that are used to fulfill requirements for quality; and (iii) system of activities and checks used to ensure that measurement systems are maintained within prescribed limits,

providing protection against "out of control" conditions and ensuring that the results are of acceptable quality.

"Quality manual" means a document stating the management policies, objectives, principles, organizational structure and authority, responsibilities, accountability, and implementation of an agency, organization, or laboratory, to ensure the quality of its product and the utility of its product to its users.

"Quality system" means a structured and documented management system describing the policies, objectives, principles, organizational authority, responsibilities, accountability, and implementation plan of an organization for ensuring quality in its work processes, products (items), and services. The quality system provides the framework for planning, implementing, and assessing work performed by the organization and for carrying out required quality assurance and quality control activities.

~~"Quality system matrix," for purposes of batch and quality control requirements, means the following:~~

~~1. Air and emissions. Whole gas or vapor samples, including those contained in flexible or rigid wall containers and the extracted concentrated analytes of interest from a gas or vapor that are collected with a sorbent tube, impinger solution, filter, or other device.~~

~~2. Aqueous. Any aqueous sample excluded from the definition of drinking water matrix or saline/estuarine source. Includes surface water, groundwater, effluents, and TCLP or other extracts.~~

~~3. Biological tissue. Any sample of a biological origin such as fish tissue, shellfish, or plant material. Such samples shall be grouped according to origin.~~

~~4. Chemical waste. A product or byproduct of an industrial process that results in a matrix not previously defined.~~

~~5. Drinking water. Any aqueous sample that has been designated a potable or potential potable water source.~~

~~6. Non-aqueous liquid. Any organic liquid with less than 15% settleable solids.~~

~~7. Saline/estuarine. Any aqueous sample from an ocean or estuary, or other salt water source such as the Great Salt Lake.~~

~~8. Solids. Includes soils, sediments, sludges, and other matrices with more than 15% settleable solids.~~

"Responsible official" means one of the following, as appropriate:

1. If the laboratory is owned or operated by a private corporation, "responsible official" means (i) a president, secretary, treasurer, or a vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy-making or decision-making functions for the corporation or (ii) the manager of one or more manufacturing, production, or operating facilities employing more than 250 persons or having gross annual sales or expenditures exceeding $25 million (in second-quarter 1980 dollars), if authority to sign documents has been assigned or delegated in accordance with corporate procedures.

2. If the laboratory is owned or operated by a partnership, association, or a sole proprietor, "responsible official" means a general partner, officer of the association, or the proprietor, respectively.

3. If the laboratory is owned or operated by a governmental body, "responsible official" means a director or highest official appointed or designated to oversee the operation and performance of the activities of the governmental laboratory.

4. Any person designated as the responsible official by an individual described in subdivision 1, 2, or 3 of this definition provided the designation is in writing, the designation specifies an individual or position with responsibility for the overall operation of the laboratory, and the designation is submitted to DCLS.

"Sampling" means ~~the act of collection for the purpose of analysis~~ an activity related to obtaining a representative sample of the object of conformity assessment, according to a procedure.

"Sanitation district" means a sanitation district created under the provisions of Chapters 3 (§ 21-141 et seq.) through 5 (§ 21-291 et seq.) of Title 21 of the Code of Virginia.

"Secondary accreditation body" or "secondary AB" means the accreditation body that grants ~~TNI accreditation to laboratories based on their accreditation by a TNI recognized primary accreditation body~~ laboratory accreditation for a field of accreditation based on recognition of accreditation from a primary accreditation body for the same field of accreditation.

"Sewage" means the water-carried human wastes from residences, buildings, industrial establishments, or other places together with such industrial wastes and underground, surface, storm, or other water as may be present.

"Standard operating procedure" or "SOP" means a written document that details the method for an operation, analysis, or action with thoroughly prescribed techniques and steps. An SOP is officially approved as the method for performing certain routine or repetitive tasks.

"TCLP" or "toxicity characteristic leachate procedure" means Test Method 1311 in "Test Methods for Evaluating Solid Waste, Physical/Chemical Methods," EPA Publication SW-846, as incorporated by reference in 40 CFR 260.11. This method is used to determine whether a solid waste exhibits the characteristic of toxicity (see 40 CFR 261.24).

"Technical manager (however named)" means the person who has overall responsibility for the technical operation of the

environmental laboratory and who exercises actual day-to-day supervision of laboratory operation for the appropriate fields of testing and reporting of results. The title of this person may include but is not limited to laboratory director, technical manager, laboratory supervisor, or laboratory manager.

"Technology" means a specific arrangement of analytical instruments, detection systems, or preparation techniques, or any combination of these elements.

"Test" means a technical operation that consists of the determination of one or more characteristics or performance of a given product, material, equipment, organism, physical phenomenon, process, or service according to a specified procedure.

"Test, analysis, measurement or monitoring required pursuant to the Virginia Air Pollution Control Law" means any method of analysis required by the Virginia Air Pollution Control Law (§ 10.1-1300 et seq. of the Code of Virginia); by the regulations promulgated under this law (9VAC5), including any method of analysis listed either in the definition of "reference method" in 9VAC5-10-20, or listed or adopted by reference in 9VAC5; or by any permit or order issued under and in accordance with this law and these regulations.

"Test, analysis, measurement or monitoring required pursuant to the Virginia Waste Management Act" means any method of analysis required by the Virginia Waste Management Act (§ 10.1-1400 et seq. of the Code of Virginia); by the regulations promulgated under this law (9VAC20), including any method of analysis listed or adopted by reference in 9VAC20; or by any permit or order issued under and in accordance with this law and these regulations.

"Test, analysis, measurement or monitoring required pursuant to the Virginia Water Control Law" means any method of analysis required by the Virginia Water Control Law (§ 62.1-44.2 et seq. of the Code of Virginia); by the regulations promulgated under this law (9VAC25), including any method of analysis listed or adopted by reference in 9VAC25; or by any permit or order issued under and in accordance with this law and these regulations.

"Test method" means an adoption of a scientific technique for performing a specific measurement, as documented in a laboratory standard operating procedure or as published by a recognized authority.

"The NELAC Institute ~~(TNI)~~" or "TNI" means the organization whose standards environmental laboratories must meet to be accredited in Virginia.

"TNI standards" means the ~~2009~~ 2016 Standards for Environmental Laboratories and Accreditation Bodies approved by TNI.

"Virginia Air Pollution Control Law" means Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 of the Code of Virginia that is titled "Air Pollution Control Board."

"Virginia Environmental Laboratory Accreditation Program" or "VELAP" means the program DCLS operates to accredit environmental laboratories under this chapter.

"Wastewater" means liquid and water-carried industrial wastes and domestic sewage from residential dwellings, commercial buildings, industrial and manufacturing facilities, and institutions.

"Waterworks" means each system of structures and appliances used in connection with the collection, storage, purification, and treatment of water for drinking or domestic use and the distribution thereof to the public, except distribution piping.

"Zooplankton" means microscopic animals that float freely with voluntary movement in a body of water.

1VAC30-46-70. Process to apply and obtain accreditation.

A. Duty to apply. All owners of (i) commercial environmental laboratories and (ii) TNI-accredited commercial environmental laboratories applying for secondary accreditation shall apply for accreditation as specified by the provisions of this section. Applications for accreditation must be obtained from DCLS program staff by email at Lab_Cert@dgs.virginia.gov.

B. Initial applications. Owners of commercial environmental laboratories applying for accreditation under this chapter for the first time shall submit an application to DCLS as specified under subsection F of this section.

C. Renewal and reassessment.

1. DCLS shall renew accreditation annually for the accredited laboratory provided the laboratory does the following:

a. Maintains compliance with this chapter.

b. Attests to this compliance by signing the certificate of compliance provided under subdivision F 3 of this section.

c. Reports acceptable proficiency test values as required by 1VAC30-46-210 B.

d. Pays the fee required by 1VAC30-46-150.

2. DCLS shall reassess the accredited environmental laboratory during an on-site assessment as required by 1VAC30-46-220.

D. Responsibilities of the owner and operator when the laboratory is owned by one person and operated by another person.

1. When an environmental laboratory is owned by one person but is operated by another person, the operator may submit the application for the owner.

2. If the operator fails to submit the application, the owner is not relieved of his responsibility to apply for accreditation.

3. While DCLS may notify environmental laboratories of the date their applications are due, failure of DCLS to notify does not relieve the owner of his obligation to apply under this chapter.

E. Submission of applications for modifications to accreditation. An owner of an accredited environmental laboratory shall follow the process set out in 1VAC30-46-90 B to modify the laboratory's scope of accreditation.

F. Contents of application.

1. Applications shall include but not be limited to the following information and documents:

a. Legal name of laboratory;

b. Name of owner of laboratory;

c. Name of operator of laboratory, if different than owner;

d. Street address and description of location of laboratory;

e. Mailing address of laboratory, if different from street address;

f. Address of owner, if different from laboratory address;

g. Name, address, telephone number, facsimile number, and email, as applicable, of responsible official;

h. Name, address, telephone number, facsimile number, and email, as applicable, of technical manager;

i. Name, address, telephone number, facsimile number, and email, as applicable, of designated quality assurance officer;

j. Name and telephone number of laboratory contact person;

k. Laboratory type (e.g., commercial, public wastewater system, mobile);

l. Laboratory hours of operation;

m. Fields of accreditation for which the laboratory is seeking accreditation;

n. The results of two successful unique TNI-compliant PT studies for each accreditation field of proficiency testing as required by 1VAC30-46-210 B (for primary accreditation only);

o. Quality assurance manual (for primary accreditation only);

p. Copy of the primary certificate of accreditation for secondary accreditation applications; and

q. For mobile laboratories, a unique vehicle identification number, such as a manufacturer's vehicle identification number (VIN #), serial number, or license number.

2. Fee. The application shall include payment of the fee as specified in 1VAC30-46-150.

3. Certification of compliance.

a. The application shall include a "Certification of Compliance" statement signed and dated by (i) the quality assurance officer, and (ii) the responsible official or the technical manager, or both.

b. The certification of compliance shall state: "The applicant understands and acknowledges that the laboratory is required to be continually in compliance with the Virginia environmental laboratory accreditation program regulation (1VAC30 Chapter 46) and is subject to the provisions of 1VAC30-46-100 in the event of noncompliance. Specifically the applicant:

(1) Shall commit to fulfill continually the requirements for accreditation set by DCLS for the areas where accreditation is sought or granted.

(2) When requested, shall afford such accommodation and cooperation as is necessary to enable DCLS to verify fulfillment of requirements for accreditation. This applies to all premises where laboratory services take place.

(3) Shall provide access to information, documents, and records as necessary for the assessment and maintenance of the accreditation.

(4) Shall provide access to those documents that provide insight into the level of independence and impartiality of the laboratory from its related bodies, where applicable.

(5) Shall arrange the witnessing of laboratory services when requested by DCLS.

(6) Shall claim accreditation only with respect to the scope for which it has been granted accreditation.

(7) Shall pay fees as shall be determined by the accreditation body.

(8) Shall have access to a copy of the TNI standards incorporated by reference into this chapter.

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the laboratory or those persons directly responsible for gathering and evaluating the information, the information submitted is, to the best of my knowledge and belief, true, accurate and complete. Submitting false information or data shall result in denial or withdrawal of accreditation. I further certify that I am authorized to sign this application."

G. Completeness determination.

1. DCLS shall determine whether an application is complete and notify the laboratory of the result of such determination. DCLS shall provide this notice within 90 calendar days of its receipt of the application.

2. An application shall be determined complete if it contains all the information required pursuant to subsection F of this section and is sufficient to evaluate the laboratory prior to the on-site assessment. Designating an application complete

does not preclude DCLS from requesting or accepting additional information.

3. If DCLS determines that an application is incomplete, the DCLS notification of such determination shall explain why the application is incomplete and specify the additional information needed to make the application complete.

4. If DCLS makes no determination within 90 calendar days of its receipt of either (i) the application or (ii) additional information, in the case of an application determined to be incomplete, the application shall be determined to be complete.

5. If the laboratory has not submitted the required additional information within 90 days of receiving a notice from DCLS requesting additional information, DCLS may inform the laboratory that the application cannot be processed. The laboratory may then submit a new application.

H. Grant of interim accreditation pending final determination on application.

1. DCLS shall grant interim accreditation status to laboratories applying initially under the following conditions:

a. The laboratory's application is determined to be complete;

b. The laboratory has satisfied all the requirements for accreditation, including all requests for additional information, with the exception of on-site assessment; and

c. DCLS is unable to schedule the on-site assessment within 120 days of its determination that the application is complete.

2. A laboratory with interim accreditation status shall have the same rights and status as a laboratory that has been granted accreditation by DCLS.

3. Interim accreditation status shall not exceed 12 months.

I. On-site assessment. An on-site assessment shall be performed and the follow-up and reporting procedures for such assessments shall be completed in accordance with 1VAC30-46-220 prior to issuance of a final determination on accreditation.

J. Final determination on accreditation. Upon completion of the accreditation review process and corrective action, if any, DCLS shall grant accreditation in accordance with subsection K of this section or deny accreditation in accordance with subsection L of this section.

K. Grant of accreditation.

1. When a laboratory meets the requirements specified for receiving accreditation, DCLS shall issue a certificate to the laboratory. The certificate shall be sent to the technical manager, and the responsible official shall be notified.

2. The director of DCLS or his designee shall sign the certificate.

3. The certificate shall include the following information:

a. Name of owner of laboratory;

b. Name of operator of laboratory, if different from owner;

c. Name of responsible official;

d. Address and location of laboratory;

e. Laboratory identification number;

f. Fields of accreditation (matrix, technology/method, and analyte) for which accreditation is granted;

g. Any addenda or attachments; and

h. Issuance date and expiration date.

4. TNI accreditation status.

a. Laboratories accredited under this chapter are accredited under the standards of TNI.

b. The certificate of accreditation shall contain the TNI insignia.

c. Accredited laboratories shall comply with the provisions of 1VAC30-46-130 with regard to the use of these certificates and their status as TNI-accredited laboratories.

5. The laboratory shall post the most recent certificate of accreditation and any addenda to the certificate issued by DCLS in a prominent place in the laboratory facility.

6. Accreditation shall expire one year after the date on which accreditation is granted.

L. Denial of accreditation.

1. DCLS shall deny accreditation to an environmental laboratory in total if the laboratory is found to be falsifying any data or providing false information to support accreditation.

2. Denial of accreditation in total or in part.

a. DCLS may deny accreditation to an environmental laboratory in total or in part if the laboratory fails to do any of the following:

(1) Pay the required fees;

(2) Employ laboratory staff to meet the personnel qualifications as required by 1VAC30-46-210 A;

(3) Successfully analyze and report proficiency testing samples as required by 1VAC30-46-210 B;

(4) Submit a corrective action plan in accordance with 1VAC30-46-220 in response to a deficiency report from the on-site assessment team within the required 30 calendar days;

(5) Implement the corrective actions detailed in the corrective action plan within the time frame specified by DCLS;

(6) Pass required on-site assessment as specified in 1VAC30-46-220; or

(7) Implement a quality system as defined in 1VAC30-46-210 C.

b. DCLS may deny accreditation to an environmental laboratory in total or in part if the laboratory's application is not determined to be complete within 90 days following notification of incompleteness because the laboratory is delinquent in submitting information required by DCLS in accordance with this chapter.

c. DCLS may deny accreditation to an environmental laboratory in total or in part if the DCLS on-site assessment team is unable to carry out the on-site assessment pursuant to 1VAC30-46-220 because a representative of the environmental laboratory denied the team entry during the laboratory's normal business hours that it specified in the laboratory application.

3. DCLS shall follow the process specified in 1VAC30-46-110 when denying accreditation to an environmental laboratory.

M. Reapplication following denial of accreditation. DCLS shall not waive application fees for a laboratory reapplying for accreditation.

1VAC30-46-95. Suspension of accreditation.

A. Before withdrawing accreditation, DCLS may suspend accreditation from an environmental laboratory in total or in part to allow the laboratory time to correct the reason for which DCLS may withdraw accreditation. Suspension is limited to the reasons listed in subsection B of this section.

B. DCLS may suspend accreditation from an environmental laboratory in part or in total when the laboratory has failed to do any of the following:

1. Participate in the proficiency testing program as required by 1VAC30-46-210 B.

2. Complete proficiency testing studies and maintain a history of at least two successful proficiency testing studies for each accredited field of testing out of the three most recent proficiency testing studies as defined in 1VAC30-46-210 B.

3. Submit an acceptable corrective action plan after two opportunities as specified in 1VAC30-46-220 L.

4. Maintain a quality system as defined in 1VAC30-46-210 C.

~~4.~~ 5. Employ staff that meets the personnel qualifications of 1VAC30-46-210 A.

~~5.~~ 6. Notify DCLS of any changes in key accreditation criteria as set forth in 1VAC30-46-90.

C. Process to suspend accreditation.

1. When DCLS determines that cause exists to suspend a laboratory, the agency shall send notification to the responsible official and the technical manager stating the agency's determination that the laboratory has failed to meet the 1VAC30-46 standards for one or more of the reasons listed in subsection B of this section. DCLS shall send the notification by certified mail.

2. In its notice, DCLS shall request the laboratory to notify DCLS in writing if the laboratory believes the agency is incorrect in its determination.

3. The notification shall state that the laboratory is required to take corrective action whenever a failure occurs and to document the corrective action. The notification shall require the laboratory to provide DCLS with documentation of the corrective action taken with regard to its failure to meet a standard under this chapter.

4. The notification shall state what the laboratory is required to do to restore its accreditation status and the time allowed to do so.

5. The environmental laboratory may proceed to correct the deficiencies for which DCLS has suspended the laboratory's accreditation.

6. Alternatively the laboratory may state in writing that DCLS is incorrect in its determination regarding suspension, giving specific reasons why the laboratory believes DCLS should not suspend accreditation.

7. With the exception of subdivision B 4 of this section, DCLS may allow the laboratory up to 60 days to correct the problem for which it may have its accreditation suspended.

8. DCLS shall set a date for suspension that follows the period provided under subdivision 7 of this subsection to restore accreditation.

9. If the laboratory does not correct its deficiencies within the time period allowed, DCLS shall suspend a laboratory in part or in total.

10. DCLS shall notify the laboratory by letter of its suspension status. DCLS shall send the notification by certified mail. DCLS shall also notify the pertinent Virginia state agency of the laboratory's suspension status.

11. The laboratory may provide information demonstrating why suspension is not warranted in accordance with the standard referenced in the initial DCLS notification. If such information is not provided prior to the suspension date, the laboratory accepts the DCLS decision to suspend.

12. The laboratory has the right to due process as set forth in 1VAC30-46-110.

D. Responsibilities of the environmental laboratory and DCLS when accreditation has been suspended.

1. The term of suspension shall be limited to six months or the period of accreditation whichever is longer.

2. The environmental laboratory shall not continue to analyze samples or report analysis for the fields of accreditation for which DCLS has suspended accreditation.

3. The environmental laboratory shall retain accreditation for the fields of accreditation, methods, and analytes where it continues to meet the requirements of this chapter.

4. The laboratory's suspended accreditation status shall change to accredited when the laboratory demonstrates to DCLS that the laboratory has corrected the deficiency or deficiencies for which its accreditation was suspended.

5. An environmental laboratory with suspended accreditation shall not have to reapply for accreditation if the cause or causes for suspension are corrected within the term of suspension.

6. An environmental laboratory that DCLS has suspended in total shall pay the cost of any necessary follow-up on-site assessments or data review or both to determine compliance. This cost shall be calculated under the provisions of 1VAC30-46-150 E and F.

7. If the laboratory fails to correct the causes of suspension within the term of suspension, DCLS shall withdraw the laboratory's accreditation in total or in part.

1VAC30-46-100. Withdrawal of accreditation.

A. DCLS shall withdraw accreditation from an environmental laboratory in total if the laboratory is found to be falsifying any data or providing false information to support accreditation.

B. DCLS may withdraw accreditation from an environmental laboratory in part or in total when the laboratory has failed to do any of the following:

1. Participate in the proficiency testing program as required by 1VAC30-46-210 B.

2. Complete proficiency testing studies and maintain a history of at least two successful proficiency testing studies for each affected accredited field of testing out of the three most recent proficiency testing studies as defined in 1VAC30-46-210 B.

[~~3. Successfully complete three consecutive PT studies, either by failure to participate in the required PT study or by failure to obtain acceptable results for the same field of accreditation.~~]

[~~4.~~ 3.] Maintain a quality system as defined in 1VAC30-46-210 C.

[4. ~~5.~~] Employ staff that meets the personnel qualifications of 1VAC30-46-210 A.

[5. ~~6.~~] Submit an acceptable corrective action plan after two opportunities as specified in 1VAC30-46-220.

[6. ~~7.~~] Implement corrective action specified in the laboratory's corrective action plan as set out under 1VAC30-46-220.

[7. ~~8.~~] Correct the causes of suspension within the term of suspension.

[~~9.~~ 8.] Notify DCLS of any changes in key accreditation criteria as set forth in 1VAC30-46-90.

[~~8. 10.~~ 9.] Use correct and authorized references to the laboratory's accreditation status or that of DCLS in the laboratory's documentation and advertising as set forth in 1VAC30-46-130.

[~~9. 11.~~ 10.] Allow a DCLS assessment team entry during normal business hours to conduct an on-site assessment required by 1VAC30-46-220.

[~~10. 12.~~ 11.] Pay required fees specified in 1VAC30-46-150.

[~~13.~~ 12.] Meet the provisions regarding communication with others in Volume 1, Module 1, Section 4.1.5 of the 2016 TNI Standards.

C. [DCLS may withdraw accreditation from an environmental laboratory in part or in total when the laboratory has failed three consecutive proficiency testing studies for the same field of accreditation either by failure to participate in the proficiency testing study or by failure to obtain acceptable results.

D.] DCLS shall follow the process specified in 1VAC30-46-110 when withdrawing accreditation from an environmental laboratory.

[~~D.~~ E.] Responsibilities of the environmental laboratory and DCLS when accreditation has been withdrawn.

1. Laboratories that lose their accreditation in full shall return their certificate to DCLS.

2. If a laboratory loses accreditation in part, DCLS shall issue a revised certificate to the laboratory.

3. The laboratory shall discontinue the use of all materials that contain either a reference to the environmental laboratory's past accreditation status or that display the TNI logo. These materials may include catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical reports, or other materials.

4. The environmental laboratory shall not continue to analyze samples or report analyses for the fields of accreditation for which DCLS has withdrawn accreditation.

[~~E.~~ F.] After correcting the reason or cause for the withdrawal of accreditation under 1VAC30-46-100 A or B, the laboratory owner may reapply for accreditation under 1VAC30-46-70 B and E.

1VAC30-46-140. Secondary accreditation.

A. DCLS may grant secondary accreditation to an environmental laboratory that holds a current accreditation from another ~~TNI-recognized~~ NELAP-recognized primary accreditation body.

B. The owner of a TNI-accredited environmental laboratory that seeks accreditation under this chapter shall apply as specified in 1VAC30-46-70 with the exception of 1VAC30-46-70 F 1 n and o.

C. The owner of the applicant laboratory shall pay the fee required by 1VAC30-46-150.

D. DCLS shall not require a TNI-accredited environmental laboratory that seeks accreditation under this section to meet any additional proficiency testing, quality assurance, or on-site assessment requirements for the fields of accreditation for which the laboratory holds primary TNI accreditation.

E. DCLS shall consider only the current certificate of accreditation issued by the TNI-recognized primary accreditation body.

F. DCLS shall grant secondary accreditation for only the fields of accreditation offered under this chapter for which the laboratory holds current primary TNI accreditation.

1VAC30-46-150. Fees.

A. General.

1. Environmental laboratories shall pay a fee with all applications, including reapplications, for accreditation. DCLS shall not designate an application as complete until it receives payment of the fee.

2. Each accredited environmental laboratory shall pay an annual fee to maintain its accreditation. DCLS shall send an invoice to the accredited environmental laboratory.

3. An environmental laboratory applying for secondary accreditation under 1VAC30-46-140 shall pay the same fee as other laboratories subject to this chapter.

4. Fees shall be nonrefundable.

5. DCLS, as part of its regular budgetary review of the program, shall determine whether the fees charged under this section offset the program costs as required under § 2.2-1105 of the Code of Virginia.

B. Fee computation.

1. Fees shall be applied on an annual basis.

2. Environmental laboratories shall pay the total of the base fee and the test category fees set out in subsections C and D of this section.

C. Base fee.

1. DCLS determines the base fee for a laboratory by taking into account both the total number of methods and the total number of field of accreditation matrices for which the laboratory would be accredited.

2. DCLS shall charge the base fees set out in Table 1. The base fee for a laboratory is located by first finding the row for the total number of methods to be accredited and then finding the box on that row located in the column headed by the total number of matrices to be accredited. For example, DCLS charges a base fee of $1625 to a laboratory performing a total of eight methods for one matrix.

TABLE 1: BASE FEES

Number of Methods	One Matrix	Two Matrices	Three Matrices	Four or more Matrices
1 - 9	$1625	$1788	$1969	$2163
10 - 29	$1750	$1969	$2188	$2438
30 - 99	$1938	$2281	$2688	$3188
100 - 149	$2063	$2475	$2969	$3563
150+	$2250	$2813	$3531	$4406

D. Test category fees.

1. The test category fees cover the types of testing for which a laboratory may be accredited as specified in the laboratory's application or as accredited at the time of annual billing.

2. Fees shall be charged for each category of tests to be accredited.

3. Fees shall be charged for the total number of field of accreditation matrices to be accredited under the specific test category. For example, if a laboratory is performing inorganic chemistry for both nonpotable water and solid and chemical matrices, the fee for this test category would be found in the column for two matrices.

4. The fee for each category includes one or more analytical methods unless otherwise specified.

5. Test category fees. DCLS shall charge the test category fees set out in Table 2. The test category fees for a laboratory are located by first finding the row with the total number of test methods for the test category to be accredited. The fee to be charged for the test category will be found on that row in the column headed by the total number of matrices to be accredited. A laboratory performing four test methods for bacteriology in both nonpotable and drinking water (two matrices) would be charged a test category fee of $413.

TABLE 2: TEST CATEGORY FEES			
	Fees by Number of Matrices		
Test Category	One	Two	Three or More
Aquatic toxicity, acute methods only	$740	N/A	N/A
Aquatic toxicity, acute and chronic methods	$990	N/A	N/A
Oxygen demand	$281	$419	$544
Bacteriology, 1 - 3 total methods	$219	$331	$431
Bacteriology, 4 or more total methods	$275	$413	$538
Physical, 1 - 5 total methods	$219	$331	$431
Physical, 6 - 10 total methods	$275	$413	$538
Physical, 11 or more total methods	$344	$519	$675
Inorganic chemistry, 1 - 10 total methods	$313	$469	$613
Inorganic chemistry, 11 - 20 total methods	$394	$594	$775
Inorganic chemistry, 21 - 49 total methods	$493	$738	$959
Inorganic chemistry, 50 or more total methods	$615	$925	$1203
Chemistry metals, 1 - 5 total methods	$406	$613	$796
Chemistry metals, 6 - 20 total methods	$513	$769	$1000
Chemistry metals, 21 or more total methods	$640	$963	$1250
Organic chemistry, 1 - 5 total methods	$1020	$1270	$1495
Organic chemistry, 6 - 20 total methods	$1145	$1458	$1739
Organic chemistry, 21 - 40 total methods	$1301	$1695	$2048
Organic chemistry, 41 or more total methods	$1495	$1983	$2420
Radiochemical, 1 - 10 total methods	$990	$1365	$1703
Radiochemical, 11 or more total methods	$1146	$1603	$2015
Asbestos	$1146	$1603	$2015

6. Fee examples. Three examples are provided.

a. Example 1:

Base Fee	One matrix and four test methods	$1625
Test Category Fees		
One Matrix		
Nonpotable Water	Bacteriology (2 methods)	$219
Nonpotable Water	Oxygen demand (1 method)	$281
Nonpotable Water	Physical (1 method)	$219
TOTAL		$2344

b. Example 2:

Base Fee	One matrix and 15 test methods	$1750
Test Category Fees		
One Matrix		
Nonpotable Water	Bacteriology (2 methods)	$219
Nonpotable Water	Inorganic chemistry (9 methods)	$313
Nonpotable Water	Metals (2 methods)	$406
Nonpotable Water	Oxygen demand (1 method)	$281
Nonpotable Water	Physical (1 method)	$219
TOTAL		$3188

c. Example 3:

Base Fee	Two matrices and 27 test methods	$1969
Test Category Fees		
One Matrix		
Nonpotable Water	Bacteriology (4 methods)	$275
Nonpotable Water	Oxygen demand (1 method)	$281
Solid and Chemical Materials	Metals (1 method)	$406
Two Matrices		
Nonpotable Water and Solid and Chemical Materials	Inorganic chemistry (13 methods)	$594
Nonpotable Water and Solid and Chemical Materials	Physical (7 methods)	$413
TOTAL		$3938

E. Additional fees. Additional fees shall be charged to laboratories applying for the following: (i) modification to scope of accreditation under 1VAC30-46-90 B, (ii) transfer of ownership under 1VAC30-46-90 C, (iii) review of compliance following total suspension, or ~~(iii)~~ (iv) petition for a variance under 1VAC30-46-160.

1. For any accredited environmental laboratory that applies to modify its scope of accreditation as specified under 1VAC30-46-90 B, DCLS shall assess a fee determined by the method in subsection F of this section.

2. Under 1VAC30-46-90 C, DCLS may charge a transfer fee to a certified laboratory that transfers ownership. A fee shall be charged if DCLS (i) needs to review documentation sent by the laboratory about the transfer of ownership or (ii) determines that an on-site assessment is necessary to evaluate the effect of the transfer of ownership. DCLS shall assess a fee determined by the method in subsection F of this section. If, under 1VAC30-46-90 C, DCLS determines that the change of ownership or location of laboratory requires reaccreditation of or reapplication by the laboratory, the laboratory shall pay the application fee required under this section.

3. Under 1VAC30-46-95 D 6, an environmental laboratory that DCLS has suspended in total shall be charged the cost of any necessary follow-up on-site assessments or data review or both to determine compliance. This charge shall be calculated under the method specified in subsection F of this section.

4. Under 1VAC30-46-160, any person regulated by this chapter may petition the director to grant a variance from any requirement of this chapter. DCLS shall charge a fee for the time needed to review the petition, including any on-site assessment required. The fee shall be determined by the method specified in subsection F of this section.

F. Additional fees determination.

1. The fee shall be the sum of the total hourly charges for all reviewers plus any on-site review costs incurred.

2. An hourly charge per reviewer shall be determined by (i) obtaining a yearly cost by multiplying the reviewer's annual salary by 1.35 (accounts for overhead such as taxes and insurance) and then (ii) dividing the yearly cost by 1,642 (number of annual hours established by Fiscal Services, Department of General Services, for billing purposes).

3. The charge per reviewer shall be determined by multiplying the number of hours expended in the review by the reviewer's hourly charge.

4. If an on-site review is required, travel time and on-site review time shall be charged at the same hourly charge per reviewer, and any travel expenses shall be added.

G. Out-of-state laboratories applying for primary accreditation.

1. The owner of an environmental laboratory located in another state who applies for primary accreditation under this chapter shall pay a surcharge of $5000 plus the labor costs of the on-site assessment and reasonable travel costs associated with conducting an on-site assessment at the laboratory. Reasonable travel costs include transportation, lodging, per diem, and telephone and duplication charges. These charges shall be in addition to the fees charged under subdivision A 1 and subsections B through D of this section.

2. Once the laboratory is accredited, DCLS shall charge the annual fee specified in subdivision A 2 and subsections B through D of this section, the labor costs for the on-site assessment, and reasonable travel costs associated with conducting the on-site assessment.

H. DCLS shall derive the travel costs charged under subsections F and G of this section from the Commonwealth of Virginia reimbursement allowances and rates for lodging, per diem, and mileage.

1VAC30-46-200. Incorporation by reference of TNI standards.

A. The following TNI standards are incorporated by reference into this chapter: The Standards for Environmental Laboratories and Accreditation Bodies, ~~2009~~ 2016 (The NELAC Institute (TNI)), Volume 1: Management and Technical Requirements for Laboratories Performing Environmental Analysis, and Volume 2: General Requirements for Accreditation Bodies Accrediting Environmental Laboratories, except for ~~section~~ Section 6.6 of Module 3 concerning confidential business information.

B. Environmental laboratories applying for accreditation and accredited under this chapter shall comply with the TNI standards incorporated by reference into subsection A of this section. For convenience these standards are specified by accreditation component in 1VAC30-46-210 and 1VAC30-46-220.

C. The TNI standards are organized by volume and module.

1. Volume 1 - Management and Technical Requirements for Laboratories Performing Environmental Analysis includes the following modules:

a. Proficiency Testing.

b. Quality Systems General Requirements.

c. Quality Systems for Asbestos Testing.

d. Quality Systems for Chemical Testing.

e. Quality Systems for Microbiological Testing.

f. Quality Systems for Radiochemical Testing.

g. Quality Systems for Toxicity Testing.

2. Volume 2 - General Requirements for Accreditation Bodies Accrediting Environmental Laboratories includes the following modules:

a. General Requirements.

b. Proficiency Testing.

c. On-Site Assessment.

1VAC30-46-210. Standards for accreditation.

A. Standards for personnel. The standards for personnel are found in Section 5.2 of Volume 1, Module 2 of the TNI standards.

B. Standards for proficiency testing.

~~1.~~ The standards for proficiency testing are found in (i) Module 1 and (ii) section 4.11 of Module 2 of Volume 1 of the TNI standards.

~~2. Additional requirements from Volume 2, Module 2 of the TNI standards.~~

~~a. A laboratory shall perform two proficiency test studies each calendar year for each FoPT. These proficiency testing studies shall be performed at least five months apart and no longer than seven months apart within the calendar year.~~

~~b. The following proficiency testing studies shall not apply when meeting the requirements of subdivision 2 a of this subsection:~~

~~(1) Studies used for corrective action to reestablish successful history in order to maintain accreditation; and~~

~~(2) Studies used to reinstate accreditation after DCLS suspends accreditation.~~

~~c. DCLS shall consider a laboratory's analytical result for a FoPT not acceptable for the following reasons:~~

~~(1) When the laboratory does not report the results within the time frames specified in Volume 1, Module 1 of the TNI standards.~~

~~(2) When the laboratory makes any reporting error or omission that results in a nonspecific match between the analytical result for the FoPT and any criterion that identifies the laboratory or the field of accreditation for which the PT sample was analyzed for the purpose of initial or continued accreditation.~~

~~d. If DCLS requests a corrective action plan from a laboratory, the laboratory shall provide the plan within 30 calendar days of the request.~~

~~e. A laboratory may withdraw from a study for any FoPT on or before the close date of the study. Withdrawing from a study shall not exempt the laboratory from meeting the semiannual analysis requirements necessary for continued accreditation.~~

C. Standards for quality systems.

1. General requirements for all environmental laboratories are found in Volume 1, Module 2 of the TNI standards.

2. Requirements for the specific types of testing that may be performed by an individual environmental laboratory are found in Volume 1, Modules 3 through 7 of the TNI standards.

3. Drinking water laboratories obtaining certification under this chapter shall meet the reporting requirements set out in 1VAC30-41 for compliance with 12VAC5-590-530 and 12VAC5-590-540.

1VAC30-46-220. On-site assessment.

A. The standards for on-site assessment are found in Volume 2, Module 3 of the TNI standards. The requirements specific to environmental laboratories are set out in this section.

B. DCLS shall conduct a comprehensive on-site assessment of an environmental laboratory prior to granting final primary accreditation to the laboratory.

C. Frequency of on-site assessment.

1. DCLS shall reassess each accredited laboratory every two years starting from the date of the previous assessment plus or minus six months.

2. Other on-site assessments.

a. If DCLS identified a deficiency on a previous on-site assessment, the agency may conduct a follow-up on-site assessment.

b. DCLS may conduct an on-site assessment under the following circumstances:

(1) A laboratory applies to modify its scope of accreditation;

(2) A transfer of ownership occurs that affects personnel, equipment, or the laboratory facilities; or

(3) A laboratory applies for an exemption or a variance.

c. Any other change occurring in a laboratory's operations that might reasonably be expected to alter or impair analytical capability and quality may trigger an on-site assessment.

D. Announced and unannounced on-site assessments. DCLS, at its discretion, may conduct either announced or unannounced on-site assessments. Advance notice of an assessment shall not be necessary.

E. Preparation for the on-site assessment.

1. Prior to the actual site visit, DCLS may request in writing from a laboratory those records required to be maintained by this chapter.

2. DCLS may opt not to proceed with an on-site assessment based on nonconformities found during document and record review.

F. Areas to be assessed.

1. DCLS shall assess the laboratory against the standards incorporated by reference and specified in 1VAC30-46-200 and 1VAC30-46-210.

2. The laboratory shall ensure that its quality manual, analytical methods, quality control data, proficiency test data, laboratory SOPs, and all records needed to verify compliance with the standards specified in 1VAC30-46-200 and 1VAC30-46-210 are available for review during the on-site assessment.

G. National security considerations.

1. Assessments at facilities owned or operated by federal agencies or contractors may require security clearances, appropriate badging, or a security briefing before the assessment begins.

2. The laboratory shall notify DCLS in writing of any information that is controlled for national security reasons and cannot be released to the public.

H. Arrival, admittance, and opening conference.

1. Arrival. DCLS and the laboratory shall agree to the date and schedule for announced on-site assessments.

2. Admittance of assessment personnel. A laboratory's refusal to admit the assessment personnel for an on-site assessment shall result in an automatic failure of the laboratory to receive accreditation or loss of an existing accreditation by the laboratory, unless there are extenuating circumstances that are accepted and documented by DCLS.

3. Health and safety. Under no circumstance, and especially as a precondition to gain access to a laboratory, shall assessment personnel be required or even allowed to sign any waiver of responsibility on the part of the laboratory for injuries incurred during an assessment.

4. Opening conference. An opening conference shall be conducted and shall address the following topics:

a. The purpose of the assessment;

b. The identification of assessment personnel;

c. The test methods that will be examined;

d. Any pertinent records and procedures to be examined during the assessment and the names of the individuals in the laboratory responsible for providing assessment personnel with such records;

e. The roles and responsibilities of laboratory staff and managers;

f. Any special safety procedures that the laboratory may think necessary for the protection of assessment personnel;

g. The standards and criteria that will be used in judging the adequacy of the laboratory operation;

h. Confirmation of the tentative time for the exit conference; and

i. Discussion of any questions the laboratory may have about the assessment process.

I. On-site laboratory records review and collection.

1. Records shall be reviewed by assessment personnel for accuracy, completeness, and the use of proper methodology for each analyte and test method to be evaluated.

2. Records required to be maintained pursuant to this chapter shall be examined as part of an assessment for accreditation.

J. Observations of and interviews with laboratory personnel.

1. As an element of the assessment process, the assessment team shall evaluate an analysis regimen by requesting that the analyst normally conducting the procedure give a step-by-step description of exactly what is done and what equipment and supplies are needed to complete the regimen. Any deficiencies shall be noted and discussed with the

analyst. In addition, the deficiencies shall be discussed in the closing conference.

2. Assessment personnel may conduct interviews with appropriate laboratory personnel.

3. Calculations, data transfers, calibration procedures, quality control, and quality assurance practices, adherence to test methods, and report preparation shall be assessed for the complete scope of accreditation with appropriate laboratory analysts.

K. Closing conference.

1. Assessment personnel shall meet with representatives of the laboratory following the assessment for a closing conference.

2. During the closing conference, assessment personnel shall inform the laboratory of the preliminary findings and the basis for such findings. The laboratory shall have an opportunity to provide further explanation or clarification relevant to the preliminary findings. If the laboratory objects to the preliminary findings during the closing conference, all objections shall be documented by the assessment personnel and included in the final report to DCLS.

3. Additional problem areas may be identified in the final report.

L. Follow-up and reporting procedures.

1. DCLS shall provide an on-site assessment report to the laboratory documenting any deficiencies found by DCLS within 30 calendar days of the last day of the on-site assessment.

2. When deficiencies are identified in the assessment report, the laboratory shall have 30 calendar days from the date of its receipt of the on-site assessment report to provide a corrective action plan to DCLS.

3. The laboratory's corrective action plan shall include the following:

a. Any objections that the laboratory has with regard to the on-site assessment report;

b. The action that the laboratory proposes to correct each deficiency identified in the assessment report;

c. The time period required to accomplish the corrective action; and

d. Documentation of corrective action that the laboratory has already completed at the time the corrective action plan is submitted.

4. If the corrective action plan, or a portion of the plan, is determined to be unacceptable to remedy the deficiency, DCLS shall provide written notification to the responsible official and technical manager of the laboratory, including a detailed explanation of the basis for such determination. Following receipt of such notification, the laboratory shall have an additional 30 calendar days to submit a revised corrective action plan acceptable to DCLS.

5. DCLS may suspend accreditation from a laboratory under 1VAC30-46-95 B 3 or withdraw accreditation from a laboratory under 1VAC30-46-100 B 5 if DCLS finds the second revised corrective action plan to be unacceptable.

6. The laboratory shall submit documentation to DCLS that the corrective action set out in its plan has been completed within the time period specified in the plan.

7. DCLS, under 1VAC30-46-100 B 6, may withdraw accreditation from a laboratory if the laboratory fails to implement the corrective actions set out in its corrective action plan.

8. DCLS shall grant final accreditation as specified in 1VAC30-46-70 K upon successful completion of any required corrective action following the on-site assessment.

DOCUMENTS INCORPORATED BY REFERENCE (1VAC30-46)

The Standards for Environmental Laboratories and Accreditation Bodies, ~~2009~~ 2016, The NELAC Institute (TNI), P.O. Box 2439, Weatherford, TX 76086; www.nelac-institute.org:

~~Volume 1: Management and Technical Requirements for Laboratories Performing Environmental Analysis (EL-V1-2009)~~

~~Volume 2: General Requirements for Accreditation Bodies Accrediting Environmental Laboratories (EL-V2-2009)~~

Volume 1: Management and Technical Requirements for Laboratories Performing Environmental Analysis (EL-V1-2016, rev. 2.1)

Volume 2: General Requirements for Accreditation Bodies Accrediting Environmental Laboratories (EL-V2-2016, rev. 2.0)

VA.R. Doc. No. R20-6196; Filed January 3, 2022, 11:47 a.m.

TITLE 2. AGRICULTURE

BOARD OF AGRICULTURE AND CONSUMER SERVICES

Proposed Regulation

Title of Regulation: **2VAC5-405. Regulations for the Application of Fertilizer to Nonagricultural Lands (amending 2VAC5-405-110).**

Statutory Authority: § 3.2-3602.1 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: April 1, 2022.

Agency Contact: David Gianino, Program Manager, Office of Plant Industry Services, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-3515, FAX (804) 371-7793, TDD (800) 828-1120, or email david.gianino@vdacs.virginia.gov.

Basis: Section 3.2-109 of the Code of Virginia establishes the Board of Agriculture and Consumer Services as a policy board with the authority to adopt regulations in accordance with the provisions of Title 3.2 of the Code of Virginia. Section 3.2-3602.1 of the Code of Virginia authorizes the board to adopt regulations to certify the competence of contractor-applicators; licensees; and employees, representatives, or agents of state agencies, localities, or other governmental entities that apply regulated products to nonagricultural property and to impose civil penalties upon any contractor-applicator or licensee who fails to comply with the regulations.

Purpose: The application of excessive fertilizer nutrients, primarily phosphorus and nitrogen, can result in runoff of these nutrients into Virginia's waterways, including the Chesapeake Bay, causing excess levels of algae. The excess algae negatively affects the level of dissolved oxygen in the water needed by oysters, fish, crabs, and other aquatic animals. Applying lawn and turf fertilizers at proper rates can result in reduced runoff of nitrogen and phosphorus into Virginia's waters. Compliance with the provisions of this regulation supports the health of Virginia's waters, which can positively impact the health and economic welfare of Virginia citizens. The board determined that additional penalties for violations of the regulation are necessary to ensure fertilizer applicators are applying fertilizer to nonagricultural lands in compliance with provisions of the regulation, thereby protecting Virginia's natural waterways.

Substance: Through this regulatory action, the board is proposing to amend the current penalty and add two new penalties for violations of Regulations for the Application of Fertilizer to Nonagricultural Lands (2VAC5-405). The board is also proposing to change the person responsible for compliance with the regulation's existing requirement that an individual be certified before offering services as a certified fertilizer applicator or supervising the application of fertilizer on nonagricultural land.

The proposed amendments (i) change the responsible party from an individual to the contractor-applicator or licensee who employs an individual who must be certified; (ii) replace the existing civil penalty that is assessed when a person offers services as a certified fertilizer applicator without obtaining such certification from the Department of Agriculture and Consumer Services (VDACS) with a penalty that increases with repeat violations; (iii) establish a penalty for a contractor-applicator or licensee who does not maintain records or fails to submit the annual report for fertilizer applied to more than 50 acres of nonagricultural lands; and (iv) establish a penalty for a contractor-applicator or licensee who fails to apply fertilizer in compliance with the Department of Conservation and Recreation's nutrient management standards.

Issues: The proposed amendments will increase compliance with provisions of the Regulations for the Application of Fertilizer to Nonagricultural Lands (2VAC5-405), thereby reducing runoff of excess nitrogen and phosphorus from nonagricultural land into Virginia's waterways, which is an advantage to the public. In addition, ensuring the reporting of nonagricultural lands to which fertilizer was applied will allow Virginia to receive credit in the Chesapeake Bay Watershed Implementation Plan for properly applying lawn and turf fertilizer, which is an advantage to the Commonwealth.

The proposed amendments will only negatively impact those contractor-applicators or licensees who are not in compliance with the regulation. There are no disadvantages to the public or the Commonwealth associated with the proposed amendments.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. The Board of Agriculture and Consumer Services (Board) proposes to (i) require that a contractor-applicator[2] or licensee[3] be responsible for ensuring its employees obtain a Certified Fertilizer Applicator registration, rather than penalizing an employee for not being a Certified Fertilizer Applicator,[4] (ii) amend the current penalty structure from a one-time, $250 penalty, to a penalty that increases with repeat offenses, (iii) create a new penalty for a contractor-applicator or licensee who fails to maintain certain records documenting applicator training and each application of fertilizer to nonagricultural land, or who fails to submit the required annual acreage report to Virginia Department of Agriculture and Consumer Services (VDACS), and (iv) create a new penalty for failure to apply lawn or lawn maintenance fertilizers in compliance with the Department of Conservation and Recreation's (DCR) nutrient management standards for lawns.

Background. VDACS states that the Board promulgated 2VAC5-405, Regulations for the Application of Fertilizer to Nonagricultural Lands (regulation) to ensure the proper application of fertilizer to nonagricultural lands (i.e., lawn and turf), thereby protecting the environment. Specifically, the regulation accomplishes this by requiring that lawn fertilizers applied for commercial purposes or by governmental entities are applied by a certified fertilizer applicator or a person under the control and instruction of a certified fertilizer applicator and at rates, times, and methods that reduce the runoff of nitrogen and phosphorus into Virginia's waterways.

In order to become a certified fertilizer applicator, the applicant must successfully complete Board-approved training. The current Board-approved training is an online course (with a $10 fee) that is a joint effort of the Virginia Cooperative Extension, VDACS, and DCR.[5] There are ten self-paced training modules and each are accompanied by a test that must be passed at a minimum 70% level. Certification helps ensure that the fertilizer applicator understands the rates, times, and methods that reduce the runoff of nitrogen and phosphorus. An online recertification course (also with $10 fee) must be taken every four years.

Chapter 413 of the 2020 Acts of Assembly amended the Fertilizer Law, in part, by increasing from $250 to $1,000 the maximum civil penalty that the Board may impose upon any fertilizer contractor-applicator or licensee who fails to comply with provisions of the regulation.[6]

Failure to Obtain Certification. Under the current regulation, "Any individual who offers his services as a certified fertilizer applicator or who supervises the application of any fertilizer on nonagricultural land without obtaining prior registration certification from the commissioner shall be assessed a penalty of $250." The Board proposes to amend that sentence to the following, with new language in bold:

Any contractor-applicator or licensee that employs an individual who offers his services as a certified fertilizer applicator or who supervises the application of any fertilizer on nonagricultural land without obtaining prior registration certification from the commissioner shall be assessed a penalty of (i) $250 for the first offense, (ii) $500 for the second offense within any five year period, and (iii) $1,000 for the third offense within any five year period.

Failure to Maintain Records or Send Report. The regulation requires that licensees and contractor-applicators maintain records of each application of fertilizer to nonagricultural land for at least three years following the application.[7] Contractor-applicators and licensees who apply lawn fertilizer and lawn maintenance fertilizer to more than a total of 50 acres of nonagricultural lands must submit an annual report on or before February 1 indicating the total acreage or square footage by zip code of the land receiving lawn fertilizer and lawn maintenance fertilizer in the preceding calendar year.

Currently, no penalties are assessed for a contractor-applicator or licensee who fails to maintain records or submit annual reports. In § 3.2-3625, the Virginia Fertilizer Law provides that a person convicted of a violation of a provision of the law or a regulation adopted thereunder is subject to a Class 3 misdemeanor; however, in practice VDACS has not pursued a criminal charge against anyone for failing to maintain the records required by the regulation or for failing to submit the required annual report.

The Board proposes to add the following text to the regulation:

> "Any contractor-applicator or licensee who does not maintain records as required by this chapter or submit the required annual report to the commissioner in accordance with 2VAC5-405-100 shall be (i) issued a warning for the first offense, (ii) assessed a penalty of $250 for the second offense within any five year period, (iii) assessed a penalty of $500 for the third offense within any five year period, and (iv) assessed a penalty of $1,000 for the fourth offense within any five year period."

Violating Standards and Criteria for Nutrient Management. The regulation requires that licensees and contractor-applicators apply fertilizer at rates, times, and methods that are consistent with standards and criteria for nutrient management promulgated pursuant to § 10.1-104.2 of the Code of Virginia (DCR's lawn nutrient management standards). Currently, though, no penalties are assessed for a contractor-applicator or licensee who applies lawn fertilizer at rates, times, or methods that are inconsistent with DCR's lawn nutrient management standards. As stated above, § 3.2-3625 of the Virginia Fertilizer Law provides that a person convicted of a violation of a provision of the law or a regulation adopted thereunder is subject to a Class 3 misdemeanor; however, in practice VDACS has not pursued a criminal charge against anyone for applying lawn fertilizer at rates, times, or methods that are inconsistent with DCR's lawn nutrient management standards.

The Board proposes to add the following text to the regulation:

> "Any contractor-applicator or licensee who applies lawn fertilizer or lawn maintenance fertilizer at a rate, time, or method inconsistent with the standards and criteria for nutrient management promulgated pursuant to § 10.1-104.2 of the Code of Virginia shall be (i) issued a warning for the first offense, (ii) assessed a penalty of $250 for the second offense within any five year period, (iii) assessed a penalty of $500 for the third offense within any five year period, and (iv) assessed a penalty of $1,000 for the fourth offense within any five year period."

Estimated Benefits and Costs. All of the proposed amendments are intended to make it more likely that licensees and contractor-applicators comply with the requirements of the regulation. Making the businesses responsible (and punishable) for ensuring their employees obtain a Certified Fertilizer Applicator registration prior to applying fertilizer, and increasing the fines, may make it less likely that uncertified individuals do this work. This could reduce occurrences where there is excessive runoff of nitrogen and phosphorus due to the applicator's lack of knowledge on how to minimize runoff.

Establishing financial penalties for contractor-applicators or licensees who apply lawn fertilizer at rates, times, or methods that are inconsistent with DCR's lawn nutrient management standards may encourage compliance with the standards, which would reduce nitrogen and phosphorus runoff. Establishing financial penalties for contractor-applicators or licensees who fail to maintain records or submit annual reports may encourage these firms to comply with these requirements. This information is needed to help understand how much and where fertilizer is being applied in the Commonwealth.

Reducing runoff of nitrogen and phosphorus is beneficial for Virginia's waterways. According to the U.S. Environmental Protection Agency, too much nitrogen and phosphorus in the water causes algae to grow faster than ecosystems can handle. Significant increases in algae harm water quality, food resources and habitats, and decrease the oxygen that fish and other aquatic life need to survive. Large growths of algae are called algal blooms and they can severely reduce or eliminate oxygen in the water, leading to illnesses in fish and the death of large numbers of fish. Some algal blooms are harmful to humans because they produce elevated toxins and bacterial growth that can make people sick if they come into contact with polluted water, consume tainted fish or shellfish, or drink contaminated water.[8]

Businesses and Other Entities Affected. The proposed amendments potentially affect the 408 fertilizer contractor-applicators and the 739 licensed fertilizer distributors in the Commonwealth.[9]

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[10] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. Contractor-applicators and licensees who do not comply with the regulation would encounter higher costs. Thus, an adverse impact is indicated.

Small Businesses[11] Affected.[12]

Types and Estimated Number of Small Businesses Affected. VDACS believes that the majority of affected firms would qualify as small businesses, but a specific number is not available.

Costs and Other Effects. The proposed amendments increase costs for small lawn care/fertilizer firms that do not comply with the regulations.

Alternative Method that Minimizes Adverse Impact. There are no clear alternative methods that both reduce adverse impact and meet the intended policy goals.

Localities[13] Affected.[14] The proposed amendments are not expected to disproportionately affect any particular localities or substantively affect costs for local governments.

Projected Impact on Employment. The proposed amendments are unlikely to substantively affect total employment.

Effects on the Use and Value of Private Property. The proposed amendments would not affect the use and value of private firms that comply with the requirements of the regulation. The proposal would increase costs for firms that do not comply, and may moderately reduce their value. For firms that comply with the regulation's requirements when creating lawns for developing real estate, costs would not increase.

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[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]"Contractor-applicator" is defined in the regulation as "any person required to hold a permit to apply any fertilizer pursuant to § 3.2-3608 of the Code of Virginia." The Code essentially defines that as any person, other than a licensee or an agent of a licensee, who intends to apply fertilizer, specialty fertilizer, soil amendment, or horticultural growing medium for profit.

[3]"Licensee" is defined in the regulation as "the person who receives a license to distribute any fertilizer under the provisions of § 3.2-3606 of the Code of Virginia." Section 3.2-3600 of the Code of Virginia, defines "distribute" as "to import, consign, manufacture, produce, compound, mix, blend, or in any way alter, the chemical or physical characteristics of a regulated product, or to offer for sale, sell, barter, warehouse or otherwise supply regulated product in the Commonwealth."

[4]"Certified fertilizer applicator" is defined in the regulation as "any individual who has successfully completed board-approved training."

[5]See https://ext.vt.edu/agriculture/commercial-horticulture/greenhouse-nursery/fertilizer-application.html

[6]See https://leg1.state.va.us/cgi-bin/legp504.exe?201+ful+CHAP0413

[7]The records must contain: 1. Name, mailing address, and telephone number of customer, as well as address of application site if different from customer's mailing address; 2. Name of the person making or supervising the application; 3. Day, month, and year of application; 4. Weather conditions at the start of the application; 5. Acreage, area, square footage, or plants treated; 6. Analysis of fertilizer applied; 7. Amount of fertilizer used, by weight or volume; and 8. Type of application equipment used.

[8]See https://www.epa.gov/nutrientpollution/issue

[9]Data source: VDACS

[10]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[11]Pursuant to § 2.2-4007.04, 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."

[12]If the proposed regulatory action may have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to § 2.2-4007.1 of the Code of Virginia, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[13]"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.

[14]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

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

Summary:

The proposed amendments (i) change the responsible party to the contractor-applicator or licensee who employs an individual who must be certified; (ii) replace the existing civil penalty that is assessed when a person offers services as a certified fertilizer applicator without obtaining such certification from the Department of Agriculture and Consumer Services with a penalty that increases with repeat violations; (iii) establish a penalty for a contractor-applicator or licensee who does not maintain records or fails to submit the annual report for fertilizer applied to more than 50 acres of nonagricultural lands; and (iv) establish a penalty for a contractor-applicator or licensee who fails to apply fertilizer in compliance with the Department of Conservation and Recreation's nutrient management standards.

2VAC5-405-110. Violations and penalties for noncompliance.

A. Any contractor-applicator or licensee that employs an individual who offers his services as a certified fertilizer applicator or who supervises the application of any fertilizer on nonagricultural land without obtaining prior registration certification from the commissioner shall be assessed a penalty of (i) $250 for the first offense, (ii) $500 for the second offense within any five-year period, and (iii) $1,000 for the third offense within any five-year period.

B. Any contractor-applicator or licensee that does not maintain records as required by this chapter or submit the required annual report to the commissioner in accordance with 2VAC5-405-100 shall be (i) issued a warning for the first offense, (ii) assessed a penalty of $250 for the second offense within any five-year period, (iii) assessed a penalty of $500 for the third offense within any five-year period, and (iv) assessed a penalty of $1,000 for the fourth offense within any five-year period.

C. Any contractor-applicator or licensee that applies lawn fertilizer or lawn maintenance fertilizer at a rate, time, or method inconsistent with the standards and criteria for nutrient management promulgated pursuant to § 10.1-104.2 of the Code of Virginia shall be (i) issued a warning for the first offense, (ii) assessed a penalty of $250 for the second offense within any five-year period, (iii) assessed a penalty of $500 for the third offense within any five-year period, and (iv) assessed a penalty of $1,000 for the fourth offense within any five-year period.

D. Violations of the provisions of ~~these regulations~~ this chapter shall be handled in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

~~C.~~ E. Any penalties assessed for violations of this ~~regulation~~ chapter shall be handled in accordance with a board-approved administrative process.

~~D.~~ F. In addition to any monetary penalties provided in this section, certified fertilizer applicators who violate any provision of this ~~regulation~~ chapter may also be subject to the provisions of § 3.2-3621 of the Code of Virginia regarding the cancellation of certification.

VA.R. Doc. No. R21-6716; Filed January 5, 2022, 9:17 a.m.

Fast-Track Regulation

Titles of Regulations: **2VAC5-675. Regulations Governing Pesticide Fees Charged by the Department of Agriculture and Consumer Services (amending 2VAC5-675-30, 2VAC5-675-40).**

2VAC5-685. Regulations Governing Pesticide Applicator Certification under Authority of Virginia Pesticide Control Act (amending 2VAC5-685-130).

Statutory Authority: § 3.2-3906 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: March 2, 2022.

Effective Date: March 17, 2022.

Agency Contact: Liza Fleeson Trossbach, Program Manager, Office of Pesticide Services, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 371-6559, FAX (804) 371-2283, TDD (800) 828-1120, or email liza.fleeson@vdacs.virginia.gov.

Basis: Section 3.2-109 of the Code of Virginia establishes the Board of Agriculture and Consumer Services as a policy board with the authority to adopt regulations in accordance with the provisions of Title 3.2 of the Code of Virginia. Section 3.2-3906 of the Code of Virginia authorizes the board to adopt regulations establishing a fee structure for licensure, registration, and certification to defray the costs of implementing the act.

Purpose: The agency has determined that current fees provide more than adequate funding for the Department of Agriculture and Consumer Services (VDACS) pesticide program. The fees prescribed in 2VAC5-675 and 2VAC5-685 are utilized to operate VDACS's pesticide programs, which protect human health and the environment by ensuring the proper use of pesticides used to control pests that adversely affect crops, structures, health, and domestic animals. Pesticide program activities include the certification of approximately 24,000 pesticide applicators, licensing of approximately 3,000 pesticide businesses, registration of approximately 16,000 pesticide products, and conducting routine inspections and investigations. VDACS is able to ensure compliance with all applicable laws and regulations related to the use of pesticides, thereby protecting human health, while eliminating the fee for pesticide applicator renewals, which will support the economic

welfare of the businesses currently responsible for paying these renewal fees.

Rationale for Using Fast-Track Rulemaking Process: The proposed amendments eliminate certification renewal fees charged to industry and, as such, are expected to be noncontroversial and appropriate for the fast-track rulemaking process.

Substance: The proposed amendments eliminate the certification renewal fee for (i) commercial applicators, which is currently $100 every two years; and (ii) registered technicians, which is currently $50 every two years.

Issues: The proposed regulatory action is advantageous to the public, the regulated industry, and the agency as the amended fee structure eliminates fees assessed on the regulated industry, thereby reducing the costs to pesticide applicators and pesticide businesses while allowing for the continuation of VDACS's pesticide program services, which protect human health and the environment by ensuring the proper use of pesticides used to control pests that adversely affect crops, structures, health, and domestic animals. Eliminating the pesticide applicator renewal fees does not add any additional regulatory requirements to pesticide applicators or pesticide businesses. There are no disadvantages to the public or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. The Board of Agriculture and Consumer Services (Board) proposes to remove the biennial renewal fees for commercial pesticide applicator[2] certifications ($100) and registered pesticide technician[3] certifications ($50).

Background. The Virginia Department of Agriculture and Consumer Services' (VDACS) pesticide programs protect human health and the environment by ensuring the proper use of pesticides used to control pests that adversely affect crops, structures, health, and domestic animals. Pesticide program activities include the certification of approximately 24,000 pesticide applicators, licensing of approximately 3,000 pesticide businesses, registration of approximately 16,000 pesticide products, and conducting routine inspections and investigations.[4]

VDACS has determined that current fees provide more than adequate funding for its pesticide programs. The agency states that it is able to ensure compliance with all applicable laws and regulations related to the use of pesticides, while eliminating the fees for the specified certification renewals.

Estimated Benefits and Costs. VDACS estimates that the proposed removal of renewal fees would result in an annual revenue loss of approximately $600,000; however, their long-term projection is that the remaining revenue is sufficient to carry out the program's mission. Commercial pesticide applicators and registered pesticide technicians would benefit by saving $100 and $50 biennially, respectively.

Businesses and Other Entities Affected. The proposed amendments would affect the approximate 3,000 licensed pesticide businesses and 17,000 certified pesticide applicators, including commercial applicators and registered technicians, in Virginia.[5]

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[6] With one exception, an adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. The exception is when agencies choose to reduce their fees since revenues are projected to exceed their needs. Thus, no adverse impact is indicated.

Small Businesses[7] Affected.[8] The proposed amendments do not adversely affect small businesses.

Localities[9] Affected.[10]The proposed amendments potentially affect all localities, but may particularly affect those that are agriculturally oriented. Since § 3.2-3931 of the Code provides an exemption from certification fees for government entities, the proposal would not directly affect local governments and their costs.

Projected Impact on Employment. The proposed amendments are unlikely to substantively affect total employment.

Effects on the Use and Value of Private Property. The proposed amendments modestly reduce costs for pesticide applicators, which may commensurately increase the value of their businesses. The proposed amendments do not affect real estate development costs.

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[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]Section 3.2-3900 of the Code of Virginia defines "commercial applicator" as "any person who has completed the requirements for certification to use or supervise the use of any pesticide for any purpose or on any property other than as provided in the definition of private applicator."

[3]Section 3.2-3900 defines "registered technician" as "an individual who has satisfactorily completed the Board requirements for certification to apply general use pesticides, and to apply restricted use pesticides while under the direct supervision of a certified commercial applicator. Registered technicians render services similar to those of a certified commercial applicator, but have not completed all the requirements to be eligible for certification as a commercial applicator."

[4]Source: VDACS

[5]Data source: VDACS

[6]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[7]Pursuant to § 2.2-4007.04, 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."

[8]If the proposed regulatory action may have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to § 2.2-4007.1 of the Code of Virginia, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[9]"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.

[10]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

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

Summary:

The amendments remove the renewal fee for commercial applicator renewal certifications and registered technician renewal certifications.

2VAC5-675-30. Commercial applicator certificate fee.

Any person applying for a certificate as a commercial applicator shall pay to the department an initial nonrefundable certificate fee of $100 ~~and a biennial nonrefundable renewal fee of $100 thereafter~~. All certificates shall expire ~~at midnight~~ on June 30 in the second year after issuance unless suspended or revoked for cause. ~~All certificates~~ A certificate not suspended or revoked for cause will be renewed upon receipt of ~~the biennial renewal fee. If the applicator does not file~~ an application for renewal ~~of his certificate prior to COB~~ submitted by June 30~~, the commissioner shall assess a late filing fee of 20% that shall be added to the renewal fee. The applicant shall pay the total fee prior to the commissioner's issuance of the renewal~~. ~~However, if~~ If the certificate is not renewed within 60 days following the expiration of the certificate, then such certificate holder shall be required to take another examination. The fee for this reexamination or for any commercial applicator reexamination pursuant to subsection C of § 3.2-3930 of the Code of Virginia shall be $100 and shall be nonrefundable. Any person applying to add a category or subcategory to his certificate shall pay to the department a nonrefundable fee of $35. Federal, state, and local government employees certified to use, or supervise the use of, pesticides in government programs shall be exempt from any certification fees.

2VAC5-675-40. Registered technician certificate fee.

Any person applying for a certificate as a registered technician shall pay to the department an initial nonrefundable certificate fee of $50 ~~and a biennial nonrefundable renewal fee of $50 thereafter~~. All certificates shall expire ~~at midnight~~ on June 30 in the second year after issuance unless suspended or revoked for cause. A certificate not suspended or revoked for cause will be renewed upon receipt of ~~the biennial renewal fee. If the~~ an application for renewal ~~of any certificate is not filed prior to COB~~ submitted by June 30~~, a late filing fee of 20% shall be assessed and added to the renewal fee and shall be paid by the applicant before the renewal shall be issued~~. If the certificate is not renewed within 60 days following the expiration of the certificate, then such certificate holder shall be required to take another examination. The fee for this reexamination pursuant to subsection C of § 3.2-3930 of the Code of Virginia shall be $50 and shall be nonrefundable. Federal, state, and local government employees certified to use pesticides in government programs shall be exempt from any certification fees.

2VAC5-685-130. Renewal of certification.

A. Any certified private or commercial applicator or registered technician who desires to renew his certification shall do so biennially for the category or subcategory for which he is certified. A certified private or commercial applicator or registered technician must first attend board-approved recertification courses and submit proof of attendance at such courses~~,~~ or be reexamined in basic pesticide safety and the categories desired for recertification. In addition to the requirement in this subsection, commercial applicators and registered technicians shall also ~~pay the biennial certificate fee and~~ submit an application for renewal before the commissioner will renew their certification.

B. A certified commercial applicator or registered technician must complete a board-approved recertification course that, at a minimum, addresses the following topics:

1. Legal aspects including:

a. A reminder to follow label directions including those on use, storage, disposal, and transportation;

b. A review of possible consequences of violating the law;

c. A reminder that restricted use pesticides purchased under an applicator's certificate number must be for use by certified commercial applicators only;

d. A review of a certified commercial applicator's responsibilities in supervising the use of restricted use pesticides by noncertified applicators; and

e. A review of recordkeeping responsibilities of certified commercial applicators for restricted use pesticide applications; and

2. Category-related training including:

a. A review of general safety for the applicator, coworkers, and the public;

b. A review of the environmental aspects of pesticide use, including impact on nontarget organisms, wildlife, domestic animals, groundwater, etc.;

c. A review of application techniques, including equipment, calibration, and maintenance;

d. A review of hazards, both personal safety and environmental, unique to that specific category;

e. A review of pertinent information regarding new chemistry or new formulations available that would be of use to applicators certified in the category;

f. A review of integrated pest management programs applicable to the category; and

g. A review of pests specific to category, including in-depth training on identification and control of selected specific pests. This section may be tailored to local needs.

C. A certified private applicator must complete a board-approved recertification course that, at a minimum, addresses the following topics:

1. General safety;

2. Legal update; and

3. Pest management and application technology, including:

a. A review of category-specific pest management and pesticide use patterns; and

b. A review of category-specific pesticide application and handling technology.

D. A certified private or commercial applicator or registered technician may accumulate up to four years of credit by attending board-approved recertification courses.

E. Upon expiration of certification, the certificate of a private applicator, commercial applicator, or registered technician shall become invalid. Any private applicator, commercial applicator, or registered technician who desires to renew his certification, but fails to do so within 60 days after its expiration, shall be reexamined.

VA.R. Doc. No. R22-6869; Filed December 30, 2021, 9:09 a.m.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

DEPARTMENT OF CONSERVATION AND RECREATION

Final Regulation

Title of Regulation: **4VAC5-30. Virginia State Parks Regulations (amending 4VAC5-30-10 through 4VAC5-30-32, 4VAC5-30-50, 4VAC5-30-150, 4VAC5-30-160, 4VAC5-30-170, 4VAC5-30-190, 4VAC5-30-220, 4VAC5-30-230, 4VAC5-30-250, 4VAC5-30-260, 4VAC5-30-274 through 4VAC5-30-300, 4VAC5-30-370, 4VAC5-30-390 through 4VAC5-30-420; adding 4VAC5-30-95; repealing 4VAC5-30-180).**

Statutory Authority: § 10.1-104 of the Code of Virginia.

Effective Date: March 2, 2022.

Agency Contact: 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.

Summary:

The amendments (i) add 4VAC5-30-95, prohibiting public urination or defecation, and repeal 4VAC30-180 regarding dressing and undressing; (ii) prohibit the use of generators at campsites and in the campground at all times; (iii) update definitions to reflect current statutory definitions; (iv) update procedures to accurately reflect current technologies; and (v) clarify rules for individuals visiting department properties or using department facilities.

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

4VAC5-30-10. ~~Definition of terms~~ Definitions.

Whenever used in this chapter, the following ~~respective~~ words and terms~~, unless otherwise therein expressly defined,~~ shall ~~mean and include each of~~ have the following meanings ~~herein respectively set forth.~~ unless the context clearly indicates otherwise:

~~"Bathing area" means any beach or water area designated by the department as a bathing area.~~

"Bicycle path" means any path or trail maintained for bicycles.

"Bridle path or trail" means any path or trail maintained for persons riding on horseback.

"Camping ~~Unit~~ unit" means a tent, tent trailer, travel trailer, camping trailer, pick-up camper, motor ~~homes~~ home, or any other portable device or vehicular-type structure as may be developed, marketed, or used for temporary living quarters or

shelter during periods of recreation, vacation, leisure time, or travel.

"Department" means the Department of Conservation and Recreation.

"Electric power assisted bicycle" means a vehicle that travels on not more than three wheels in contact with the ground and is equipped with (i) pedals that allow propulsion by human power, (ii) a seat for the use of the rider, and (iii) an electric motor with an input of no more than 750 watts.

"Foot path or trail" means any path or trail maintained for pedestrians or disabled persons.

"Immediate family" means relatives living at the same common household of residence.

"Motor vehicle" means any vehicle ~~which~~ that possesses a motor of any description used for propulsion or to assist in the propulsion of the vehicle.

"Owner" means any person, firm, association, copartnership, or corporation owning, leasing, operating, or having the exclusive use of a vehicle, animal, or any other property under a lease or otherwise.

"Park" means, unless specifically limited, all designated state parks, recreational areas, parkways, historical and natural areas, natural area preserves, sites, and other areas under the jurisdiction or management of the Department of Conservation and Recreation.

"Permits" means ~~any~~ all written ~~license~~ licenses issued by or under authority of the department, permitting the performance of a specified act ~~or acts~~.

"Person" means any corporation, company, association, firm, an individual, proprietorship, partnership, joint venture, joint stock company, syndicate, business trust, estate, club, committee, organization, or group of persons acting in concert.

"Power-driven mobility device" means any mobility device powered by batteries, fuel, or other engines, whether or not designed primarily for use by individuals with mobility disabilities, that is used by individuals with mobility disabilities for the purpose of locomotion, including golf carts, electronic personal assistance mobility devices (EPAMDs), such as the Segway® PT, or any mobility device designed to operate in areas without defined pedestrian routes, but that is not defined as a "wheelchair."

"Swimming area" means any beach or water area designated by the department as a swimming area.

"Wheelchair" means a manually-operated or power-driven device designed primarily for use by an individual with a mobility disability for the main purpose of both indoor and outdoor locomotion.

4VAC5-30-20. Construction of regulations.

In the interpretation of ~~the Virginia State Parks Regulations~~ this chapter, ~~their~~ the provisions shall be construed as follows: (i) any terms in the singular shall include the plural; (ii) any term in the masculine shall include the feminine and the neuter; (iii) any requirements or prohibition of any act shall, respectively, extend to and include the causing or procuring, directly or indirectly, of such act; (iv) no provision hereof shall make unlawful any act necessarily performed by any law-enforcement officer as defined by § 9.1-101 of the Code of Virginia or employee of the department in line of duty or work as such, or by any person, his agents or employees, in the proper and necessary execution of the terms of any agreement with the department; (v) any act otherwise prohibited by ~~Virginia State Parks Regulations~~ this chapter, provided it is not otherwise prohibited by law or local ordinance, shall be lawful if performed under, by virtue of, and strictly within the provisions of a permit so to do, and to the extent authorized thereby~~,~~; and (vi) this chapter ~~are~~ is in addition to and a supplement to the ~~state vehicle and traffic~~ laws set out in the Code of Virginia, which are in force in all parks and which are incorporated herein and made a part hereof.

4VAC5-30-30. Territorial scope.

~~All Virginia State Parks Regulations~~ This chapter shall be effective within and upon all state parks, recreational areas, historical and natural areas, natural area preserves, roads, sites, and other areas in the Commonwealth ~~which~~ that may be under the management or control of the Department of Conservation and Recreation and shall regulate the use thereof by all persons. This chapter shall also be effective in any lands operated as Breaks Interstate Park in accordance with the Compact entered into pursuant to § 10.1-205.1 of the Code of Virginia.

4VAC5-30-32. General.

Failure to comply with ~~the Virginia State Parks Regulations~~ this chapter, as well as other applicable laws and regulations, and agency signage, may result in revocation of permits or registrations, forfeiture of applicable prices paid, a Virginia uniform summons, arrest, and prosecution.

4VAC5-30-50. Flowers, plants, minerals, etc.

No person shall remove, destroy, cut down, scar, mutilate, injure, deface, take, or gather in any manner any tree, flower, fern, shrub, rock or plant, historical artifact, or mineral in any park unless a special permit has been obtained for scientific collecting. Edible fruits, berries, fungi, or nuts may be collected for personal or individual use only. To obtain a special permit for scientific collecting in a state park, a natural area, or a natural area preserve, a Research and Collecting Permit Application must be completed and provided to the department ~~at:~~ in a manner specified by the department.

~~Department of Conservation and Recreation~~

~~203 Governor Street, Suite 306~~

~~Richmond, Virginia 23219-2010.~~

~~To obtain a special permit for scientific collecting in a natural area or natural area preserve, a Research and Collecting Permit Application must be completed and provided to the department at:~~

~~Department of Conservation and Recreation~~

~~Division of Natural Heritage~~

~~217 Governor Street, Third Floor~~

~~Richmond, Virginia 23219.~~

4VAC5-30-95. Public urination or defecation.

Urinating or defecating other than at the places provided therefore is prohibited, with the exception for path or trail areas or other remote sites that may not have utilities provided. In such cases, urinating or defecating should not be seen by the public and should take place at least 200 feet from any waterway or trail.

4VAC5-30-150. Camping.

A. ~~Permit~~ Reservation. Camping will be conducted only under ~~permit~~ a valid reservation. A ~~permit~~ reservation is obtained ~~by completing a valid Virginia State Parks Camping Permit Form or Honor Camping Application and submitting payment~~ from the individual park office, through the department's designated reservation system, or through the completion of the self-pay process. Payment must be submitted in accordance with all applicable prices and payment policies. ~~A camping permit can only be issued by the park management.~~ Only an individual 18 years of age or older who is a member of and accepts responsibility for the camping party may be issued a camping ~~permit~~ reservation. ~~The act of placing a reservation through the state parks reservation center does not constitute a camping permit.~~

Camping may only be performed in strict accordance with the terms and conditions of the ~~permit~~ reservation. Any violation of the ~~permit by the permittee or~~ terms of the reservation by any member of the party shall constitute grounds for ~~permit~~ reservation revocation by the department, or by its authorized representative, whose action shall be final. In case of revocation of any ~~permit~~ reservation, all moneys paid for or on account thereof shall at the option of the department be forfeited and retained by the department.

B. Occupancy. Occupancy of each campsite shall be limited to not more than six persons or one immediate family, or other maximum occupancy permitted through an approved special use permit. ~~The term immediate family shall mean relatives living at the same common household of residence.~~

C. Camping units, equipment, and vehicles. All camping units, equipment, and vehicles shall be placed within the perimeter of the designated campsite without infringing on adjoining campsites or vegetation. Where high impact areas have been designated, all camping units, equipment, and vehicles shall be placed within the defined borders of the high impact area. There is a maximum of two camping units allowed per campsite; no more than one axled camping unit is allowed per campsite.

D. Camping periods. No camping shall be permitted in excess of 14 nights within a 30-day period. Park managers shall have the authority to increase the number of nights permitted by an approved special use permit. ~~Check-in time shall be 4 p.m. Check-out time is 3 p.m. Campers may be permitted to occupy campsites prior to 4 p.m., but no earlier than 8 a.m., if campsites are available.~~ Any personal property left at the campsite after the reservation period check-out time shall be removed by park staff at the owner's expense.

E. Motor vehicles. Only two motor vehicles in addition to the camping unit allowed under subsection C of this section are permitted on a campsite with no additional prices. All motor vehicles shall be parked in the designated parking area of each campsite. Any additional vehicles beyond two are subject to daily parking prices and shall be parked at designated overflow parking areas.

F. Visitors. ~~All visitors shall register on the visitors register.~~ No visitor shall be allowed before 6 a.m. and all visitors must leave the campground area by 10 p.m. All visitors shall be charged the appropriate daily parking or admissions prices prior to entering the park.

G. Quiet hours. Quiet hours in the campgrounds shall be from 10 p.m. to 6 a.m. ~~Generators~~ Excessive noise, amplified music, or other disturbances that can be heard outside the perimeters of the user's campsite are prohibited during the designated quiet hours.

H. Pets. Domestic and household pets are permitted in campgrounds ~~only with payment of all applicable prices~~. Owners are responsible for cleaning up after their pets and for ensuring their pets do not disturb other campers. Horses and other livestock are not permitted unless facilities are specifically provided for them.

I. Generators. The use of combustion generators at campsites and in the campground is prohibited except when used by the department to perform necessary construction, maintenance, or repairs or for an activity approved by special permit.

J. Damage to any campground or campsite, not considered normal wear and tear, may be billed to the person registering for the campground or campsite on an itemized cost basis in accordance with the reservation acknowledgment or reservation confirmation.

4VAC5-30-160. Cabins.

A. Use of state park cabins, camping cabins, lodges, and yurts shall only be permitted pursuant to the reservation acknowledgment, reservation confirmation, or established department ~~regulations (4VAC5-36) and~~ policy dealing with

reservations, registration, occupancy, prices, length of stay, and rental period.

B. Damage to any park cabin, camping cabin, lodge, or yurt not considered normal wear and tear may be billed to the person registering for the cabin on an itemized cost basis in accordance with the reservation acknowledgment or reservation confirmation.

4VAC5-30-170. ~~Bathing~~ Swimming, where permitted.

No person shall bathe, wade, or swim in any department-owned waters in any park except at such times~~,~~ and in such places~~,~~ as the department may designate as ~~bathing~~ swimming areas~~, and unless so covered with a bathing suit as to prevent any indecent exposure of the person~~.

4VAC5-30-180. ~~Dressing and undressing.~~ (Repealed.)

~~Dressing and undressing, except in bathhouses, camping units or cabins is prohibited.~~

4VAC5-30-190. Boating.

Boating of any kind in a ~~bathing~~ swimming area is prohibited.

4VAC5-30-220. Fires.

No person shall kindle, build, maintain, or use a fire other than in places provided or designated for such purposes in any park. Any fire shall be continuously under the care and direction of a competent person ~~over sixteen~~ older than 16 years of age from the time it is kindled until it is extinguished. No person within the confines of any park shall throw away or discard any lighted match, cigarette, cigar, charcoal, or other burning object. Any lighted match, cigarette, cigar, charcoal, or other burning object must be entirely extinguished before being thrown away or discarded.

4VAC5-30-230. Smoking.

No person shall smoke or use electronic vaporizing devices in any structure or place in any park where smoking is prohibited. Smoking or the use of electronic vaporizing devices may be forbidden by the department or its authorized agent in any part of any park.

4VAC5-30-250. Fishing.

The taking of fish by hook and line, the taking of bait fish by cast net, and crabbing by line and net is permitted in the designated areas in each park, the only stipulations being that persons taking fish by hook and line must have a state fishing license required by law and comply with the applicable Department of ~~Game and Inland Fisheries~~ Wildlife Resources or Marine Resources Commission rules and regulations. This is intended to be a complete list of authorized fishing activities in parks and does not allow other activities requiring fishing licenses such as bow-fishing or the taking of amphibians, which are prohibited.

4VAC5-30-260. Animals at large.

No person shall cause or permit any animal owned by him, in his custody, or under his control, except an animal restrained by a leash not exceeding six feet in length, to enter any park, and each such animal found at large may be seized and disposed of as provided by the law or ordinance covering disposal of stray animals on highways or public property then in effect at the place where such stray animals may be seized. No animal shall be left unattended by its owner in any park at any time, except for animals in designated stables. Animals shall not be allowed in ~~bathing~~ swimming areas under any circumstances, except for service or hearing dogs identifiable in accordance with § 51.5-44 of the Code of Virginia.

4VAC5-30-274. Foot path or trail use.

Persons shall only use paths, trails, or other designated areas in any park. No person shall engage in an activity expressly prohibited by a trail safety sign. With the exception of wheelchairs, power-driven mobility devices are only allowed on those paths or trails that have been designated by the department as appropriate for such use.

4VAC5-30-276. Bicycle path use.

No person shall use a bicycle, an electric power-assisted bicycle, or a similarly propelled ~~devices~~ device in any area other than designated bicycle paths in any park. Any authorized use of an electric power-assisted bicycle will be limited to class one or class two bicycles as defined in § 46.2-100 of the Code of Virginia. No person shall engage in an activity expressly prohibited by ~~a trail safety sign~~ park rules and regulations.

4VAC5-30-280. Bridle path use.

No person shall use, ride, or drive a horse or other animal in any park except along a bridle path, to or from a parking area associated with such bridle path, or other designated area. No person shall engage in an activity expressly prohibited by ~~a trail safety sign~~ park rules and regulations.

4VAC5-30-290. Vehicles; where prohibited.

No person shall drive a motor vehicle in any park within or upon a safety zone, walk, bicycle or bridle path, fire truck trail, service road or any part of any park not designated for, or customarily used by motor vehicles, except properly authorized individuals engaged in fire ~~control~~ management, park maintenance, or other necessary park-related activities.

4VAC5-30-300. Parking.

No owner or driver shall cause or permit a vehicle to stand anywhere in any park outside of designated parking spaces, except ~~a reasonable time in a drive~~ to receive or discharge passengers in a reasonable amount of time in areas where standing vehicles are not prohibited. Parking in designated camping or cabin parking spaces is prohibited unless the

individual is registered as an occupant of or a visitor to that specific campsite or cabin [.]

4VAC5-30-370. Advertising.

No sign, notice, or advertisements of any nature shall be erected or posted at any place within any park, nor shall any noise be made for the purpose of attracting attention to any exhibition of any kind except for services, programs, and events approved by the park management.

4VAC5-30-390. Alms and contributions.

No person or organization shall within any park solicit alms or contributions for any purpose unless approved by the park management.

4VAC5-30-400. Aviation.

No person shall voluntarily ~~bring,~~ land~~,~~ or ~~cause to descend or alight~~ unlawfully operate within or upon any park, any airplane, remote control model aircraft, ~~flying machine~~ helicopter, unmanned aerial system, drone, balloon, parachute, or other apparatus for aviation. "Voluntarily" in this connection shall mean anything other than a forced landing. Rescue and evacuation aircraft are exempt for emergencies and approved training exercises.

4VAC5-30-410. Importation of firewood.

A. The Director of the Department of Conservation and Recreation may prohibit the importation of firewood or certain types of firewood into any park or allow such entry only under specified conditions when such firewood may be infected or infested with a species of concern. Any firewood transported to the park by a person found to be in violation of such prohibition shall be confiscated and destroyed. Should any person charged under this section be found not guilty, the person shall be reimbursed for only the cost of the firewood.

B. When the director makes a written determination to implement subsection A of this section, the following minimum requirements apply:

1. Such determination shall be posted to the department's website and posted at the park where applicable.

2. Firewood to be used by any person within a park must be purchased from the park, must be proven to be from a certified source in accordance with subdivision 3 of this subsection if transported to the park, or may be collected from within the confines of the park in accordance with park policy. The department may allow for the sale or distribution of firewood within the park with prior written agreement that it has been treated in accordance with subdivision 3 of this subsection. Firewood includes all wood, processed or unprocessed, meant for use in a campfire. Such ban shall not include scrap building materials, such as ~~2x4s;~~ two-by-fours, but may extend to wood pallets and other wood product packing materials as determined by the director.

3. Firewood certified to be sold and distributed within the park by a firewood dealer shall be subject to at least one of the following conditions:

a. Exclude all ~~ash tree material~~ quarantined tree species from the firewood production area. Dealers will have to demonstrate ability to identify and separate firewood species.

b. Remove bark and outer half inch of sapwood off of all nonconiferous firewood.

c. Kiln dry all nonconiferous firewood to USDA specifications.

d. Heat treat all nonconiferous firewood to USDA specifications.

e. Fumigate all nonconiferous firewood to USDA specifications.

f. Offer conclusive proof demonstrating to the satisfaction of the department that the origin of the wood was from a noninfected area.

g. Offer conclusive proof demonstrating to the satisfaction of the department that the wood containing the infecting or infesting species of concern has been properly treated and the species is controlled by an alternative control mechanism.

The director may eliminate or restrict conditions offered in this subsection as determined to be necessary to properly address the infecting or infesting species of concern to the satisfaction of the department.

4VAC5-30-420. Release of domestic animals or wildlife on park property.

No person shall release domestic animals, fish, or wildlife captured or propagated elsewhere into any park, unless approved by the park management.

NOTICE: The following forms used in administering the regulation have been filed by the agency. Amended or added forms are reflected in the listing and are published following the listing. Online users of this issue of the Virginia Register of Regulations may also click on the name to access a form. The forms are also available from the agency contact or may be viewed at the Office of Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (4VAC5-30)

[~~Natural Area Preserve Research and Collecting Permit Application, DCR 199-003 (11/07).~~

~~Research and Collecting Permit Application, DCR 199-043 (12/00).~~

~~Cabin & Camping Permit (1/10).~~

Research and Collecting Permit Application, DCR 199-043 (rev. 7/2014)]

VA.R. Doc. No. R20-4581; Filed January 11, 2022, 3:07 p.m.

TITLE 6. CRIMINAL JUSTICE AND CORRECTIONS

BOARD OF JUVENILE JUSTICE

Fast-Track Regulation

Title of Regulation: **6VAC35-210. Compulsory Minimum Training Standards for Direct Care and Security Employees in Juvenile Correctional Centers (adding 6VAC35-210-10 through 6VAC35-210-90).**

Statutory Authority:§ 66-10 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: March 2, 2022.

Effective Date: March 18, 2022.

Agency Contact: Ken Davis, Regulatory Affairs Coordinator, Department of Juvenile Justice, 600 East Main Street, 20th Floor, Richmond, VA 23219, telephone (804) 807-0486, FAX (804) 371-6490, or email kenneth.davis@djj.virginia.gov.

Basis: Section 66-10 of the Code of Virginia vests the Board of Juvenile Justice with the authority to establish compulsory minimum entry-level, in service, and advanced training standards and the time required for completion of such training for persons employed as juvenile correctional officers at a juvenile correctional facility and requires such training to address various topics related to pregnant residents.

Purpose: The new regulation is essential to meet the statutory directives and to ensure that direct care and security employees in state-operated juvenile correctional centers receive adequate, timely, and relevant training to execute their duties in juvenile correctional centers safely and efficiently. Additionally, the new regulation will ensure that staff are prepared to supervise any pregnant youth who may be assigned to a juvenile correctional center. Finally, the new regulation will authorize department staff to apply appropriate sanctions for direct care and security staff who fail to satisfy the training requirements.

Rationale for Using Fast-Track Rulemaking Process: The department does not expect these regulatory provisions to generate controversy. The proposal complies with the statutory mandate by identifying the various training requirements and topics for direct care employees in state-operated juvenile correctional centers. The proposal was developed with consensus among representatives from the department's Training and Development Unit, Division of Residential Services, and Executive Staff, and the department believes these minimum standards will ensure that entry-level and seasoned direct care and security staff are sufficiently trained to perform their roles competently and safely.

Substance: The new regulatory chapter: (i) provides the new chapter's scope as applying exclusively to direct care and security employees in state-operated and certain privately operated juvenile correction centers (JCCs); (ii) requires department-approved instructors to provide the applicable training; (iii) breaks down the 180 hours of training required for direct care and security employees to include a combination of academy and unit training, orientation, and staff observation, along with additional training regarding pregnant residents; (iv) establishes the required volume of annual training for such employees and imposes advanced or specialized training before authorized staff may use certain equipment; (v) outlines the time requirements for completion of training; (vi) sets out testing and attendance requirements for the successful completion of training and establishing sanctions for staff who fail to meet such requirements; (vii) directs the department to develop and the board to approve performance outcomes that identify the competencies and knowledge that should result from training; and (viii) directs the department to maintain documentation for a three-year period demonstrating each applicable employee's compliance with these requirements.

Issues: The proposed regulation is expected to provide numerous benefits to the public and the department. Ensuring that staff receive sufficient and proper training helps to reduce the number of facility incidents and creates an environment more conducive to resident growth and rehabilitation, which ultimately increases the likelihood of the resident's success after release. Applicants for direct care or security positions in JCCs will have clear guidance as to the expectations regarding training, which may decrease staff turnover and conserve training resources. The department does not anticipate any disadvantages to the public or the Commonwealth associated with the proposed new regulation.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. The Board of Juvenile Justice (Board) proposes to promulgate a new regulation, 6VAC35-210 Compulsory Minimum Training Standards for Direct Care Employees (regulation).

Background. The Board's existing 6VAC35-71 Regulation Governing Juvenile Correctional Centers contains requirements for initial and annual training for direct care and security employees in juvenile correctional centers (JCCs).[2]

Chapter 526 of the 2020 Acts of Assembly added that for juvenile correctional officers who may have contact with pregnant inmates, such standards shall include training on the general care of pregnant women, the impact of restraints on pregnant inmates and fetuses, the impact of being placed in restrictive housing or solitary confinement on pregnant inmates, and the impact of body cavity searches on pregnant

inmates. Consequently, the proposed regulation includes such training.

The Board proposes to further specify the training required at JCCs by promulgating 6VAC35-210 Compulsory Minimum Training Standards for Direct Care Employees. The proposed regulation works in concert with 6VAC35-71 Regulation Governing Juvenile Correctional Centers and includes requirements pertaining to Chapter 526.

The proposed regulation consists of the following sections:

Section 10 Definitions

Section 20 Applicability - Limits the proposed regulation's scope to apply exclusively to direct care employees[3] and security employees[4] working full-time or part-time in state-operated and certain privately operated JCCs.

Section 30 Training providers - States that all training required by the regulation be provided by Department of Juvenile Justice (DJJ) approved general instructors unless otherwise specified.

Section 40 Compulsory minimum training standards - States that individuals hired as direct care employees or security employees shall successfully complete: (i) a minimum of 120 hours of DJJ-approved initial training in accordance with 6VAC35-71-160 Regulation Governing Juvenile Correctional Centers; (ii) facility orientation in accordance with 6VAC35-71-150 Regulation Governing Juvenile Correctional Centers; (iii) a minimum of 24 hours of juvenile correctional center staff observation; and (iv) at least 36 hours of training on a juvenile correctional center housing unit. States that direct care employees and security employees shall receive training by medical staff on the topics specified in Chapter 526. States that existing direct care employees and security employees shall complete a minimum of 40 hours of DJJ-approved annual training in accordance with 6VAC35-71-170 Regulation Governing Juvenile Correctional Centers. States that advanced or specialized training shall be required only for direct care and security employees authorized to use mechanical restraints, the mechanical restraint chair, and protective devices.

Section 50 Time requirements for completion of training - States that a direct care or security employee may not work directly with a resident until the employee has completed all training and orientation required in Section 40 or unless at least one other employee who has completed all applicable facility-based orientation and training is present and supervising the resident. States that required advanced or specialized training shall be completed before direct care or security employees may apply mechanical restraints, the mechanical restraint chair, or protective devices.

Section 60 Testing and attendance requirements - States that direct care employees and security employees shall be deemed to have successfully completed training upon satisfying the following testing requirements:(i) successful passage of all administered written and practical tests, and (ii) demonstrated mastery in all physical restraint techniques. States that direct care employees and security employees shall be deemed noncompliant with these minimum standards and subject to the sanctions set out in Section 70 if they are absent from training for a cumulative period of 32 hours or more during the first five weeks of initial training, regardless of the topic addressed.

Section 70 Failure to comply with minimum standards - States that a direct care or security employee who fails to comply with the minimum attendance requirements or to successfully complete the compulsory initial training shall be removed from service with the department and required to repeat the application and training process in order to qualify for a direct care or security employee position in the future.

Section 80 Development and approval of performance outcomes - Directs DJJ to develop and the Board to approve performance outcomes that identify the competencies and knowledge that should result from training.

Section 90 Training documentation - Directs DJJ to maintain documentation for a three-year period demonstrating each applicable employee's compliance with these requirements.

Estimated Benefits and Costs. Currently there is only one JCC, a state-operated facility in Chesterfield County (Bon Air Juvenile Correctional Center). There are no current plans to open or use additional JCCs.[5]

According to DJJ, with the exception of training for pregnant residents, all of the requirements in the proposed regulation are consistent with current practice at the JCC. All training is conducted by DJJ employees (Section 30). Pursuant to the existing 6VAC35-71-160 Regulation Governing Juvenile Correctional Centers, there are already 120 hours of initial classroom/academic training provided (Section 40). There is facility orientation in accordance with 6VAC35-71-150 Regulation Governing Juvenile Correctional Centers (Section 40). Existing employees annually complete a minimum of 40 hours of training in accordance with 6VAC35-71-170 Regulation Governing Juvenile Correctional Centers (Section 40). The requirements concerning advanced or specialized training for employees authorized to use mechanical restraints, the mechanical restraint chair, and protective devices is consistent with 6VAC35-71-1180 Regulation Governing Juvenile Correctional Centers (Section 40). Time requirements for completion of training (Section 50) is consistent with 6VAC35-71-160 and 6VAC35-71-170 Regulation Governing Juvenile Correctional Centers. The proposed requirement that DJJ maintain documentation for a minimum period of three years demonstrating that each direct care employee and security employee has complied with the requirements

(Section 90) is consistent with 6VAC35-71-30 Regulation Governing Juvenile Correctional Centers.

Requirements for a minimum of 24 hours of JCC staff observation (watching, not hands-on) and at least 36 hours of training on a JCC housing unit (hands-on) are not currently specified in regulation or statute, but are consistently done in practice according to DJJ (Section 40). The testing and attendance requirements of proposed Section 60 are consistent with what DJJ applies in practice, but the specific requirements are not currently in regulation or statute. The proposed Section 70 formalizes DJJ's current process for addressing JCC direct care and security staff who fail to meet the initial training requirements and thus is not expected to have a substantive impact on facility operations. DJJ has already produced, and the Board has already approved, a document with performance outcomes that identify the competencies and knowledge that should result from training (Section 80).

DJJ states that it does not currently include the training concerning pregnant residents in its curriculum since the JCC does not currently have any female residents (Section 40). The agency states that if in the future there were to be female residents, the medical staff would then provide the training.

None of the proposed requirements would likely substantively produce additional or reduced expenditures, as with the exception of the training concerning pregnant residents, all of the proposed requirements reflect current practice. The agency believes the training regarding pregnant residents can be provided by their medical staff, and the additional time and effort required would be minimal.

Businesses and Other Entities Affected. The proposed regulation would affect the one existing state-operated JCC. There current are no privately-operated JCCs.

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[6] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. No adverse impact is indicated for this proposal.

Small Businesses[7] Affected. The proposal is unlikely to affect costs for small businesses.

Localities[8] Affected.[9] The proposed regulation would affect the one state-operated JCC, which is located in Chesterfield County. The proposal does not require additional expenditures for this or any other localities.

Projected Impact on Employment. The proposed regulation is unlikely to substantively affect total employment.

Effects on the Use and Value of Private Property. The proposed regulation is unlikely to substantively affect the use and value of private property or real estate development costs.

[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]"Juvenile correctional center" is a public or private facility operated by or under contract with the department where care is provided to residents under the direct care of the Department of Juvenile Justice 24 hours a day, seven days a week.

[3]"Direct care employee" is an employee whose primary job responsibilities are (i) maintaining the safety, care, and well-being of residents; (ii) implementing the structured program of care and the behavior management program; and (iii) maintaining the security of juvenile correction center facility. For purposes of this regulation, the term "direct care employee" shall include a security employee assigned, either on a primary or as-needed basis, to perform the duties of clauses (i) through (iii) of this definition and who is required to receive initial and annual training in these areas in order to carry out the responsibilities in clauses (i) through (iii) of this definition.

[4]"Security employee" means an employee who is responsible for maintaining the safety, care, and well-being of residents and the safety and security of the facility.

[5]Source: DJJ

[6]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[7]Pursuant to § 2.2-4007.04, 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."

[8]"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.

[9]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

Agency's Response to Economic Impact Analysis: The responsible Board of Juvenile Justice agency representatives have reviewed the Department of Planning and Budget's (DPB's) economic impact analysis, and the agency is in agreement with DPB's analysis.

Summary:

The action establishes a new regulation providing compulsory training requirements for direct care and security employees in juvenile correctional centers operated by the Department of Juvenile Justice. In addition, the new regulation satisfies requirements of Chapter 366 of the 2019 Acts of Assembly and Chapter 526 of the 2020 Acts of Assembly by requiring the standards include training on various topics involving pregnant residents.

Chapter 210
Compulsory Minimum Training Standards for Direct Care and Security Employees in Juvenile Correctional Centers

6VAC35-210-10. Definitions.

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

"Board" means the Board of Juvenile Justice.

"Department" means the Department of Juvenile Justice.

"Direct care employee" means an employee whose primary job responsibilities are (i) maintaining the safety, care, and well-being of residents; (ii) implementing the structured program of care and the behavior management program; and (iii) maintaining the security of the facility. For purposes of this chapter, the term "direct care employee" shall include a security employee assigned, either on a primary or as-needed basis, to perform the duties of clauses (i), (ii), and (iii) of this definition and who is required to receive initial and annual training in these areas in order to carry out the responsibilities in clauses (i), (ii), and (iii) of this definition.

"Director" means the director of the department.

"Juvenile correctional center" means a public or private facility operated by or under contract with the department where care is provided to residents under the direct care of the department 24 hours a day, seven days a week.

"Mechanical restraint" means an approved mechanical device that involuntarily restricts the freedom of movement or voluntary functioning of a limb or portion of an individual's body as a means of controlling his physical activities when the individual being restricted does not have the ability to remove the device.

"Mechanical restraint chair" means an approved chair used to restrict the freedom of movement or voluntary functioning of a portion of an individual's body as a means of controlling the individual's physical activities while seated and either stationary or being transported.

"Protective device" means an approved device placed on a portion of a resident's body to protect the resident or staff from injury.

"Security employee" means an employee who is responsible for maintaining the safety, care, and well-being of residents and the safety and security of the facility.

6VAC35-210-20. Applicability.

This chapter applies exclusively to direct care employees and security employees working full-time or part-time in a state-operated juvenile correctional center or in a privately operated juvenile correctional center governed by the Juvenile Corrections Private Management Act (§ 66-25.3 et seq. of the Code of Virginia). Staff employed in juvenile boot camps or locally, regionally, or privately operated alternative direct care programs for juveniles are not subject to the requirements of this chapter.

6VAC35-210-30. Training providers.

All training required by this chapter shall be provided by department-approved general instructors unless otherwise specified.

6VAC35-210-40. Compulsory minimum training standards.

A. Pursuant to the provisions of subdivision 9 of § 66-10 of the Code of Virginia, the board establishes these compulsory minimum training standards.

B. Individuals hired as direct care employees or security employees shall successfully complete the following:

1. A minimum of 120 hours of department-approved initial training in accordance with 6VAC35-71-160;

2. Facility orientation in accordance with 6VAC35-71-150;

3. A minimum of 24 hours of juvenile correctional center staff observation, during which time the trainee shall not be counted in coverage for purposes of meeting the staffing ratio requirements in 6VAC35-71-830; and

4. At least 36 hours of training on a juvenile correctional center housing unit.

C. Direct care employees and security employees shall receive training by medical staff on the following topics: (i) the general care of pregnant residents; (ii) the impact of placement in restrictive housing or room confinement, body cavity searches, and restraints on pregnant residents; and (iii) the impact of restraints on fetuses.

D. Direct care employees and security employees shall complete a minimum of 40 hours of department-approved annual training in accordance with 6VAC35-71-170.

E. Advanced or specialized training shall be required only for direct care and security employees authorized to use mechanical restraints, the mechanical restraint chair, and protective devices. The department shall make other advanced or specialized training available to direct care employees and security employees as a means of enhancing job skills and competencies but shall not require direct care or security employees to complete advanced or specialized training in order to assume position responsibilities.

6VAC35-210-50. Time requirements for completion of training.

A. A direct care or security employee may not work directly with a resident until the employee has completed all training and orientation required in 6VAC35-210-40 or unless at least one other employee who has completed all applicable facility-

based orientation and training is present and supervising the resident.

B. Direct care and security employees shall successfully complete additional refresher training on a recurring basis in accordance with subsection D of 6VAC35-210-40.

C. Required advanced or specialized training shall be completed before direct care or security employees may apply mechanical restraints, the mechanical restraint chair, or protective devices.

6VAC35-210-60. Testing and attendance requirements.

A. Direct care employees and security employees shall be deemed in successful completion of training upon satisfying the following testing requirements:

1. Successful passage of all administered written and practical tests, and

2. Demonstrated mastery in all physical restraint techniques.

B. Direct care employees and security employees shall be deemed noncompliant with these minimum standards and subject to the sanctions set out in 6VAC35-210-70 if they are absent from training for a cumulative period of 32 hours or more during the first five weeks of initial training, regardless of the topic addressed.

6VAC35-210-70. Failure to comply with minimum standards.

A direct care or security employee who fails to comply with the minimum attendance requirements or to successfully complete the compulsory initial training shall be removed from service with the department and required to repeat the application and training process in order to qualify for a direct care or security employee position in the future. The department shall follow all applicable policies, rules, and regulations of the Virginia Department of Human Resource Management before imposing this sanction.

6VAC35-210-80. Development and approval of performance outcomes.

A. The department shall develop a performance outcomes document that describes the knowledge and competencies the department expects an employee to demonstrate after completing the training required in this chapter.

B. The performance outcomes shall be approved by the board. The board shall have the authority to amend these outcomes at any time and to establish a practicable timeline for implementation.

6VAC35-210-90. Training documentation.

The department shall maintain documentation for a minimum period of three years demonstrating that each direct care employee and security employee has complied with the requirements in this chapter.

VA.R. Doc. No. R22-6594; Filed January 5, 2022, 2:07 p.m.

TITLE 8. EDUCATION

STATE BOARD OF EDUCATION

Fast-Track Regulation

Titles of Regulations: **8VAC20-23. Licensure Regulations for School Personnel (amending 8VAC20-23-40, 8VAC20-23-110, 8VAC20-23-390).**

8VAC20-543. Regulations Governing the Review and Approval of Education Programs in Virginia (amending 8VAC20-543-20, 8VAC20-543-80, 8VAC20-543-340, 8VAC20-543-570).

Statutory Authority: §§ 22.1-16 and 22.1-298.2 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: March 2, 2022.

Effective Date: April 1, 2022.

Agency Contact: Dr. Leslie Sale, Director of Policy, Department of Education, James Monroe Building, 101 North 14th Street, 25th Floor, Richmond, VA 23219, telephone (804) 225-2092, or email leslie.sale@doe.virginia.gov.

Basis: Section 22.1-16 of the Code of Virginia establishes the State Board of Education's authority to promulgate regulations, generally, allowing the board to promulgate such regulations as may be necessary to carry out its powers and duties. Additionally, § 22.1-298.1 of the Code of Virginia requires the board prescribe by regulation the requirements for the licensure of teachers and other school personnel.

Purpose: This regulatory change is to conform regulations to legislation of 2021 Special Session I of the General Assembly. The bills that initiated these regulatory changes were each offered to protect the health, safety, and welfare of citizens. Regulatory changes related to requirements for earning or renewing a license with a history and social science endorsement are the result of recommendations from the Virginia African American History Education Commission which sought to ensure that content in Virginia schools is accurate, inclusive, and relatable for all Virginia students. Many educators employed by the Commonwealth's school divisions have not taken a course or received professional development on teaching African American history and thus may not have the knowledge necessary to present students with a full and comprehensive representation of African American voices. Additional robust professional development is needed that outlines specific knowledge required to teach African American history.

Regulatory changes related to special education respond to recommendations from Joint Legislative Audit and Review Commission's K-12 Special Education in Virginia. In Virginia and nationally, approximately 95% of students with disabilities are served in public schools, and a majority of students with disabilities spend most, and increasingly more, of their time in

the general education classroom. Seventy-one percent of students with disabilities receive instruction for most of their day in the general education classroom. As such, general education teachers play a critical role in educating students with disabilities, but many general education teachers do not know how to effectively teach and support students with disabilities. Additionally, there seems to be inconsistent knowledge among key school staff about individualized education programs (IEPs) and staff roles in developing them.

These regulatory changes help to address these gaps in teacher preparation and training. Amending the requirements for teacher licensure and endorsement help to guarantee that those qualified to teach are even better-equipped to serve their students in the classroom. As a result, public school environments will be more inclusive and prepared to meet the needs of all students, giving more students an opportunity to thrive and succeed in the public school setting.

Rationale for Using Fast-Track Rulemaking Process: The board is initiating this regulatory change at the direction of the General Assembly. During its 2021 Special Session I, the General Assembly passed several bills related to requirements for teacher licensure and endorsements as well as educator preparation programs in Virginia, each of which required a change in the regulations. The board expects this action to be noncontroversial and therefore appropriate for the fast-track process because the changes were required by legislative mandate and the board has exercised minimal discretion in effectuating the requirements.

Substance: This regulatory action amends 8VAC20-23-40, 8VAC20-23-110, and 8VAC20-23-390, outlining the new requirements for initial license or a renewal of a license with an endorsement in history and social science as well as the renewal of a license, generally. This action also amends 8VAC20-543-20 and 8VAC20-543-80, adding the requirement that approved education preparation programs provide instruction in African American history and certain topics related to students with disabilities.

Issues: The primary advantage of this regulatory change is the assurance that those teachers trained in Virginia-approved educator programs or licensed by the State Board of Education will be even better-equipped to serve their students. This in turn, will create cultures of learning and inclusiveness that improve the student experience. In turn, students will have a well-rounded knowledge and skillsets to thrive in school and beyond.

While this does add a few new training requirements for individuals in the profession, the Virginia African American History Commission and Joint Legislative Audit and Review Commission highlighted the importance and necessity of these amendments. Additionally, the impact the relevant changes will have on approved educator preparation programs will be marginal as many have already begun to incorporate these types of instruction or training opportunities into their course maps. Lastly, both teachers and preparation programs will be able to leverage resources provided by the Department of Education in order to meet these new requirements.

As a result of this regulatory action, the Commonwealth can expect to benefit from future cohorts of students who have a more complete understanding of Virginia and United States history, and more students with disabilities will be better positioned to take on their postsecondary goals, whether that be in career or college. There were no disadvantages to the agency or Commonwealth identified.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. Pursuant to legislation from the 2021 Special Session I, the Board of Education (Board) proposes to add requirements concerning teacher training on the instruction of students with disabilities and teacher training on African American history.

Background.

Legislation on Education for Students with Disabilities. Chapters 451 and 452 (Chapters 451 and 452) of the 2021 Special Session I Acts of Assembly[2] specify that:

> "regulations shall include requirements that: 9. Every person seeking renewal of a license as a teacher shall complete training in the instruction of students with disabilities that includes (i) differentiating instruction for students depending on their needs; (ii) understanding the role of general education teachers on the individualized education program team; (iii) implementing effective models of collaborative instruction, including co-teaching; and (iv) understanding the goals and benefits of inclusive education for all students."

Starting with "Every person," the Board proposes to add this exact language to 8VAC20-23 Licensure Regulations for School Personnel. These requirements would pertain to all teachers who seek to renew their license.

Additionally, the 5th enactment clause of Chapters 451 and 452 adds four areas of proficiency, stating that:

> "5. That the Board of Education shall review and amend its regulations governing general education teacher preparation programs for kindergarten through twelfth grade to ensure graduates are required to demonstrate proficiency in (i) differentiating instruction for students depending on their needs; (ii) understanding the role of general education teachers on the individualized education program team;[3] (iii) implementing effective models of collaborative instruction, including co-teaching; and (iv) understanding the goals and benefits of inclusive education for all students."

Consequently, the Board proposes to state in 8VAC20-543 Regulations Governing the Review and Approval of Education Programs in Virginia that all educator preparation programs must ensure that graduates of candidates in general education teacher preparation programs for K-12 demonstrate proficiency in the four specified areas noted in the enactment clause.

Additionally, the 6th enactment clause of Chapters 451 and 452 adds requirements for the Board's regulations, stating that:

> "6. That the Board of Education shall review and amend its regulations governing administrator preparation programs to ensure graduates are required to demonstrate comprehension of (i) key special education laws and regulations, (ii) individualized education program development, (iii) the roles and responsibilities of special education teachers, and (iv) appropriate behavior management practices."

The current Regulations Governing the Review and Approval of Education Programs in Virginia include the following:

> "The program in administration and supervision preK-12 shall ensure that the candidate has completed three years of successful, full-time experience in a public school or accredited nonpublic school in an instructional personnel position that requires licensure in Virginia and demonstrated the following competencies: f. Knowledge, understanding, and application of the federal and state regulatory requirements, and expectations associated with identification, education, and evaluation of students with disabilities;"

Due to the 6th enactment clause of Chapters 451 and 452, the Board proposes to append the following text, which is identical to the text in the legislation:

> "comprehension of (i) key special education laws and regulations, (ii) individualized education program development; (iii) the roles and responsibilities of special education teachers, and (iv) appropriate behavior management practices;"

Legislation on Instruction in African American History. Chapters 23 and 24 (Chapters 23 and 24) of the 2021 Special Session I Acts of Assembly[4] specify that:

> "regulations shall include requirements that: 10. Every person seeking initial licensure or renewal of a license with an endorsement in history and social sciences shall complete instruction in African American history, as prescribed by the Board."

In response, the Board proposes to add the following discretionary text to 8VAC20-23 Licensure Regulations for School Personnel:

> "Every person seeking initial licensure or renewal of a license with an endorsement in history and social sciences shall complete instruction in African American history, which shall include (i) an understanding of African origins; (ii) the African diaspora; (iii) developments of the Black experience in North America; (iv) the institution of slavery in the United States, including historical perspectives of the enslaved; and (v) how African Americans helped shape and have been shaped by American society."

These requirements would pertain to all teachers with an endorsement in history and social sciences who seek to become licensed or renew their license.

The Board also proposes to add the following discretionary text to 8VAC20-543 Regulations Governing the Review and Approval of Education Programs in Virginia:[5]

> "The program in history and social sciences shall ensure that the candidate has demonstrated the following competencies: (8) The history, culture, contributions, and agency of African Americans including (i) an understanding of African origins; (ii) the African diaspora; (iii) developments of the Black experience in North America; (iv) the institution of slavery in the United States, including historical perspectives of the enslaved; and (v) how African Americans helped shape and have been shaped by American society."

Professional Development Points. Teacher licensure may be renewed upon the completion of 270 professional development points within a 10-year validity period. Individuals renewing a five-year renewable license must complete 180 professional development points.[6] The Board is not proposing any changes to the professional development point requirements for license renewal, but as discussed, the proposed required training would count toward teachers' professional development points.

Estimated Benefits and Costs.

Licensure Regulations for School Personnel. According to the Department of Education (DOE), the agency will provide free online modules for the four requirements pertaining to instruction of students with disabilities, and for the five requirements about African American history. Thus, the proposed requirements stating that for license renewal all teachers must complete training in the four instruction of students with disabilities categories, and that teachers with an endorsement in history and social sciences must complete training in the five African American history categories, would not require teachers to spend additional money on training.

Additionally, training through the modules would count toward teachers' professional development points.[7] For those teachers who substitute the new required training for other professional development activities that would have taken the same or more time, the proposed new requirements would also not require more of the teachers' time in net. Those teachers who choose to not eliminate other activities that could count toward professional development points would be spending more time due to the proposed requirements. DOE estimates that the online training for African American history would take up to five hours. The agency does not yet have an estimate for the time it would take to complete the modules for the instruction of students with disabilities.

The proposed required training likely would provide some benefit. The magnitude of the likely benefit would vary depending on the effectiveness of the required instruction and the policy views of the observer.

Regulations Governing the Review and Approval of Education Programs in Virginia. DOE believes that educator preparation programs already provide instruction in (i) differentiating instruction for students depending on their needs; (ii) understanding the role of general education teachers on the individualized education program team; (iii) implementing effective models of collaborative instruction, including co-teaching; and (iv) understanding the goals and benefits of inclusive education for all students, in existing required courses. For programs that already provide such instruction, adding the requirement that programs must ensure that graduates demonstrate proficiency in the four categories to the Regulations Governing the Review and Approval of Education Programs in Virginia would have no impact beyond better informing the public that such requirements exist.

According to DOE, the educator preparation programs would have flexibility in how the instruction of students with disabilities competencies are addressed, whether as stand-alone courses, part of existing specialized courses, or through workshops/seminars, etc. The educator preparation programs would be responsible for making sure the syllabi for courses within approved programs include this content. If there are educator preparation programs that are not already providing instruction in the four categories, the requirement that programs must ensure that graduates demonstrate proficiency in the four categories may reduce time spent in other areas due to the limits of time for lectures, etc., or require that students in the programs spend additional time receiving instruction.

Concerning the proposed requirement that programs in history and social sciences ensure that the candidate has demonstrated competencies in the five African American history categories, DOE states that the programs would have flexibility in or options for how the competencies are addressed, that is, stand-alone courses, major or minor in African American history, workshops or seminars, or embedded within secondary history methods courses. The proposed requirement may reduce time spent in other areas due to the limits of time for lectures, etc., or require that students in the programs spend additional time receiving instruction.

The proposal to append "comprehension of (i) key special education laws and regulations, (ii) individualized education program development; (iii) the roles and responsibilities of special education teachers, and (iv) appropriate behavior management practices" to the existing requirement that programs in administration and supervision preK-12 ensure that the candidate demonstrates competency in "Knowledge, understanding, and application of the federal and state regulatory requirements, and expectations associated with identification, education, and evaluation of students with disabilities" essentially brings more specificity to the existing requirement rather than adding to the requirement.

As with the proposed requirements for the Licensure Regulations for School Personnel, the proposed requirements for the Regulations Governing the Review and Approval of Education Programs in Virginia would likely produce some benefit. The magnitude of the likely benefit would vary depending on the effectiveness of the required instruction and the policy views of the observer.

Businesses and Other Entities Affected. The proposed amendments affect public school teachers in the Commonwealth as well as colleges and universities with educator preparation programs and their students. The Virginia colleges and universities with approved educator preparation programs are: Averett University, Bluefield College, Bridgewater College, Christopher Newport University, Eastern Mennonite University, Emory and Henry College, Ferrum College, George Mason University, Hampton University, Hollins University, James Madison University, Liberty University, Longwood University, Mary Baldwin University, Marymount University, Norfolk State University, Old Dominion University, Radford University, Randolph College, Randolph-Macon College, Regent University, Roanoke College, Shenandoah University, Southern Virginia University,[8] Sweet Briar College, University of Lynchburg, University of Mary Washington, University of Richmond, University of Virginia, University of Virginia's College at Wise, Virginia Commonwealth University, Virginia State University, Virginia Tech, Virginia Union University, Virginia Wesleyan University, Washington and Lee University,[9] and William & Mary.

The Code of Virginia requires the Department of Planning and Budget to assess whether an adverse impact may result from the proposed regulation. An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. Since, as described, some students in educator preparation programs would need to spend additional time receiving instruction, or receive less instruction on other topics, and the educator preparation programs would need to prepare and present additional instruction, the proposal would produce some cost.[10] Thus, an adverse impact is indicated.

Small Businesses[11] Affected. The proposed amendments do not appear to adversely affect small businesses.

Localities[12] Affected.[13] The proposed amendments do not disproportionately affect particular localities. The proposed amendments do not introduce costs for local governments.

Projected Impact on Employment. The proposed amendments would not likely substantively affect employment.

Effects on the Use and Value of Private Property. Some of the private colleges and universities that have educator preparation programs would need to add instruction on new topics. Additional staff would not likely be needed though. The

proposed amendments do not affect real estate development costs.

[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]Chapters 451 and 452 of the 2021 Special Session I Acts of Assembly are identical.

[3]Chapter 173 of the 2021 Special Session I Acts of Assembly also specifies that he Board shall amend its Regulations Governing the Review and Approval of Education Programs in Virginia to ensure that each education preparation program graduate in a K-12 demonstrates proficiency in understanding the role of general education teachers on the IEP team.

[4]Chapters 23 and 24 of the 2021 Special Session I Acts of Assembly are identical.

[5]Chapters 23 and 24 do not address the regulations governing education teacher preparation programs.

[6]See 8VAC20-23-110 for more detail.

[7]DOE has not yet determined the number of professional development points that completing the modules would earn.

[8]Washington and Lee University and Southern Virginia University have partnered to form the Rockbridge Teacher Education Consortium. See https://columns.wlu.edu/rockbridge-county-universities-form-teacher-education-consortium/

[9]Ibid

[10]It is acknowledged that much of the costs stem from the legislation rather than from discretionary decisions of the Board.

[11]Pursuant to § 2.2-4007.04, 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."

[12]"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.

[13]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

Agency's Response to Economic Impact Analysis: The agency largely concurs with the economic impact analysis completed by the Department of Planning and Budget. However, the agency reiterates that the broader reason for these regulatory changes is to ensure the teacher workforce in Virginia is best equipped to serve all of Virginia's public school students. Moreover, although this action is in response to legislative mandates, these changes were originally proposed by the Joint Legislative Audit and Review Commission and the African American History Commission after a thorough and comprehensive review of special education and history education in Virginia public schools.

Summary:

The amendments to teacher and administrator preparation requirements (i) add the requirement of completion of instruction in African American history for initial license or a renewal of a license with an endorsement in history and social science as well as the renewal of a license generally, (ii) add the requirement that approved education preparation programs provide instruction in African American history, and (iii) add the requirement that approved education preparation programs provide instruction in certain topics related to students with disabilities. The amendments conform the regulations to Chapters 23 and 24, 173, and 451 and 452 of the 2021 Acts of Assembly, Special Session I.

8VAC20-23-40. Conditions for licensure.

A. Applicants for licensure shall:

1. Be at least 18 years of age;

2. Pay the appropriate fees as determined by the Virginia Board of Education and complete the application process;

3. Have earned a baccalaureate degree, with the exception of the Technical Professional License, from a regionally accredited college or university and meet requirements for the license sought. Persons seeking initial licensure through approved programs from Virginia institutions of higher education shall only be licensed as instructional personnel if the education endorsement programs have approval by the Virginia Board of Education; individuals who have earned a degree from an institution in another country shall hold the equivalent of a regionally accredited college or university degree in the United States, as verified by a Virginia Department of Education-approved credential evaluation agency, for the required degree for the license; and

4. Possess good moral character and be free of conditions outlined in Part VII (8VAC20-23-720 et seq.) of this chapter.

B. All candidates who hold at least a baccalaureate degree from a regionally accredited college or university and who seek an initial Virginia teaching license shall obtain passing scores on professional teacher's assessments prescribed by the Virginia Board of Education. With the exception of the career switcher program that requires assessments as prerequisites, individuals shall complete the professional teacher's assessment requirements within the three-year validity of the initial provisional license. Candidates seeking a Technical Professional License, International Educator License, School Manager License, or Pupil Personnel Services License are not required to take the professional teacher's assessments. Individuals who hold a valid out-of-state license (full credential without deficiencies) and who have completed a minimum of three years of full-time, successful teaching experience in a public or an accredited nonpublic school, kindergarten through grade 12, outside of Virginia are exempt from the professional teacher's assessment requirements. Documentation shall be submitted to verify the school's status as a public or an accredited nonpublic school.

C. All individuals seeking an initial endorsement in early/primary education preK-3, elementary education preK-6,

special education-general curriculum, special education-deaf and hard of hearing, special education-blindness and visual impairments, and individuals seeking an endorsement as a reading specialist shall obtain passing scores on a reading instructional assessment prescribed by the Virginia Board of Education.

D. Licensure by reciprocity is set forth in 8VAC20-23-100. A school leaders licensure assessment prescribed by the Virginia Board of Education shall be met for all individuals who are seeking an endorsement authorizing them to serve as principals and assistant principals in the public schools. Individuals seeking an initial administration and supervision endorsement who are interested in serving as central office instructional personnel are not required to take and pass the school leaders licensure assessment prescribed by the Virginia Board of Education.

E. Individuals seeking initial licensure shall demonstrate proficiency in the relevant content area, communication, literacy, and other core skills for educators by achieving a qualifying score on professional assessments or meeting alternatives evaluation standards as prescribed by the board; complete study in attention deficit disorder; complete study in gifted education, including the use of multiple criteria to identify gifted students; complete study in methods of improving communication between schools and families and ways of increasing family involvement in student learning at home and at school.

F. Every person seeking initial licensure shall (i) complete awareness training, provided by the Department of Education on the indicators of dyslexia, as that term is defined by the board pursuant to regulations, and the evidence-based interventions and accommodations for dyslexia; (ii) complete study in child abuse recognition and intervention in accordance with curriculum guidelines, developed by the Virginia Board of Education in consultation with the Virginia Department of Social Services; and (iii) provide evidence of completion of certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of automated external defibrillators. The certification or training program shall (a) be based on the current national evidenced-based emergency cardiovascular care guidelines for cardiopulmonary resuscitation and the use of an automated external defibrillator, such as a program developed by the American Heart Association or the American Red Cross; and (b) include hands-on practice of the skills necessary to perform cardiopulmonary resuscitation. The Virginia Board of Education shall provide a waiver for this requirement for any person with a disability whose disability prohibits such person from completing the certification or training.

G. Every person seeking initial licensure as a teacher who has not received the instruction described in subsection D of § 23.1-902 of the Code of Virginia shall receive instruction or training on positive behavior interventions and supports; crisis prevention and de-escalation; the use of physical restraint and seclusion, consistent with regulations of the Virginia Board of Education; and appropriate alternative methods to reduce and prevent the need for the use of physical restraint and seclusion.

H. The teacher of record for verified credit courses for high school graduation shall hold a Virginia license with the appropriate content endorsement.

I. Every teacher seeking an initial license in the Commonwealth with an endorsement in the area of career and technical education shall have an industry certification credential, as defined in 8VAC20-23-10, in the area in which the teacher seeks endorsement. If a teacher seeking an initial license in the Commonwealth has not attained an industry certification credential in the area in which the teacher seeks endorsement, the Virginia Board of Education may, upon request of the employing school division or educational agency, issue the teacher a provisional license to allow time for the teacher to attain such credential.

J. Every person seeking renewal of a license shall complete awareness training, provided by the Virginia Department of Education, on the indicators of dyslexia, as that term is defined by the Virginia Board of Education pursuant to regulations, and the evidence-based interventions and accommodations for dyslexia.

K. Every person seeking renewal of a license as a teacher shall complete training in the instruction of students with disabilities that includes (i) differentiating instruction for students depending on their needs; (ii) understanding the role of general education teachers on individual education program teams; (iii) implementing effective models of collaborative instruction, including co-teaching; and (iv) understanding the goals and benefits of inclusive education for all students.

L. No teacher who seeks a provisional license shall be required to meet any requirement set forth in subdivision F, G, or I as a condition of such licensure, but each teacher shall complete each such requirement during the first year of provisional licensure.

~~L.~~ M. Every person seeking initial licensure of a license with an endorsement as a school counselor shall complete training in the recognition of mental health disorder and behavioral distress, including depression, trauma, violence, youth suicide, and substance abuse.

N. Every person seeking initial licensure or renewal of a license with an endorsement in history and social sciences shall complete instruction in African American history, which shall include (i) an understanding of African origins; (ii) the African diaspora; (iii) developments of the Black experience in North America; (iv) the institution of slavery in the United States, including historical perspectives of the enslaved; and (v) how African Americans helped shape and have been shaped by American society.

8VAC20-23-110. Requirements for renewing a license.

A. The Division Superintendent, Postgraduate Professional, Collegiate Professional, Technical Professional, Pupil Personnel Services, Online Teacher, and School Manager Licenses may be renewed upon the completion of 270 professional development points within a 10-year validity period based on an individualized professional development plan that includes ongoing, sustained, and high-quality professional development. Individuals renewing a five-year renewable license must complete 180 professional development points. Every person seeking renewal of a license shall complete all renewal requirements, including professional development in a manner prescribed by the Virginia Board of Education, except that no person seeking renewal of a license shall be required to satisfy any such requirement by completing coursework and earning credit at an institution of higher education.

B. An individual seeking renewal shall submit a completed licensure application at the time a renewal request is submitted.

C. Any individual licensed and endorsed to teach (i) middle school civics or economics or (ii) high school government or history who is seeking renewal of such license is required to demonstrate knowledge of Virginia history or state and local government by completing a module or professional development course specifically related to Virginia history or state and local government that has a value of five professional development points.

D. Every person seeking renewal of a license shall provide evidence of completion of certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of automated external defibrillators. The certification or training program shall (i) be based on the current national evidence-based emergency cardiovascular care guidelines for cardiopulmonary resuscitation and the use of an automated external defibrillator, such as a program developed by the American Heart Association or the American Red Cross, and (ii) include hands-on practice of the skills necessary to perform cardiopulmonary resuscitation. The Virginia Board of Education shall provide a waiver for this requirement for any person with a disability whose disability prohibits such person from completing the certification or training.

E. Every person seeking renewal of a license with an endorsement as a school counselor shall complete training in the recognition of mental health disorder and behavioral distress, including depression, trauma, violence, youth suicide, and substance abuse.

F. Every person seeking renewal of a license shall complete awareness training, provided by the Virginia Department of Education, on the indicators of dyslexia, as that term is defined by the Virginia Board of Education pursuant to regulations, and the evidence-based interventions and accommodations for dyslexia.

G. Every person seeking renewal or initial license shall complete a study in child abuse recognition and intervention in accordance with curriculum guidelines developed by the Virginia Board of Education in consultation with the Virginia Department of Social Services.

H. Every person seeking renewal of a license with an endorsement in history and social science shall complete instruction in African American history, which shall include (i) an understanding of African origins; (ii) the African diaspora; (iii) developments of the Black experience in North America; (iv) the institution of slavery in the United States, including historical perspectives of the enslaved; and (v) how African Americans helped shape and have been shaped by American society.

I. Every person seeking renewal of a license as a teacher shall complete training in the instruction of students with disabilities that includes (i) differentiating instruction for students depending on their needs; (ii) understanding the role of general education teachers on the individualized education program team; (iii) implementing effective models of collaborative instruction, including co-teaching; and (iv) understanding the goals and benefits of inclusive education for all students.

J. When provided by the state, individuals shall complete other professional development activities prescribed by the Virginia Board of Education.

~~I.~~ K. Professional development points may be accrued by the completion of professional development activities to improve and increase instructional personnel's knowledge of the academic subjects the teachers teach or the area assigned from one or more of the following eight options, in accordance with Virginia Board of Education guidelines set forth in the Virginia Licensure Renewal Manual.

1. College credit. Acceptable coursework offers content that provides new information and is offered on campus, off campus, or through extension by any regionally accredited two-year or four-year college or university. College coursework shall develop further experiences in subject content taught, teaching strategies, uses of technologies, leadership, and other essential elements in teaching to high standards and increasing student learning. No person seeking renewal of a license shall be required to complete coursework and earn credit at an institution of higher learning.

2. Professional conference. A professional conference is a workshop, institute, or seminar of four or more hours that contributes to ongoing, sustained, and high-quality professional development.

3. Curriculum development. Curriculum development is a group activity in which the license holder contributes to the improvement of the curriculum of a school, a school division, or an educational institution in the teaching area assigned. This includes the alignment of curriculum

frameworks, instructional materials, and assessments to provide a system with clear expectations of what is to be taught and learned.

4. Publication of article. The article shall contribute to the education profession or to the body of knowledge of the license holder's teaching area or instructional position. This article shall be published in a recognized professional journal. Grant reports that present the results of educational research are acceptable provided the license holder had an active role in planning, analyzing, interpreting, demonstrating, disseminating, or evaluating the study or innovation.

5. Publication of book. Books shall be published for purchase and shall contribute to the education profession or to the body of knowledge of the license holder's teaching area or instructional position. The published book shall increase the field of content knowledge; provide information on planning and assessment for evaluating and providing students with feedback that encourages student progress and measures student achievement; reference instruction, safety, and learning environment; expand upon and communication and community relations working with students, parents, and members of the community to promote broad support for student learning. Points will not be awarded for self-published books.

6. Mentorship. Mentoring is the process by which an experienced professional who has received mentorship training provides assistance to one or more persons for the purpose of improving their performance. Assistance may involve role modeling, direct instruction, demonstration, observation with feedback, developing of plans, and consultation to promote instructional excellence and increased student achievement. Mentoring may include the supervision of a field experience of a pre-service student teacher or an intern in an approved teacher or principal preparation program, as well as mentoring as part of the induction process for a beginning teacher or a first-year administrator. Individuals serving in this role and submitting documentation for license renewal based on the mentorship option shall receive training as a mentor prior to the assignment and at least once during the 10-year renewal cycle.

7. Educational project. Educational projects shall be planned, focused projects based on high standards of teaching and learning. Projects shall result in a written report or other tangible product. Projects shall contribute to the education profession or to the body of knowledge of the license holder's teaching area or instructional position. A project could include participation in new professional responsibilities, such as leading a school improvement initiative.

8. Professional development activity. Professional development activities shall focus on student learning and achievement, schoolwide educational improvement, leadership, subject content, teaching strategies, and use of technologies or other essential elements in teaching to high standards. Activities shall be planned, rigorous, systematic, and promote continuous inquiry and reflection. Local employing educational agencies are encouraged to design professional development activities that are conducted in school settings and linked to student learning and achievement.

~~J.~~ L. The 270 points may be accrued by activities drawn from one or more of the eight renewal options. Individuals renewing a five-year renewable license must complete 180 professional development points as prescribed by the Virginia Board of Education. Renewal work is designed to provide licensed personnel with opportunities for professional development relative to the grade levels or teaching fields to which they are assigned or for which they seek an added endorsement. Such professional development encompasses (i) responsible remediation of any area of an individual's knowledge or skills that fails to meet the standards of competency and (ii) responsible efforts to increase the individual's knowledge of new developments in his field and to respond to new curricular demands within the individual's area of professional competence.

~~K.~~ M. The proposed work toward renewal in certain options shall be approved in advance by the chief executive officer or designee of the employing educational agency. Persons who are not employed by an educational agency may renew their license by submitting to the Office of Professional Licensure, Virginia Department of Education, a renewal application, fee, the individualized renewal record, and verification of the completion of all renewal requirements, including official student transcripts of coursework taken at a regionally accredited two-year or four-year college or university.

~~L.~~ N. Virginia school divisions and accredited nonpublic schools shall recommend renewal of licenses using the renewal point system.

8VAC20-23-390. History and social sciences.

A. Endorsement requirements. The candidate shall have:

1. Earned a baccalaureate degree from a regionally accredited college or university and graduated from an approved teacher preparation program in history and social sciences; or

2. Earned a baccalaureate degree from a regionally accredited college or university and completed 51 semester hours of coursework distributed in each of the following areas:

a. History: a major in history or 18 semester hours in history (shall include coursework in American history, Virginia history, and world history and may include African American history);

b. Political science: a major in political science or 18 semester hours in political science, which shall include coursework in American government (state and local government);

c. Geography: ~~9~~ nine semester hours; and

d. Economics: ~~6~~ six semester hours.

All candidates shall have also completed instruction in African American history, either as part of the degree program or through other department-approved alternatives, which shall include (i) an understanding of African origins; (ii) the African diaspora; (iii) developments of the Black experience in North America; (iv) the institution of slavery in the United States, including historical perspectives of the enslaved; and (v) how African Americans helped shape and have been shaped by American society.

B. Add-on endorsement requirements in history, political science, geography, and economics. The candidate shall have:

1. Earned a baccalaureate degree from a regionally accredited college or university and hold a teaching license with an endorsement in history, political science, geography, or economics; ~~and~~

2. Completed 21 semester hours of coursework in the additional social science area - history, political science, geography, or economics for which the add-on endorsement is sought; and

3. Completed instruction in African American history, either as part of the degree program or through other department-approved alternatives, which shall include (i) an understanding of African origins; (ii) the African diaspora; (iii) developments of the Black experience in North America; (iv) the institution of slavery in the United States, including historical perspectives of the enslaved; and (v) how African Americans helped shape and have been shaped by American society.

8VAC20-543-20. Accreditation and administering this chapter.

A. Institutions of higher education seeking approval of an education endorsement program shall be accredited by a regional accrediting agency.

B. Professional education programs in Virginia shall obtain and maintain national accreditation from the Council for the Accreditation of Educator Preparation (CAEP). Professional education programs in Virginia seeking accreditation through CAEP shall adhere to procedures and timelines established by CAEP and the CAEP/Virginia Partnership Agreement. Professional education programs shall ensure and document that programs are aligned with standards set forth in 8VAC20-543-40 through 8VAC20-543-50 and meet competencies outlined in 8VAC20-543-60 through 8VAC20-543-640.

C. If a professional education program fails to maintain accreditation, enrolled candidates shall be permitted to complete their programs of study. Professional education programs that fail to maintain accreditation shall not admit new candidates. Candidates shall be notified of the education endorsement program's approval status.

D. Teacher candidates may complete academic degrees in the arts and sciences, or equivalent. "Education preparation program" includes four-year bachelor's degree programs in teacher education. Candidates in early/primary education (preK-3), elementary education (preK-6), middle education (6-8), and special education programs may complete a major in interdisciplinary studies or its equivalent. Candidates seeking a secondary endorsement area must have earned a major, or the equivalent, in the area sought.

E. Professional studies coursework and methodology, including field experiences, required in this chapter shall be designed for completion within an approved program.

F. Professional education programs shall ensure that candidates demonstrate proficiency in the use of educational technology for instruction; complete study in child abuse recognition and intervention; and complete training or certification in emergency first aid, cardiopulmonary resuscitation, and the use of automated external defibrillators. Candidates in education endorsement programs must demonstrate an understanding of competencies, including the core concepts and facts of the disciplines and the Virginia Standards of Learning, for the content areas they plan to teach. Professional education programs shall ensure that candidates demonstrate skills needed to help preK-12 students achieve college and career performance expectations.

G. Each education preparation program graduate in a K-12 general education endorsement area is required to demonstrate proficiency in (i) differentiating instruction for students depending on their needs; (ii) understanding the role of general education teachers on the individualized education program team; (iii) implementing effective models of collaborative instruction, including co-teaching; and (iv) understanding the goals and benefits of inclusive education for all students.

H. Standards and procedures for the review and approval of each education endorsement program shall adhere to procedures for administering the chapter as defined in this section and in 8VAC20-543-40, 8VAC20-543-50, and 8VAC20-543-60. These procedures shall result in biennial recommendations to the Board of Education for one of the following three ratings: "approved," "approved with stipulations," or "approval denied."

~~H.~~ I. Education endorsement programs shall be approved under this chapter biennially based on compliance with the criteria described in 8VAC20-543-40, 8VAC20-543-50, and 8VAC20-543-60.

~~I.~~ J. The Department of Education will determine the timeline and procedures for applying for education endorsement program approval.

~~J.~~ K. Education endorsement programs in Virginia shall address the competencies set forth in this chapter, and the curriculum for each program must be documented and submitted to the Department of Education for approval.

~~K.~~ L. Professional education programs shall submit to the Department of Education on behalf of each education endorsement program under consideration a biennial accountability measurement report and an annual professional education program profile to include data prescribed by the Board of Education on education endorsement programs in accordance with department procedures and timelines.

~~L.~~ M. The professional education program authorized administrator shall maintain copies of approved education endorsement programs and required reports.

~~M.~~ N. The Department of Education may conduct onsite visits to review education endorsement programs and verify data.

~~N.~~ O. The Advisory Board on Teacher Education and Licensure (ABTEL) is authorized to review and make recommendations to the Board of Education on approval of Virginia education endorsement programs for school personnel. The Board of Education has final authority on education endorsement program approval.

~~O.~~ P. In administering this chapter, licensure requirements for Virginia are outlined in the Licensure Regulations for School Personnel (8VAC20-23). This document should be referenced for detailed information regarding requirements for Virginia licensure. An individual must meet licensure requirements set forth in the Code of Virginia.

~~P.~~ Q. Modifications may be made by the Superintendent of Public Instruction in the administration of this chapter. Proposed modifications shall be made in writing to the Superintendent of Public Instruction, Commonwealth of Virginia.

~~Q.~~ R. Upon the effective date of this chapter, the Board of Education grants colleges and universities two years to align their existing approved programs with this chapter and allows only college and universities that on the effective date of this chapter are accredited by the Board of Education process four years to become accredited by the Council for the Accreditation of Educator Preparation (CAEP) with the option of submitting a progress report to the Superintendent of Public Instruction to request an additional year, if needed.

8VAC20-543-80. Competencies and requirements for ~~endorsement areas~~ professional education programs.

A. The professional education program develops, maintains, and continuously evaluates high quality education endorsement programs that are collaboratively designed and based on identified needs of the preK-12 community. Candidates in education endorsement programs shall demonstrate competence in the areas in which they plan to practice and complete professional studies requirements and applicable assessments, in addition to meeting requirements for specific licenses, pursuant to the Licensure Regulations for School Personnel (8VAC20-23). The Licensure Regulations for School Personnel set forth the required degrees from regionally accredited colleges or universities for licenses, endorsements, and prerequisite licenses or endorsements for add-on endorsements.

B. All educator preparation programs must ensure that graduates of candidates in general education teacher preparation programs for kindergarten through 12th grade demonstrate proficiency in (i) differentiating instruction for students depending on their needs; (ii) understanding the role of general education teachers on the individualized education program team; (iii) implementing effective models of collaborative instruction, including co-teaching; and (iv) understanding the goals and benefits of inclusive education for all students.

C. All education endorsement programs in early/primary education preK-3, elementary education preK-6, middle education 6-8, and history and social sciences must include local government and civics instruction specific to Virginia.

~~C.~~ D. Candidates in education endorsement programs demonstrate an understanding of competencies, including the core concepts and facts of the disciplines and the Virginia Standards of Learning, for the content areas in which they plan to teach where required.

~~D.~~ E. Candidates in early/primary education preK-3, elementary education preK-6, and special education complete a minimum of six semester hours of reading coursework as outlined in the reading competencies.

~~E.~~ F. Candidates seeking an early/primary education preK-3 or an elementary education preK-6 endorsement must complete a minimum of 12 semester hours each in English, history and social sciences, mathematics, and science addressing competencies set forth in this chapter or complete the following:

1. English: complete six semester hours in English and pass a rigorous assessment in elementary English prescribed by the Board of Education.

2. History and social sciences: complete six semester hours in history and social sciences, complete a methods of teaching elementary history and social sciences course, and pass a rigorous assessment in elementary history and social sciences prescribed by the Board of Education.

3. Mathematics: complete six semester hours in mathematics, complete a methods of teaching elementary mathematics course, and pass a rigorous assessment in

elementary mathematics prescribed by the Board of Education.

4. Science: complete six semester hours in laboratory sciences in two science disciplines, complete a methods of teaching elementary science course, and pass a rigorous assessment in elementary science prescribed by the Board of Education.

~~F.~~ G. Candidates seeking a middle education endorsement must have an area of concentration in English, history and social sciences, mathematics, or science with 21 semester hours in the concentration area.

H. Candidates seeking an endorsement in history and social sciences must complete instruction in African American history, which shall include (i) an understanding of African origins; (ii) the African diaspora; (iii) developments of the Black experience in North America; (iv) the institution of slavery in the United States, including historical perspectives of the enslaved; and (v) how African Americans helped shape and have been shaped by American society.

8VAC20-543-340. History and social sciences.

The program in history and social sciences shall ensure that the candidate has demonstrated the following competencies:

1. Understanding of the knowledge, skills, and processes of history and the social science disciplines as defined by the Virginia History and Social Sciences Standards of Learning and how the standards provide the foundation for teaching history and the social sciences, including in:

a. United States history.

(1) The evolution of the American constitutional republic and its ideas, institutions, and practices from the philosophical origins in the Enlightenment through the debates of the colonial period to the present; the American Revolution, including ideas and principles preserved in significant Virginia and United States historical documents as required by § 22.1-201 of the Code of Virginia (the Declaration of American Independence; the general principles of the Constitution of the United States; the Virginia Statute of Religious Freedom; the charters of The Virginia Company of April 10, 1606, May 23, 1609, and March 12, 1612; and the Virginia Declaration of Rights); Articles of Confederation; and historical challenges to the American political system;

(2) The influence of religious traditions on American heritage and contemporary American society;

(3) The influence of immigration on American political, social, cultural, and economic life;

(4) The origins, effects, aftermath, and significance of the two world wars, the Korean and Vietnam conflicts, and the post-Cold War era;

(5) The social, political, and economic transformations in American life during the 20th century;

(6) The tensions between liberty and equality, liberty and order, region and nation, individualism and the common welfare, and cultural diversity and national unity; ~~and~~

(7) The difference between a democracy and a republic and other types of economic and political systems; and

(8) The history, culture, contributions, and agency of African Americans, including (i) an understanding of African origins; (ii) the African diaspora; (iii) developments of the Black experience in North America; (iv) the institution of slavery in the United States, including historical perspectives of the enslaved; and (v) how African Americans helped shape and have been shaped by American society.

b. World history.

(1) The political, philosophical, and cultural legacies of ancient American, Asian, African, and European civilizations;

(2) The origins, ideas, and institutions of Judaism, Christianity, Hinduism, Confucianism and Taoism, and Shinto, Buddhist, and Islamic religious traditions;

(3) Medieval society, institutions, and civilizations; feudalism; and the evolution of representative government;

(4) The social, political, cultural, and economic innovations of selected civilizations in Africa, Asia, Europe, and the Americas;

(5) The ideas of the Renaissance and the Reformation, European exploration, and the origins of capitalism and colonization;

(6) The cultural ideas of the Enlightenment and the intellectual and political revolution of the 17th and 18th centuries;

(7) The sources, results, and influences of the American, French, and Latin American revolutions;

(8) The social and economic consequences of the Industrial Revolution and its impact on politics, culture, and the lives of everyday people;

(9) The influence of global ideologies of the 19th and 20th centuries;

(10) The origins, effects, aftermath, and significance of the two world wars, the Korean and Vietnam conflicts, and the post-Cold War era; and

(11) The development of globalization and the growing interdependence and inter-relationship among countries and cultures in the world.

c. Civics, government, and economics.

(1) The essential characteristics of governments;

(2) The importance of the rule of law for the protection of individual rights and the common good;

(3) The rights and responsibilities of American citizenship;

(4) The nature and purposes of constitutions and alternative ways of organizing constitutional governments;

(5) American political culture;

(6) Principles of the American constitutional republic;

(7) The idea of federalism and states' rights;

(8) The structures, functions, and powers of local and state government;

(9) Importance of citizen participation in the political process in local and state government;

(10) Local government and civics instruction specific to Virginia;

(11) The structures, functions, and powers of the national government;

(12) The role of the United States government in foreign policy and national security;

(13) The structure and role of the local, state, and federal judiciary;

(14) The structure and function of the United States market economy as compared with other economies;

(15) Knowledge of the impact of the government role in the economy and individual economic and political freedoms;

(16) Knowledge of economic systems in the areas of productivity and key economic indicators;

(17) The analysis of global economic trends; and

(18) Knowledge of international organizations, both political and economic, such as the United Nations, International Court in the Hague, and the International Monetary Fund.

d. Geography.

(1) Relationship between human activity and the physical environment, the ways in which geography governs human activity, and the effects of human activity on geographic features;

(2) Use of maps and other geographic representations, tools, and technologies to acquire, process, and report information;

(3) Physical and human characteristics of places;

(4) Physical processes that shape the surface of the earth;

(5) Characteristics, distribution, and migration of human populations;

(6) Patterns and networks of economic interdependence;

(7) Processes, patterns, and functions of human settlement;

(8) How the forces of conflict and cooperation influence the division and control of the earth's surface;

(9) Changes that occur in the meaning, use, distribution, and importance of resources;

(10) Applying geography to interpret the past and the present and to plan for the future; and

(11) Impact of geospatial technologies on the study of geography, physical and human.

2. Understanding of history and social sciences to appreciate the significance of:

a. Diverse cultures and shared humanity;

b. How things happen, how they change, and how human intervention matters;

c. The interplay of change and continuity;

d. How people in other times and places have struggled with fundamental questions of truth, justice, and personal responsibility;

e. The importance of individuals and groups who have made a difference in history and the significance of personal character to the future of society;

f. The relationship among history, geography, civics, and economics;

g. The difference between fact and conjecture, evidence and assertion, and the importance of framing useful questions;

h. How ideas have real consequences; and

i. The importance of primary documents and the potential problems with second-hand accounts.

3. Understanding of the use of the content and processes of history and social sciences instruction, including:

a. Fluency in historical thinking and geographic analysis skills;

b. Skill in debate, discussion, and persuasive writing;

c. The ability to organize key social science content into meaningful units of instruction based on historical thinking skills;

d. The ability to provide instruction using a variety of instructional techniques;

e. The ability to evaluate primary and secondary instructional resources, instruction, and student achievement;

f. The ability to incorporate appropriate technologies into social science instruction; and

g. The development of digital literacy skills while recognizing the influence of the media.

4. Understanding of the content, processes, and skills of one of the social sciences disciplines at a level equivalent to an undergraduate major, along with proficient understanding of supporting disciplines to ensure:

a. The ability to teach the processes and organizing concepts of social science;

b. An understanding of the significance of the social sciences; and

c. Student achievement in the social sciences.

5. Understanding of and proficiency in grammar, usage, and mechanics and their integration in writing and communications.

6. Understanding of and proficiency in pedagogy to incorporate writing as an instructional and assessment tool for candidates to generate, gather, plan, organize, and present ideas in writing to communicate for a variety of purposes.

7. Skills necessary to teach research including use of primary and secondary sources, ethical accessing, evaluating, organizing, crediting, and synthesizing information.

8VAC20-543-570. Administration and supervision preK-12.

A. The program in administration and supervision preK-12 shall ensure that the candidate has completed three years of successful, full-time experience in a public school or accredited nonpublic school in an instructional personnel position that requires licensure in Virginia and demonstrated the following competencies:

1. Knowledge, understanding, and application of planning, assessment, and instructional leadership that builds collective professional capacity, including;

a. Principles of student motivation, growth, and development as a foundation for age-appropriate and grade-appropriate curriculum, instruction, and assessment;

b. Collaborative leadership in gathering and analyzing data to identify needs to develop and implement a school improvement plan that results in increased student learning;

c. Planning, implementation, and refinement of standards-based curriculum aligned with instruction and assessment;

d. Collaborative planning and implementation of a variety of assessment techniques, including examination of student work, that yield individual, class, grade level, and school level data as a foundation for identifying existing competencies and targeting areas in need of further attention;

e. Incorporation of differentiated and effective instruction that responds to individual learner needs including appropriate response to cultural, ethnic, and linguistic diversity;

f. Knowledge, understanding, and application of the federal and state regulatory requirements~~,~~ and expectations associated with identification, education, and evaluation of students with disabilities; comprehension of (i) key special education laws and regulations; (ii) individualized education program development; (iii) the roles and responsibilities of special education teachers; and (iv) appropriate behavior management practices;

g. Collaboratively working with parents and school personnel to ensure that students with disabilities are included as a valued part of the school community, and that they receive effective and appropriately intensive instruction to assist them in meeting the standards set for all students, as well as individual goals outlined in their individualized education plans (IEPs);

h. Integration of technology in curriculum and instruction to enhance learner understanding;

i. Identification, analysis, and resolution of problems using effective problem-solving techniques; and

j. Development, articulation, implementation, and stewardship of a vision of excellence linked to mission and core beliefs that promote continuous improvement consistent with the goals of the school division.

2. Knowledge, understanding, and application of leadership and organizations, including;

a. The change process of systems, organizations, and individuals using appropriate and effective adult learning models;

b. Aligning organizational practice, division mission, and core beliefs for developing and implementing strategic plans;

c. Information sources and processing, including data collection and data analysis strategies;

d. Using data as a part of ongoing program evaluation to inform and lead change;

e. Developing a change management strategy for improved student outcomes;

f. Developing distributed leadership strategies to create personalized learning environments for diverse schools; and

g. Effective two-way communication skills including consensus building, negotiation, and mediation skills.

3. Knowledge, understanding, and application of management and leadership skills that achieve effective and efficient organizational operations and sustain an instructional program conducive to student academic progress, including;

a. Alignment of curriculum and instruction and assessment of the educational program to achieve high academic success at the school and division or district level;

b. Principles and issues of supervising and leading others to ensure a working and learning climate that is safe, secure, and respectful of a diverse school community;

c. Management decisions that ensure successful teaching and learning including human resources management and development, theories of motivation, change in school culture, innovation and creativity, conflict resolution, adult learning, and professional development models;

d. Knowledge, understanding, and application of Virginia's Guidelines for Uniform Performance Standards and Evaluation Criteria for Teachers and the Guidelines for Uniform Performance Standards and Evaluation Criteria for Principals;

e. Principles and issues related to fiscal operations of school management;

f. Principles and issues related to school facilities and use of space and time for supporting high-quality school instruction and student learning;

g. Legal issues impacting school operations and management;

h. Technologies that support management functions; and

i. Application of data-driven decision-making to initiate and continue improvement in school and classroom practices and student achievement.

4. Knowledge, understanding, and application of the conditions and dynamics impacting a diverse school community, including:

a. Emerging issues and trends within school and community relations;

b. Working collaboratively with staff, families, and community members to secure resources and to support the success of a diverse population;

c. Developing appropriate public relations and public engagement strategies and processes for building and sustaining positive relationships with families, caregivers, and community partners; and

d. Integration of technology to support communication efforts.

5. Knowledge, understanding, and application of the purpose of education and the role of professionalism in advancing educational goals, including:

a. Philosophy of education that reflects commitment to principles of honesty, fairness, caring, and equity in day-to-day professional behavior;

b. Integration of high quality, content rich, job-embedded professional learning that respects the contribution of all faculty and staff members in building a diverse professional learning community;

c. Reflective understanding of potential moral and legal consequences of decision-making in the school setting;

d. Intentional and purposeful effort to model professional, moral, and ethical standards, as well as personal integrity in all interactions; and

e. Intentional and purposeful effort to model continuous professional learning and to work collegially and collaboratively with all members of the school community to support the school's goals and enhance its collective capacity.

6. Knowledge, understanding, and application of basic leadership theories and influences that impact schools including:

a. Concepts of leadership including systems theory, change theory, learning organizations, and current leadership theory;

b. Ability to identify and respond to internal and external forces and influences on a school;

c. Ability to identify and apply the processes of educational policy development at the state, local, and school level; and

d. Ability to identify and demonstrate ways to influence educational policy development at the state, local, and school level.

B. Complete a deliberately structured and supervised internship that is focused on student academic progress for all students and

1. Provides significant experiences within a school environment for candidates to synthesize and apply the content knowledge and develop professional skills through school-based leadership experiences;

2. Shall occur in a public or accredited nonpublic school;

3. Provides exposure to five different multiple sites, including elementary, middle, high, central office, and agency with diverse student populations; and

4. Documents a minimum of 320 clock hours of administration and supervision internship, of which at least 120 clock hours are embedded as experiential field-based opportunities experienced during coursework.

C. Satisfy the requirements for the school leaders licensure assessment prescribed by the Board of Education. Individuals seeking an initial administration and supervision endorsement who are interested in serving as central office instructional personnel are not required to take and pass the school leaders assessment prescribed by the Board of Education.

VA.R. Doc. No. R22-6895; Filed January 10, 2022, 12:47 p.m.

Proposed Regulation

Title of Regulation: **8VAC20-543. Regulations Governing the Review and Approval of Education Programs in Virginia (amending 8VAC20-543-90; adding 8VAC20-543-275 through 8VAC20-543-279).**

Statutory Authority: §§ 22.1-16 and 22.1-298.2 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: April 1, 2022.

Agency Contact: Tara McDaniel, Director of Teacher Education, Department of Education, James Monroe Building,

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Basis: Section 22.1-16 of the Code of Virginia gives the State Board of Education authority to promulgate regulations to carry out its statutory powers and duties. Pursuant to the § 22.1-298.2 of the Code of Virginia, the board has the authority to prescribe by regulation the requirements for accreditation and approval of education preparation programs. Section 22.1-200.03 of the Code of Virginia requires the board to develop and approve objectives for economics education and financial literacy to be required of all students at the middle and high school levels.

Purpose: The regulatory action is to establish an add-on endorsement to teach economics and personal finance. The add-on endorsement will expand the number of teachers who may teach economics and personal finance and ensure that such teachers have completing training in economics and personal finance. Students who gain knowledge and skills in economics and personal finance are more productive citizens in society.

The regulatory action also establishes endorsements in dual language so that individuals who had expertise in elementary education or world languages can teach in dual language programs and seek a specific endorsement addressing the area in which they are teaching. This will allow someone who has world language preparation to teach in an elementary dual language program without seeking both a world language endorsement and an elementary endorsement.

Substance: The substantive provision is the addition of the add-on endorsement in economics and personal finance to provide assurances that teachers instructing the courses have preparation in economics and personal finance. The amendments also include the following plan related to the implementation of the new add-on endorsement. Upon the effective date of the establishment of the economics and personal finance endorsement, individuals who hold a teaching license may be eligible for the economics and personal finance add-on endorsement if the individual completed one year of successful teaching experience in Virginia as the teacher of record in economics and personal finance prior to the effective date of this endorsement and receives the recommendation from the Virginia school division superintendent where the individual is employed at the time of the request. Individuals who are teaching in Virginia public schools and meet grandfathering requirements will receive the economics and personal finance endorsement at no additional cost. The $50 fee to apply for an additional endorsement would be waived because these individuals currently may teach economics and personal finance with the endorsements on their license. A transition period of two years should be implemented from the effective date of the endorsement for individuals to complete the requirements to add the endorsement. As of the effective date of the endorsement, those currently teaching the course and those receiving the endorsement through grandfathering, will be endorsed to teach the course.

The amendments also make revisions to professional studies requirements and add the following new endorsements:

Professional Studies Requirements for Dual Language, Dual Language (English) Endorsement PreK-6, Dual Language English PreK-6 Add-on Endorsement, Dual Language Target Language Endorsement PreK-6, Dual Language Target Language PreK-6 Add-on Endorsement.

Issues: The advantages include that by requiring teachers to obtain training in economics and personal finance will better prepare them to teach courses in economics and personal finance to students who take the course. Experienced teachers who have been teaching the course, as specified by the board, may be recommended for the add-on endorsement by the employing school division superintendent. The advantages of the endorsements allow additional options for individuals seeking endorsements to teach elementary dual language classes.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Education (Board) proposes to amend the Regulations Governing the Review and Approval of Education Programs in Virginia in order to establish an add-on endorsement[1] to teach economics and personal finance, as well as endorsements and add-on endorsements to teach in dual language instruction in pre-kindergarten through grade six (preK-6). These proposed amendments to the regulations governing teacher education programs would complement concurrent actions that amend the regulations governing teacher licensure.

Background. The Licensure Regulations for School Personnel (Licensure Regulations) include teacher licensure endorsements (and add-on endorsements) to teach in various specified fields.[2] The requirements for each specified field typically state that to earn the particular endorsement, the teacher must either complete an approved teacher preparation program in the specified field, or alternatively complete coursework or training that is spelled out in the Licensure Regulations. In two other concurrent actions, the Board is proposing to amend the Licensure Regulations to add the Economics and Personal Finance Add-on Endorsement (Action 5233)[3] and also add endorsements and add-on endorsements in dual language instruction in pre-kindergarten through grade six (Action 5258).[4]

In the action addressed in this analysis, the Board proposes to establish in the Regulations Governing the Review and Approval of Education Programs in Virginia the requirements for teacher preparation programs at colleges and universities for those same endorsements.

Economics and Personal Finance. In order to earn a Standard or Advanced Studies Diploma, public high school students

must pass a course on economics and personal finance. Currently, there is no specific endorsement to teach courses in economics and personal finance in either the Licensure Regulations or in the Regulations Governing the Review and Approval of Education Programs in Virginia. According to the Department of Education (DOE), teachers holding valid Virginia licenses with endorsements in specific areas of agricultural education, business and information technology, family and consumer sciences, history and social science, marketing, and mathematics may teach the courses.[5]

The proposed requirements for the Economics and Personal Finance Add-on Endorsement in the Regulations Governing the Review and Approval of Education Programs in Virginia are as follows:

"The program in Economics and Personal Finance shall ensure that the candidate holds an active license (Collegiate Professional License, Postgraduate Professional License, or a Provisional License leading to a Collegiate Professional or Postgraduate Professional License) with a teaching endorsement or endorsements issued by the Virginia Board of Education and has demonstrated the following competencies:

1. Understanding and demonstration of the required knowledge, skills, and processes to support learners in achievement of the Economics and Personal Finance Virginia Standards of Learning, including:

a. integration of economic concepts and structures, including how consumers, businesses and governments face scarcity of resources and make trade-offs and incur opportunity costs;

b. role of producers and consumers in a market economy including response to incentives, the role of entrepreneurs and how costs and revenues affect profit and supply;

c. the price system;

d. factors that affect income;

e. nation's economic goals, including full employment, stable prices, and economic growth;

f. nation's financial system;

g. monetary and fiscal policy;

h. role of government in a market economy;

i. global economy including trade and comparative advantage;

j. consumer skills;

k. planning for living and leisure expenses;

l. banking transactions;

m. credit and loan functions;

n. role of insurance in risk management;

o. income earning, taxes, and reporting;

p. personal financial planning;

q. investment and savings planning;

r. financing postsecondary education (including the Free Application for Federal Student Aid); and

2. Understanding and knowledge of teaching in an online or blended learning environment.

The proposed text does not specify the course structure, number of courses, or time to be spent on the competencies."

Further, the proposed amendments in this action (as well as Action 5233) do not specify whether or not the Economics and Personal Finance Add-on Endorsement would be required for teaching courses in economics and personal finance. According to DOE, however, two years after the effective date of Action 5233, the endorsement would be required to teach the courses.[6] Also according to DOE, there would be a grandfathering exception such that upon the effective date of Action 5233, individuals who hold a teaching license (Collegiate Professional, Postgraduate Professional License, or a Provisional License leading to a Collegiate Professional or Postgraduate Professional License) may be eligible for the economics and personal finance add-on endorsement if the individual:

completed one year of successful teaching experience (satisfactory performance rating on summative evaluation) in Virginia as the teacher of record in economics and personal finance prior to the effective date of this endorsement; and

receives the recommendation from the Virginia school division superintendent where the individual is employed at the time of the request.

Dual Language. Chapter 391 of the 2018 Acts of Assembly[7] requires that the Board "provide for licensure of teachers with an endorsement in dual language instruction pre-kindergarten through grade six." The legislation defines "dual language instruction" as "instruction that is delivered in English and in a second language." There are currently elementary school dual language programs in ten school divisions.[8] According to DOE, other school divisions have expressed interest in adding such programs.

Currently, in order to teach in an elementary school dual language program in a foreign language, the teacher must have endorsements in both the foreign language and elementary education. In contrast, teaching in an elementary school dual language program in English only requires the elementary education endorsement. The Board proposes to establish separate endorsements for dual language instruction in pre-kindergarten through grade six in the "target language" and in English, where the target language would be a foreign language (such as Spanish, French, etc.) as noted on the endorsement.

The Board also proposes to establish separate add-on endorsements for dual language instruction in pre-kindergarten through grade six, in both the target language and in English. An add-on endorsement, only available for some fields, can be

earned when a teacher already has at least one other endorsement. Add-on endorsements are not available for the majority of fields. For example, foreign languages and elementary education do not have add-on endorsements. The proposed dual language add-on endorsements include fewer competencies than the comparable proposed dual language endorsements since it is presumed that skills required for teaching across different fields would be covered in in the initial endorsement for someone obtaining an add-on endorsement.

The proposed requirements for the Dual Language (Target Language) preK-6 Add-on Endorsement in the Regulations Governing the Review and Approval of Education Programs in Virginia include several specific elements that programs must meet, such as holding an active teaching license with an endorsement in the Target Language, completion of a 45-clock-hour practicum in dual language (Target Language),[9] eight listed competencies that the candidate must demonstrate, and either passing the rigorous elementary education assessment prescribed by the Board or completion of math, laboratory science, history and social science courses (including methods of teaching the specific subjects).

The proposed requirements for the Dual Language (English) PreK-6 Add-on Endorsement in the Regulations Governing the Review and Approval of Education Programs in Virginia include several specific elements that programs must meet, such as holding an active teaching license with an elementary education endorsement, completion of a 45-clock-hour practicum in dual language (English),[10] and eight listed competencies that the candidate must demonstrate.

Estimated Benefits and Costs Economics and Personal Finance. Though the proposed text for the establishment of the Economics and Personal Finance Add-on Endorsement does not directly affect who may teach economics and personal finance courses, as stated above, DOE has indicated that the endorsement would effectively be required to teach such courses two years after the effective date of Action 5233.

Colleges and universities that wish to develop an add-on endorsement program in economics and personal finance would have the discretion to design it as they wish concerning number of courses and credits, as long as all of the proposed required competency topics are covered. The program would be subject to Board approval.[11] The proposed alternative route of obtaining the Economics and Personal Finance Add-on Endorsement in Action 5233 would require six semester hours of economics[12] and three semester hours of personal finance.[13]

Notwithstanding those who would be grandfathered in, earning the Economics and Personal Finance (Add-on Endorsement) would provide much greater assurance that future teachers of economics and personal finance courses would be knowledgeable in the subject matter that they are teaching. This in turn would likely have a positive impact on students obtaining and retaining economics and personal finance knowledge and skills, perhaps positively affecting their productivity, job prospects, and personal finances.

Dual Language (Target Language). As alluded to in the Background section, currently a teacher with a foreign language endorsement would have to also obtain an elementary education endorsement to teach in an elementary school dual language program in the foreign language. Once the Dual Language (Target Language) PreK-6 Add-on Endorsement is established, a teacher with a foreign language endorsement could qualify to teach in an elementary school dual language program in the foreign language by either obtaining the Dual Language (Target Language) PreK-6 Add-on Endorsement or the elementary education endorsement.

Colleges and universities have much discretion in how they structure their elementary education endorsement programs. All of the competencies must be covered, and the Board must approve the program, but there are no set number of courses or credits required for these programs in the Regulations Governing the Review and Approval of Education Programs in Virginia. Thus, a direct comparison of the number of courses or credits in elementary education endorsement programs versus Dual Language (Target Language) PreK-6 Add-on Endorsement programs cannot be made; but as would be expected when comparing an add-on endorsement to an endorsement, the list of proposed required competencies is considerably shorter for the Dual Language (Target Language) PreK-6 Add-on Endorsement. DOE has indicated that the agency would expect that approved Dual Language (Target Language) PreK-6 Add-on Endorsement programs developed by colleges would entail fewer courses and less time to complete than would elementary education endorsement programs.

Thus, the proposed Dual Language (Target Language) PreK-6 Add-on Endorsement would likely reduce the cost for a teacher with a foreign language endorsement to teach in an elementary school dual language program in the foreign language. This reduced cost may make it easier for school districts to find qualified teachers to teach in existing or planned elementary school dual language programs.

Dual Language (English). Individuals who hold a valid Virginia teaching license with an elementary education endorsement may t each in an elementary school dual language program in English without the proposed Dual Language (English) Endorsement or Add-on Endorsement. The proposed Dual Language (English) PreK-6 Add-on Endorsement has a prerequisite of an endorsement in elementary education. So the establishment of the Dual Language (English) PreK-6 Add-on Endorsement does not reduce the cost of becoming qualified to teach in an elementary school dual language program in English. Nevertheless, as it contains dual language specific content, it could be useful for teachers who wish to distinguish themselves as candidates for teaching positions (in English) in an elementary school dual language program.

Businesses and Other Entities Affected. Virginia colleges and universities with approved educator preparation programs would be affected if they are interested in adding one or more of the proposed endorsements. The Virginia colleges and universities with approved educator preparation programs are: Averett University, Bluefield College, Bridgewater College, Christopher Newport University, Eastern Mennonite University, Emory and Henry College, Ferrum College, George Mason University, Hampton University, Hollins University, James Madison University, Liberty University, Longwood University, Mary Baldwin University, Marymount University, Norfolk State University, Old Dominion University, Radford University, Randolph College, Randolph-Macon College, Regent University, Roanoke College, Shenandoah University, Southern Virginia University,[14] Sweet Briar College, University of Lynchburg, University of Mary Washington, University of Richmond, University of Virginia, University of Virginia's College at Wise, Virginia Commonwealth University, Virginia State University, Virginia Tech, Virginia Union University, Virginia Wesleyan University, Washington and Lee University,[15] and William & Mary.

The 132 local public school divisions in the Commonwealth would be affected as well.

Small Businesses[16] Affected. The proposed amendments do not appear to adversely affect small businesses.

Localities[17] Affected.[18] All Virginia localities would be affected by the proposed Economics and Personal Finance Add-on Endorsement. Albemarle, Alexandria, Arlington, Chesterfield, Fairfax County, Harrisonburg, Newport News, Stafford, Winchester, and Virginia Beach would be particularly affected by the proposed dual language add-on endorsements and endorsements as these localities have school divisions with elementary school dual language programs. Localities considering adding elementary school dual language programs would also be particularly affected. The proposed amendments would not increase costs for local governments.

Projected Impact on Employment. To the extent that colleges and universities choose to establish some or all of the proposed new endorsements, there would likely be some additional positions created to teach and administer the new endorsement programs.

Effects on the Use and Value of Private Property. Some private colleges and universities with approved educator preparation programs may choose to add an Economics and Personal Finance Add-on Endorsement program and/or dual language add-on endorsement and endorsement programs.

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[1]An add-on endorsement, only available for some fields, can be earned when a teacher already has at least one other endorsement.

[2]See https://law.lis.virginia.gov/admincode/title8/agency20/chapter23/

[3]See https://townhall.virginia.gov/L/ViewAction.cfm?actionid=5233

[4]See https://townhall.virginia.gov/L/ViewAction.cfm?actionid=5258

[5]See https://www.doe.virginia.gov/instruction/economics_personal_finance/resources/faq.shtml

[6]DOE stated that this requirement would be established through a Superintendent's Memo and possibly further regulatory action.

[7]See https://lis.virginia.gov/cgi-bin/legp604.exe?181+ful+CHAP0391

[8]The 10 school divisions are Albemarle, Alexandria, Arlington, Chesterfield, Fairfax County, Harrisonburg, Newport News, Stafford, Winchester, and Virginia Beach.

[9]One year of successful, full-time teaching experience in a public school or accredited nonpublic school in dual language (Target Language) may be accepted in lieu of the practicum.

[10]One year of successful, full-time teaching experience in a public school or accredited nonpublic school in dual language (English) may be accepted in lieu of the practicum.

[11]See https://law.lis.virginia.gov/admincodefull/title8/agency20/chapter543/partIII/

[12]The proposed text also allows the following in lieu of the six semester hours of economics: "or a non-college credit institute in economics. The non-college credit institute in economics must be a minimum of 45 clock hours and offered by a Virginia school division or a regionally accredited college or university. The institute must include the economics content set forth in the Virginia Standards of Learning for economics and personal finance and be approved by the Department of Education."

[13]The proposed text also allows the following in lieu of the three semester hours of personal finance: "or a non-college credit institute in finance. The non-college credit institution in finance must be a minimum of 45 clock hours and offered by a Virginia school division or a regionally accredited college or university. The institute must include the personal finance content set forth in the Standards of Learning for economics and personal finance and be approved by the Department of Education."

[14]Washington and Lee University and Southern Virginia University have partnered to form the Rockbridge Teacher Education Consortium. See https://columns.wlu.edu/rockbridge-county-universities-form-teacher-education-consortium/

[15]Ibid

[16]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."

[17]"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.

[18]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

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

Summary:

The proposed regulatory action (i) establishes dual language endorsements and an economics and personal finance add-on endorsement and (ii) prescribes how teachers will qualify for the endorsements.

8VAC20-543-90. Professional studies requirements for early/primary education, elementary education, dual language, and middle education.

Professional studies requirements for early/primary education, elementary education, dual language, and middle education:

1. Human development and learning (birth through adolescence).

a. Skills in this area shall contribute to an understanding of the physical, social, emotional, speech and language, and intellectual development of children and the ability to use this understanding in guiding learning experiences and relating meaningfully to students.

b. The interaction of children with individual differences - economic, social, racial, ethnic, religious, physical, and cognitive - should be incorporated to include skills contributing to an understanding of developmental disabilities and developmental issues related, but not limited to, low socioeconomic status; attention deficit disorders; developmental disorders; gifted education, including the use of multiple criteria to identify gifted students; substance abuse; trauma, including child abuse, and neglect and other adverse childhood experiences; and family disruptions.

2. Curriculum and instruction.

a. Early/primary education preK-3 or elementary education preK-6 curriculum and instruction.

(1) Skills in this area shall contribute to an understanding of the principles of learning; the application of skills in discipline-specific methodology; varied and effective methods of communication with and among students; selection and use of materials, including media and contemporary technologies; and selection, development, and use of appropriate curricula, methodologies, and materials that support and enhance student learning and reflect the research on unique, age-appropriate, and culturally relevant curriculum and pedagogy.

(2) Understanding of the principles of online learning and online instructional strategies and the application of skills to deliver online instruction shall be included.

(3) Instructional practices that are sensitive to culturally and linguistically diverse learners, including English learners, gifted and talented students, and students with disabilities; and appropriate for the level of endorsement (preK-3 or preK-6) sought shall be included.

(4) Teaching methods shall be tailored to promote student engagement and student academic progress and effective preparation for the Virginia Standards of Learning assessments.

(5) Study in (i) methods of improving communication between schools and families~~,~~; (ii) communicating with families regarding social and instructional needs of children~~,~~; (iii) ways of increasing family engagement in student learning at home and in school~~,~~; (iv) the Virginia Standards of Learning~~, and~~; (v) English Language Development Standards (WIDA); and (vi) Virginia Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, prepared by the ~~department's~~ Virginia Department of Education's Office of ~~Humanities and~~ Early Childhood shall be included.

(6) Early childhood educators must understand the role of families in child development and in relation to teaching educational skills.

(7) Early childhood educators must understand the role of the informal and play-mediated settings for promoting students' skills and development and must demonstrate knowledge and skill in interacting in such situations to promote specific learning outcomes as reflected in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards.

(8) Demonstrated proficiency in the use of educational technology for instruction shall be included. Study in child abuse recognition and intervention in accordance with curriculum guidelines developed by the Virginia Board of Education in consultation with the Virginia Department of Social Services and training or certification in emergency first aid, cardiopulmonary resuscitation, and the use of automated external defibrillators must be included.

(9) Pre-student teaching experiences (field experiences) should be evident within these skills.

b. Dual language preK-6 curriculum and instruction.

(1) Skills in this area shall contribute to an understanding of the principles of learning; dual language acquisition; theories of second language acquisition; the application of skills in discipline-specific methodology; varied and effective methods of communication with and among students; selection and use of materials, including media and contemporary technologies; and selection, development, and use of appropriate curricula, methodologies, and materials that support and enhance student learning and reflect the research on unique, age-appropriate, and culturally relevant curriculum and pedagogy.

(2) Understanding of the principles of online learning and online instructional strategies and the application of skills to deliver online instruction shall be included.

(3) Instructional practices that are sensitive to culturally and linguistically diverse learners, including English learners, gifted and talented students, and students with disabilities, and appropriate for the preK-3 or preK-6 endorsement shall be included.

(4) Teaching methods shall be tailored to promote student engagement and student academic progress and effective preparation for the Virginia Standards of Learning assessments.

(5) Study in (i) methods of improving communication between schools and families; (ii) communicating with families regarding social and instructional needs of children; (iii) ways of increasing family engagement in student learning at home and in school; (iv) the Virginia

Standards of Learning; and (v) Virginia Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, prepared by the Virginia Department of Education's Office of Early Childhood shall be included.

(6) Early childhood educators shall understand the role of families in child development and in relation to teaching educational skills.

(7) Early childhood educators shall understand the role of the informal and play-mediated settings for promoting students' skills and development and shall demonstrate knowledge and skill in interacting in such situations to promote specific learning outcomes as reflected in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards.

(8) Demonstrated proficiency in the use of educational technology for instruction shall be required.

(9) Pre-student teaching experiences (field experiences) should be evident within these skills.

c. Middle education ~~6 8~~ six to eight curriculum and instruction.

(1) Skills in this area shall contribute to an understanding of the principles of learning; the application of skills in discipline-specific methodology; effective communication with and among students~~,~~; selection and use of materials, including media and contemporary technologies~~,~~; and evaluation of pupil performance.

(2) Understanding of the principles of online learning and online instructional strategies and the application of skills to deliver online instruction shall be included.

(3) Instructional practices that are sensitive to culturally and linguistically diverse learners including English learners, gifted and talented students, and students with disabilities, and must be appropriate for the middle education endorsement shall be included.

(4) Teaching methods shall be tailored to promote student engagement and student academic progress and effective preparation for the Virginia Standards of Learning assessments.

(5) Study in methods of improving communication between schools and families, ways of increasing family engagement in student learning at home and in school, and the Virginia Standards of Learning shall be included.

(6) Demonstrated proficiency in the use of educational technology for instruction shall be included. Study in child abuse recognition and intervention in accordance with curriculum guidelines developed by the Virginia Board of Education in consultation with the Virginia Department of Social Services and training or certification in emergency first aid cardiopulpmonary resuscitation and the use of automatic external defibrillators shall be included.

(7) Pre-student teaching experiences (field experiences) should be evident within these skills.

3. Classroom and behavior management. Skills in this area shall contribute to an understanding and application of research-based classroom and behavior management techniques, classroom community building, positive behavior supports, and individual interventions, including techniques that promote emotional well-being and teach and maintain behavioral conduct and skills consistent with norms, standards, and rules of the educational environment. This area shall address diverse approaches based upon culturally responsive behavioral, cognitive, affective, social, and ecological theory and practice. Approaches should support professionally appropriate practices that promote positive redirection of behavior, development of social skills, and development of self-discipline. Knowledge and an understanding of various school crisis management and safety plans and the demonstrated ability to create a safe, orderly classroom environment shall be included. The link between classroom management and students' ages must be understood and demonstrated in techniques used in the classroom.

4. Assessment of and for learning.

a. Skills in this area shall be designed to develop an understanding and application of creating, selecting, and implementing valid and reliable classroom-based assessments of student learning, including formative and summative assessments. Assessments designed and adapted to meet the needs of diverse learners shall be addressed.

b. Analytical skills necessary to inform ongoing planning and instruction, as well as to understand, and help students understand their own progress and growth shall be included.

c. Skills also include the ability to understand the relationships among assessment, instruction, and monitoring student progress to include student performance measures in grading practices; the ability to interpret valid assessments using a variety of formats in order to measure student attainment of essential skills in a standards-based environment; and the ability to analyze assessment data to make decisions about how to improve instruction and student performance.

d. Understanding of state assessment programs and accountability systems, including assessments used for student achievement goal setting as related to teacher evaluation and determining student academic progress must be included.

e. Knowledge of legal and ethical aspects, and skills for developing familiarity with assessments used in preK-12 education (including diagnostic, college admission exams, industry certifications, placement assessments).

5. Foundations of education and the teaching profession.

a. Skills in this area shall be designed to develop an understanding of the historical, philosophical, and sociological foundations underlying the role, development, and organization of public education in the United States.

b. Attention must be given to the legal status of teachers and students, including federal and state laws and regulations; school as an organization and culture; and contemporary issues and current trends in education, including the impact of technology on education. Local, state, and federal governance of schools, including the roles of teachers and schools in communities, shall be included.

c. Professionalism and ethical standards, as well as personal integrity shall be addressed.

d. Knowledge and understanding of Virginia's Guidelines for Uniform Performance Standards and Evaluation Criteria for Teachers shall be included.

6. Language and ~~Literacy~~ literacy.

a. Early/primary education preK-3 and elementary education preK-6 language acquisition and reading and writing. Skills listed for these endorsement areas represent the minimum competencies that a beginning teacher must be able to demonstrate. These skills are not intended to limit the scope of a beginning teacher's program. Additional knowledge and skills that add to a beginning teacher's competencies to deliver instruction and improve student achievement should be included as part of a quality learning experience.

(1) ~~Language acquisition:~~ Skills in ~~this area~~ language acquisition shall be designed to impart a thorough understanding of the Virginia English Standards of Learning, as well as the complex nature of language acquisition as a precursor to literacy. Language acquisition shall follow the typical development of linguistic competence in the areas of phonetics, semantics, syntax, morphology, phonology, and pragmatics.

(2) ~~Reading and writing:~~ Skills in ~~this area~~ reading and writing shall be designed to impart a thorough understanding of the Virginia English Standards of Learning, as well as the reciprocal nature of reading and writing. Reading shall include phonemic and other phonological awareness, concept of print, phonics, fluency, vocabulary development, and comprehension strategies. Writing shall include writing strategies and conventions as supporting the composing and written expression and usage and mechanics domains. Additional skills shall include proficiency in understanding the stages of spelling development, and the writing process, as well as the ability to foster appreciation of a variety of fiction and nonfiction text and independent reading.

b. Dual language (English) preK-6 language acquisition and reading and writing. Skills listed for these endorsement areas represent the minimum competencies that a beginning teacher shall be able to demonstrate. These skills are not intended to limit the scope of a beginning teacher's program. Additional knowledge and skills that add to a beginning teacher's competencies to deliver instruction and improve student achievement should be included as part of a quality learning experience.

(1) Skills in language acquisition shall be designed to impart a thorough understanding of the Virginia English Standards of Learning, as well as the complex nature of language acquisition as a precursor to literacy. Language acquisition shall follow the typical development of linguistic competence in the areas of phonetics, semantics, syntax, morphology, phonology, and pragmatics.

(2) Skills in literacy development (reading and writing) shall be designed to impart a thorough understanding of strategies for integration of content, literacy, and language development, researched-based strategies for differentiating instruction for language development; and language and cognitive support or scaffolding bases on the various strategies of the language and literacy acquisition process. Skills in this area shall be designed to impart a thorough understanding of the Virginia English Standards of Learning, as well as the reciprocal nature of reading and writing. Reading shall include phonemic and other phonological awareness, concept of print, phonics, fluency, vocabulary development, and comprehension strategies. Writing shall include writing strategies and conventions as supporting composing and written expression and usage and mechanics domains. Additional skills shall include proficiency in understanding the stages of spelling development and the writing process, as well as the ability to foster appreciation of a variety of fiction and nonfiction texts and independent reading.

c. Dual language (target language) preK-6 language acquisition and bilingual literacy development. Skills listed for these endorsement areas represent the minimum competencies that a beginning teacher shall be able to demonstrate. These skills are not intended to limit the scope of a beginning teacher's program. Additional knowledge and skills that add to a beginning teacher's competencies to deliver instruction and improve student achievement should be included as part of a quality learning experience.

(1) Skills in language acquisition shall be designed to impart a thorough understanding of the Virginia English Standards of Learning, as well as the complex nature of language acquisition as a precursor to literacy. Language acquisition shall follow the typical development of linguistic competence in the areas of phonetics, semantics, syntax, morphology, phonology, and pragmatics.

(2) Skills in bilingual literacy development shall be designed to impart a thorough understanding of strategies for integration of content, literacy, and language development, researched-based strategies for differentiating instruction for dual language; and language and cognitive support or scaffolding bases on the various strategies of the second language acquisition process. Reading shall include phonemic and other phonological awareness, concept of print, phonics, fluency, vocabulary development, and comprehension strategies. Writing shall include writing strategies and conventions as supporting composing and written expression and usage and mechanics domains. Additional skills shall include proficiency in understanding the stages of spelling development and the writing process, as well as the ability to foster appreciation of a variety of fiction and nonfiction texts and independent reading.

d. Middle education - language acquisition and reading development and literacy in the content areas.

(1) ~~Language acquisition and reading development:~~ Skills in ~~this area~~ language acquisition and reading development shall be designed to impart a thorough understanding of the complex nature of language acquisition and reading, to include phonemic and other phonological awareness, phonics, fluency, vocabulary development, and comprehension strategies for adolescent learners. Additional skills shall include proficiency in writing strategies, as well as the ability to foster appreciation of a variety of fiction and nonfiction text and independent reading for adolescent learners.

(2) ~~Literacy in the content areas:~~ Skills in ~~this area~~ literacy in the content areas shall be designed to impart an understanding of vocabulary development and comprehension skills in areas of English, mathematics, science, history and social science, and other content areas. Strategies include teaching students how to ask effective questions, summarize and retell both verbally and in writing, and to listen effectively. Teaching strategies include literal, interpretive, critical, and evaluative comprehension, as well as the ability to foster appreciation of a variety of fiction and nonfiction text and independent reading for adolescent readers.

7. Supervised clinical experiences. The supervised clinical experiences shall be continuous and systematic and comprised of early field experiences with a minimum of 10 weeks of successful full-time student teaching in the endorsement area sought under the supervision of a cooperating teacher with demonstrated effectiveness in the classroom. The summative supervised student teaching experience shall include at least 150 clock hours spent in direct teaching at the level of endorsement in a public or accredited nonpublic school. One year of successful full-time teaching experience in the endorsement area in any public school or accredited nonpublic school may be accepted in lieu of the supervised student teaching experience. A fully licensed, experienced teacher shall be available in the school building to assist a beginning teacher employed through the alternate route.

8VAC20-543-275. Dual language (English) endorsement preK-6.

The programs in dual language (English) preK-6 shall ensure that the candidate has demonstrated the following competencies. National standards in dual language are to be addressed in the program.

1. Methods.

a. Understanding of the needed knowledge, skills, dispositions, and processes to support learners in achievement of Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Standards of Learning in English, mathematics, history and social science, science, and computer technology;

b. Understanding of current research on the brain, its role in learning, and implications for instruction;

c. The ability to integrate English, mathematics, science, health, history and social sciences, art, music, drama, movement, and technology in learning experiences;

d. The use of differentiated instruction and flexible groupings to meet the needs of learners at different stages of development, abilities, and achievement;

e. The use of appropriate methods, including those in visual and performing arts, to help learners develop knowledge and basic skills, sustain intellectual curiosity, and problem-solve;

f. The ability to utilize effective classroom and behavior management skills through methods that build responsibility and self-discipline promote self-regulation, and maintain a positive learning environment;

g. The ability to modify and manage learning environments and experiences to meet the individual needs of children, including children with disabilities, gifted children, children who are English learners, and children with diverse cultural needs;

h. The ability to use formal and informal assessments to diagnose needs, plan and modify instruction, and record student progress;

i. A commitment to professional growth and development through reflection, collaboration, and continuous learning;

j. The ability to analyze, evaluate, and apply quantitative and qualitative research;

k. Understanding of the Virginia Standards of Learning for Computer Technology and the ability to use technology as a tool for teaching, learning, research, and communication; and

l. The ability to adapt task and interactions to maximize language development, conceptual understanding, and skill competence within each child's zone of proximal development.

2. Knowledge and skills.

a. Reading and English. Understanding of the content, knowledge, skills, and processes for teaching Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Standards of Learning for English, including communication (speaking, listening, and media literacy), reading, writing, and research and how these standards provide the core for teaching English in elementary.

(1) Assessment and diagnostic teaching. The individual shall:

(a) Be proficient in the use of both formal and informal assessment as screening diagnostic, and progress monitoring measures for the components of reading: phonemic awareness, letter recognition, decoding, fluency, vocabulary, reading level, and comprehension; and

(b) Be proficient in the ability to use diagnostic data to inform instruction for acceleration, intervention, remediation, and differentiation.

(2) Communication: speaking, listening, and media literacy. The individual shall:

(a) Be proficient in the knowledge, skills, and processes necessary for teaching communication, such as speaking, listening, and media literacy;

(b) Be proficient in developing students' phonological awareness skills;

(c) Demonstrate the ability to teach students to identify the characteristics of and apply critical thinking to media messages and to facilitate students' proficiency in using various forms of media to collaborate and communicate;

(d) Demonstrate effective strategies for facilitating the learning of standard English by speakers of other languages and dialects; and

(e) Demonstrate the ability to promote creative thinking and expression, such as through storytelling, drama, choral, and oral reading.

(3) Reading and literature. The individual shall:

(a) Be proficient in explicit and systematic phonics instruction, including an understanding of sound and symbol relationships, syllables, phonemes, morphemes, word analysis, and decoding skills;

(b) Be proficient in strategies to increase vocabulary and concept development;

(c) Be proficient in the structure of the English language, including an understanding of syntax and semantics;

(d) Be proficient in reading comprehension strategies for both fiction and nonfiction text, including questioning, predicting, inferencing, summarizing, clarifying, evaluating, and making connections;

(e) Demonstrate the ability to support students to read with fluency, accuracy, and meaningful expression (prosody);

(f) Demonstrate the ability to develop comprehension skills in all content areas;

(g) Demonstrate the ability to foster appreciation of a variety of literature;

(h) Understand the importance of promoting independent reading by selecting fiction and nonfiction texts of appropriate yet engaging topics and reading levels; and

(i) Demonstrate effective strategies for teaching students to view, interpret, analyze, and represent information and concepts in visual form with or without the spoken or written word.

(4) Writing. The individual shall:

(a) Be proficient in the knowledge, skills, and processes necessary for teaching writing, including the domains of composing and written expression, usage and mechanics and the writing process of planning, drafting, revising, editing, and publishing;

(b) Understand the stages of spelling development, promoting the generalization of spelling study to writing, and be proficient in systematic spelling instruction, including awareness of the purpose and limitations of "invented spelling";

(c) Demonstrate the ability to teach students to write cohesively for a variety of purposes and to provide instruction on the writing process: planning, drafting, revising, editing, and publishing in the narrative, descriptive, persuasive, and explanative modes; and

(d) Demonstrate the ability to facilitate student research and related skills such as accessing information, evaluating the validity of sources, citing sources, and synthesizing information.

(5) Technology. The individual shall demonstrate the ability to guide students in their use of technology for both process and product as they work with reading, writing, and research.

b. Mathematics.

(1) Understanding of the mathematics relevant to the content identified in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Standards of Learning and how the standards provide the foundation for teaching mathematics in grades preK-6. Experiences with practical applications and the use of appropriate technology and concrete materials should be used within the following content:

(a) Number systems and their structure, basic operations, and properties;

(b) Elementary number theory, ratio, proportion, and percent;

(c) Algebra: fundamental idea of equality; operations with monomials and polynomials; algebraic fractions; linear and quadratic equations and inequalities and linear systems of equations and inequalities; radicals and exponents; arithmetic and geometric sequences and series; algebraic and trigonometric functions; and transformations among graphical, tabular, and symbolic forms of functions;

(d) Geometry: geometric figures, their properties, relationships, and the Pythagorean Theorem; deductive and inductive reasoning; perimeter, area, and surface area of two-dimensional and three-dimensional figures; coordinate and transformational geometry; and constructions; and

(e) Probability and statistics: permutations and combinations; experimental and theoretical probability; data collection and graphical representations, including box-and-whisker plots; data analysis and interpretation for predictions; measures of center, spread of data, variability, range, and normal distribution.

(2) Understanding of the sequential nature of mathematics and vertical progression of mathematical standards.

(3) Understanding of the multiple representations of mathematical concepts and procedures.

(4) Understanding of and the ability to use the five processes of reasoning mathematically, solving problems, communicating mathematics effectively, making mathematical connections, and using mathematical models and representations at different levels of complexity.

(5) Understanding of the contributions of different cultures toward the development of mathematics and the role of mathematics in culture and society.

(6) Understanding of the appropriate use of calculators and technology in the teaching and learning of mathematics, including virtual manipulatives.

(7) Understanding of and the ability to use strategies to teach mathematics to diverse learners.

c. History and social sciences.

(1) Understanding of the knowledge, skills, and processes of history and the social sciences disciplines as defined in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Standards of Learning and how the standards provide the necessary foundation for teaching history and social sciences, including in:

(a) History.

(i) The contributions of ancient civilizations to modern social and political institutions;

(ii) Major events in Virginia history from 1607 to the present;

(iii) Key individuals, documents, and events in United States history; and

(iv) The evolution of America's constitutional republic and its ideas, institutions, and practices.

(b) Geography.

(i) The use of maps and other geographic representations, tools, and technologies to acquire, process, and report information;

(ii) The relationship between human activity and the physical environment in the community and the world; and

(iii) Physical processes that shape the surface of the earth.

(c) Civics.

(i) The privileges and responsibilities of good citizenship and the importance of the rule of law for the protection of individual rights;

(ii) The process of making laws in the United States and the fundamental ideals and principles of a republican form of government;

(iii) The understanding that Americans are a people of diverse ethnic origins, customs, and traditions who are united by basic principles of a republican form of government and a common identity as Americans; and

(iv) Local government and civics instruction specific to Virginia.

(d) Economics.

(i) The basic economic principles that underlie the United States market economy;

(ii) The role of the individual and how economic decisions are made in the market place; and

(iii) The role of government in the structure of the United States economy.

(2) Understanding of the nature of history and social sciences and how the study of the disciplines assists students in developing historical thinking, geographical analysis, economic decision-making, and responsible citizenship by:

(a) Using artifacts and primary and secondary sources to understand events in history;

(b) Using geographic skills to explain the interaction of people, places, and events to support an understanding of events in history;

(c) Using charts, graphs, and pictures to determine characteristics of people, places, and events in history;

(d) Asking appropriate questions and summarizing points to answer a question;

(e) Comparing and contrasting people, places, and events in history;

(f) Recognizing direct cause and effect relationships in history;

(g) Explaining connections across time and place;

(h) Using a decision-making model to identify costs and benefits of a specific choice made;

(i) Practicing good citizenship skills and respect for rules and laws, and participating in classroom activities; and

(j) Developing fluency in content vocabulary and comprehension of verbal, written, and visual sources.

d. Science.

(1) Understanding of the knowledge, skills, and practices of the four core science disciplines of Earth science, biology, chemistry, and physics as defined in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Science Standards of Learning and how these standards provide a sound foundation for teaching science in the elementary grades.

(2) Understanding of the nature of science and scientific inquiry, including the following:

(a) Function of research design and experimentation;

(b) Role and nature of the theory in explaining and predicting events and phenomena;

(c) Practices required to provide empirical answers to research questions, including data collection and analysis, modeling, argumentation with evidence, and constructing explanations;

(d) Reliability of scientific knowledge and its constant scrutiny and refinement;

(e) Self-checking mechanisms used by science to increase objectivity, including peer review; and

(f) Assumptions, influencing conditions, and limits of empirical knowledge.

(3) Understanding of the knowledge, skills, and practices for conducting an active elementary science program including the ability to:

(a) Design instruction reflecting the goals of the Virginia Science Standards of Learning;

(b) Implement classroom, field, and laboratory safety rules and procedures and ensure that students take appropriate safety precautions;

(c) Conduct research projects and experiments, including applications of the design process and technology;

(d) Conduct systematic field investigations using the school grounds, the community, and regional resources;

(e) Organize key science content, skills, and practices into meaningful units of instruction that actively engage students in learning;

(f) Design instruction to meet the needs of diverse learners using a variety of techniques;

(g) Evaluate instructional materials, technologies, and teaching practices;

(h) Conduct formative and summative assessments of student learning;

(i) Incorporate instructional technology to enhance student performance in science; and

(j) Ensure student competence in science.

(4) Understanding of the content, skills, and practices of the four core science areas, including Earth sciences, biology, chemistry, and physics supporting the teaching of preK-6 science as defined by the Virginia Science Standards of Learning and equivalent course work reflecting each of the four core science areas.

(5) Understanding of the core scientific disciplines of Earth science, biology, chemistry, and physics to ensure:

(a) The placement of the four core scientific disciplines in an appropriate interdisciplinary context;

(b) The ability to teach the skills, practices, and crosscutting concepts common to the natural and physical sciences;

(c) The application of key science principles to solve practical problems; and

(d) A "systems" understanding of the natural world.

(6) Understanding of the contributions and significance of science including:

(a) The social, cultural, and economic significance of science;

(b) The relationship of science to mathematics, the design process, and technology; and

(c) The historical development of scientific concepts and scientific reasoning.

8VAC20-543-276. Dual language (English) preK-6 (add-on endorsement).

A. The dual language (English) preK-6 endorsement is to teach dual language (English). Individuals who hold a valid Virginia teaching license with an elementary education endorsement may teach in dual language (English) in the corresponding grade levels noted on the license (such as early/primary education preK-3 or elementary education preK-6). Even though individuals holding a valid Virginia teaching license with an elementary education endorsement in the assigned dual language (English) assignment do not need the dual language (English) preK-6 add-on endorsement, the endorsement recognizes the candidate's additional preparation in dual language (English) preparation.

B. The program in dual language (English) preK-6 add-on endorsement shall ensure that the candidate holds a baccalaureate degree from a regionally accredited college or

university and an active teaching license with an elementary education endorsement issued by the State Board of Education and has demonstrated the following competencies and completed a 45-clock-hour practicum in dual language (English) from a regionally accredited college or university. One year of successful, full-time teaching experience in a public school or accredited nonpublic school in dual language (English) may be accepted in lieu of the practicum.

1. Skills in this area shall contribute to an understanding of the principles of learning; dual language acquisition; theories of second language acquisition; the application of skills in discipline-specific methodology; varied and effective methods of communication with and among students; selection and use of materials, including media and contemporary technologies; and selection, development, and use of appropriate curricula, methodologies, and materials that support and enhance student learning and reflect the research on unique, age-appropriate, and culturally relevant curriculum and pedagogy.

2. Understanding of the principles of online learning and online instructional strategies and the application of skills to deliver online instruction shall be included.

3. Instructional practices that are sensitive to culturally and linguistically diverse learners, including English learners, gifted and talented students, and students with disabilities, and appropriate for the preK-3 or preK-6 endorsement shall be included.

4. Teaching methods shall be tailored to promote student engagement and student academic progress and effective preparation for the Virginia Standards of Learning assessments.

5. Study in (i) methods of improving communication between schools and families; (ii) communicating with families regarding social and instructional needs of children; (iii) ways of increasing family engagement in student learning at home and in school; (iv) the Virginia Standards of Learning; (v) English Language Development Standards (WIDA); and (vi) Virginia Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, prepared by the Virginia Department of Education's Office of Early Childhood shall be included.

6. Early childhood educators shall understand the role of families in child development and in relation to teaching educational skills.

7. Early childhood educators shall understand the role of the informal and play-mediated settings for promoting students' skills and development and shall demonstrate knowledge and skill in interacting in such situations to promote specific learning outcomes as reflected in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards.

8. Demonstrated proficiency in the use of educational technology for instruction shall be required.

8VAC20-543-277. Dual language (target language) endorsement preK-6.

A. The programs in dual language (target language) preK-6 shall ensure that the candidate has demonstrated the following competencies. National standards in dual language are to be addressed in the program.

B. Individuals must have demonstrated proficiency in the world language by completing a major in the target language; or 12 semester hours in the target language above the intermediate level that must include composition, literature, and conversation; or a qualifying score on a foreign language assessment in the target language as prescribed by the State Board of Education.

1. Methods.

a. Understanding of the needed knowledge, skills, dispositions, and processes to support learners in achievement of Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Standards of Learning in English, mathematics, history and social science, science, and computer technology;

b. Understanding of current research on the brain, its role in learning, and implications for instruction;

c. The ability to integrate English, mathematics, science, health, history and social sciences, art, music, drama, movement, and technology in learning experiences;

d. The use of differentiated instruction and flexible groupings to meet the needs of learners at different stages of development, abilities, and achievement;

e. The use of appropriate methods, including those in visual and performing arts, to help learners develop knowledge and basic skills, sustain intellectual curiosity, and problem-solve;

f. The ability to utilize effective classroom and behavior management skills through methods that build responsibility and self-discipline promote self-regulation, and maintain a positive learning environment;

g. The ability to modify and manage learning environments and experiences to meet the individual needs of children, including children with disabilities, gifted children, children who are English learners, and children with diverse cultural needs;

h. The ability to use formal and informal assessments to diagnose needs, plan and modify instruction, and record student progress;

i. A commitment to professional growth and development through reflection, collaboration, and continuous learning;

j. The ability to analyze, evaluate, and apply quantitative and qualitative research;

k. Understanding of the Virginia Standards of Learning for Computer Technology and the ability to use technology as a tool for teaching, learning, research, and communication; and

l. The ability to adapt task and interactions to maximize language development, conceptual understanding, and skill competence within each child's zone of proximal development.

2. Knowledge and skills.

a. Reading and English. Understanding of the content, knowledge, skills, and processes for teaching Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Standards of Learning for English, including communication (speaking, listening, and media literacy), reading, writing, and research and how these standards provide the core for teaching English in elementary .

(1) Assessment and diagnostic teaching. The individual shall:

(a) Be proficient in the use of both formal and informal assessment as screening diagnostic and progress monitoring measures for the components of reading: phonemic awareness, letter recognition, decoding, fluency, vocabulary, reading level, and comprehension; and

(b) Be proficient in the ability to use diagnostic data to inform instruction for acceleration, intervention, remediation, and differentiation.

(2) Communication: speaking, listening, and media literacy. The individual shall:

(a) Be proficient in the knowledge, skills, and processes necessary for teaching communication, such as speaking, listening, and media literacy;

(b) Be proficient in developing students' phonological awareness skills;

(c) Demonstrate the ability to teach students to identify the characteristics of and apply critical thinking to media messages and to facilitate students' proficiency in using various forms of media to collaborate and communicate;

(d) Demonstrate effective strategies for facilitating the learning of standard English by speakers of other languages and dialects; and

(e) Demonstrate the ability to promote creative thinking and expression, such as through storytelling, drama, choral, and oral reading.

(3) Reading and literature. The individual shall:

(a) Be proficient in explicit and systematic phonics instruction, including an understanding of sound and symbol relationships, syllables, phonemes, morphemes, word analysis, and decoding skills;

(b) Be proficient in strategies to increase vocabulary and concept development;

(c) Be proficient in the structure of the English language, including an understanding of syntax and semantics;

(d) Be proficient in reading comprehension strategies for both fiction and nonfiction text, including questioning, predicting, inferencing, summarizing, clarifying, evaluating, and making connections;

(e) Demonstrate the ability to support students to read with fluency, accuracy, and meaningful expression (prosody);

(f) Demonstrate the ability to develop comprehension skills in all content areas;

(g) Demonstrate the ability to foster appreciation of a variety of literature;

(h) Understand the importance of promoting independent reading by selecting fiction and nonfiction texts of appropriate yet engaging topics and reading levels; and

(i) Demonstrate effective strategies for teaching students to view, interpret, analyze, and represent information and concepts in visual form with or without the spoken or written word.

(4) Writing. The individual shall:

(a) Be proficient in the knowledge, skills, and processes necessary for teaching writing, including the domains of composing and written expression, usage and mechanics and the writing process of planning, drafting, revising, editing, and publishing;

(b) Understand the stages of spelling development, promoting the generalization of spelling study to writing, and be proficient in systematic spelling instruction, including awareness of the purpose and limitations of "invented spelling";

(c) Demonstrate the ability to teach students to write cohesively for a variety of purposes and to provide instruction on the writing process: planning, drafting, revising, editing, and publishing in the narrative, descriptive, persuasive, and explanative modes; and

(d) Demonstrate the ability to facilitate student research and related skills, such as accessing information, evaluating the validity of sources, citing sources, and synthesizing information.

(5) Technology. The individual shall demonstrate the ability to guide students in their use of technology for both process and product as they work with reading, writing, and research.

b. Mathematics.

(1) Understanding of the mathematics relevant to the content identified in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Standards of Learning and how the standards provide the foundation for teaching mathematics in grades preK-6.

Experiences with practical applications and the use of appropriate technology and concrete materials should be used within the following content:

(a) Number systems and their structure, basic operations, and properties;

(b) Elementary number theory, ratio, proportion, and percent;

(c) Algebra: fundamental idea of equality; operations with monomials and polynomials; algebraic fractions; linear and quadratic equations and inequalities and linear systems of equations and inequalities; radicals and exponents; arithmetic and geometric sequences and series; algebraic and trigonometric functions; and transformations among graphical, tabular, and symbolic forms of functions;

(d) Geometry: geometric figures, their properties, relationships, and the Pythagorean Theorem; deductive and inductive reasoning; perimeter, area, and surface area of two-dimensional and three-dimensional figures; coordinate and transformational geometry; and constructions; and

(e) Probability and statistics: permutations and combinations; experimental and theoretical probability; data collection and graphical representations including box-and-whisker plots; data analysis and interpretation for predictions; and measures of center, spread of data, variability, range, and normal distribution.

(2) Understanding of the sequential nature of mathematics and vertical progression of mathematical standards.

(3) Understanding of the multiple representations of mathematical concepts and procedures.

(4) Understanding of and the ability to use the five processes of reasoning mathematically, solving problems, communicating mathematics effectively, making mathematical connections, and using mathematical models and representations at different levels of complexity.

(5) Understanding of the contributions of different cultures toward the development of mathematics and the role of mathematics in culture and society.

(6) Understanding of the appropriate use of calculators and technology in the teaching and learning of mathematics, including virtual manipulatives.

(7) Understanding of and the ability to use strategies to teach mathematics to diverse learners.

c. History and social sciences.

(1) Understanding of the knowledge, skills, and processes of history and the social sciences disciplines as defined in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Standards of Learning and how the standards provide the necessary foundation for teaching history and social sciences, including in:

(a) History.

(i) The contributions of ancient civilizations to modern social and political institutions;

(ii) Major events in Virginia history from 1607 to the present;

(iii) Key individuals, documents, and events in United States history; and

(iv) The evolution of America's constitutional republic and its ideas, institutions, and practices.

(b) Geography.

(i) The use of maps and other geographic representations, tools, and technologies to acquire, process, and report information;

(ii) The relationship between human activity and the physical environment in the community and the world; and

(iii) Physical processes that shape the surface of the earth.

(c) Civics.

(i) The privileges and responsibilities of good citizenship and the importance of the rule of law for the protection of individual rights;

(ii) The process of making laws in the United States and the fundamental ideals and principles of a republican form of government;

(iii) The understanding that Americans are a people of diverse ethnic origins, customs, and traditions, who are united by basic principles of a republican form of government and a common identity as Americans; and

(iv) Local government and civics instruction specific to Virginia.

(d) Economics.

(i) The basic economic principles that underlie the United States market economy;

(ii) The role of the individual and how economic decisions are made in the market place; and

(iii) The role of government in the structure of the United States economy.

(2) Understanding of the nature of history and social sciences and how the study of the disciplines assists students in developing historical thinking, geographical analysis, economic decision-making, and responsible citizenship by:

(a) Using artifacts and primary and secondary sources to understand events in history;

(b) Using geographic skills to explain the interaction of people, places, and events to support an understanding of events in history;

(c) Using charts, graphs, and pictures to determine characteristics of people, places, and events in history;

(d) Asking appropriate questions and summarizing points to answer a question;

(e) Comparing and contrasting people, places, and events in history;

(f) Recognizing direct cause and effect relationships in history;

(g) Explaining connections across time and place;

(h) Using a decision-making model to identify costs and benefits of a specific choice made;

(i) Practicing good citizenship skills and respect for rules and laws, and participating in classroom activities; and

(j) Developing fluency in content vocabulary and comprehension of verbal, written, and visual sources.

d. Science.

(1) Understanding of the knowledge, skills, and practices of the four core science disciplines of Earth science, biology, chemistry, and physics as defined in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, and the Virginia Science Standards of Learning and how these standards provide a sound foundation for teaching science in the elementary grades.

(2) Understanding of the nature of science and scientific inquiry, including the following:

(a) Function of research design and experimentation;

(b) Role and nature of the theory in explaining and predicting events and phenomena;

(c) Practices required to provide empirical answers to research questions, including data collection and analysis, modeling, argumentation with evidence, and constructing explanations;

(d) Reliability of scientific knowledge and its constant scrutiny and refinement;

(e) Self-checking mechanisms used by science to increase objectivity, including peer review; and

(f) Assumptions, influencing conditions, and limits of empirical knowledge.

(3) Understanding of the knowledge, skills, and practices for conducting an active elementary science program including the ability to:

(a) Design instruction reflecting the goals of the Virginia Science Standards of Learning;

(b) Implement classroom, field, and laboratory safety rules and procedures and ensure that students take appropriate safety precautions;

(c) Conduct research projects and experiments, including applications of the design process and technology;

(d) Conduct systematic field investigations using the school grounds, the community, and regional resources;

(e) Organize key science content, skills, and practices into meaningful units of instruction that actively engage students in learning;

(f) Design instruction to meet the needs of diverse learners using a variety of techniques;

(g) Evaluate instructional materials, technologies, and teaching practices;

(h) Conduct formative and summative assessments of student learning;

(i) Incorporate instructional technology to enhance student performance in science; and

(j) Ensure student competence in science.

(4) Understanding of the content, skills, and practices of the four core science areas, including Earth sciences, biology, chemistry, and physics supporting the teaching of preK-6 science as defined by the Virginia Science Standards of Learning and equivalent course work reflecting each of the four core science areas.

(5) Understanding of the core scientific disciplines of Earth science, biology, chemistry, and physics to ensure:

(a) The placement of the four core scientific disciplines in an appropriate interdisciplinary context;

(b) The ability to teach the skills, practices, and crosscutting concepts common to the natural and physical sciences;

(c) The application of key science principles to solve practical problems; and

(d) A "systems" understanding of the natural world.

(6) Understanding of the contributions and significance of science including:

(a) The social, cultural, and economic significance of science;

(b) The relationship of science to mathematics, the design process, and technology; and

(c) The historical development of scientific concepts and scientific reasoning.

8VAC20-543-278. Dual language (target language) preK-6 (add-on endorsement).

A. The dual language (target language) preK-6 add-on endorsement is to teach dual language in a World Language other than English. The target language will be noted on the endorsement.

B. The program in dual language (target language) preK-6 add-on endorsement shall ensure that the candidate holds a baccalaureate degree from a regionally accredited college or university and an active teaching license with an endorsement in a target language issued by the State Board of Education and has demonstrated the following competencies and completed a

45-clock-hour practicum in dual language (target language) from a regionally accredited college or university. One year of successful, full-time teaching experience in a public school or accredited nonpublic school in dual language (target language) may be accepted in lieu of the practicum.

1. Skills in this area shall contribute to an understanding of the principles of learning; dual language acquisition; theories of second language acquisition; the application of skills in discipline-specific methodology; varied and effective methods of communication with and among students; selection and use of materials, including media and contemporary technologies; and selection, development, and use of appropriate curricula, methodologies, and materials that support and enhance student learning and reflect the research on unique, age-appropriate, and culturally relevant curriculum and pedagogy.

2. Understanding of the principles of online learning and online instructional strategies and the application of skills to deliver online instruction shall be included.

3. Instructional practices that are sensitive to culturally and linguistically diverse learners, including English learners, gifted and talented students, and students with disabilities, and appropriate for the preK-3 or preK-6 endorsement shall be included.

4. Teaching methods shall be tailored to promote student engagement and student academic progress and effective preparation for the Virginia Standards of Learning assessments.

5. Study in (i) methods of improving communication between schools and families; (ii) communicating with families regarding social and instructional needs of children; (iii) ways of increasing family engagement in student learning at home and in school; (iv) the Virginia Standards of Learning; (v) English Language Development Standards (WIDA); and (vi) Virginia Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards, prepared by the Virginia Department of Education's Office of Early Childhood shall be included.

6. Early childhood educators shall understand the role of families in child development and in relation to teaching educational skills.

7. Early childhood educators shall understand the role of the informal and play-mediated settings for promoting students' skills and development and shall demonstrate knowledge and skill in interacting in such situations to promote specific learning outcomes as reflected in Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, or their successor standards.

8. Demonstrated proficiency in the use of educational technology for instruction shall be required.

C. The candidate must pass the rigorous elementary education assessment prescribed by the State Board of Education or completed the following coursework:

1. Mathematics- nine semester hours in mathematics that must include methods of teaching elementary mathematics;

2. Laboratory sciences (in two science disciplines)- nine semester hours that must include methods of teaching elementary science;

3. History and Social Sciences: United States history- three semester hours; geography, economics, or United States or comparative government- three semester hours; and methods of teaching elementary history and social sciences - three semester hours.

8VAC20-543-279. Economics and personal finance (add-on endorsement).

The program in economics and personal finance shall ensure that the candidate holds an active license (Collegiate Professional License, Postgraduate Professional License, or a Provisional License leading to a Collegiate Professional or Postgraduate Professional License) with a teaching endorsement or endorsements issued by the State Board of Education and has demonstrated the following competencies:

1. Understanding and demonstration of the required knowledge, skills, and processes to support learners in achievement of the Economics and Personal Finance Virginia Standards of Learning, including:

a. Integration of economic concepts and structures, including how consumers, businesses, and governments face scarcity of resources and make trade-offs and incur opportunity costs;

b. Role of producers and consumers in a market economy including response to incentives, the role of entrepreneurs, and how costs and revenues affect profit and supply;

c. The price system;

d. Factors that affect income;

e. Nation's economic goals, including full employment, stable prices, and economic growth;

f. Nation's financial system;

g. Monetary and fiscal policy;

h. Role of government in a market economy;

i. Global economy including trade and comparative advantage;

j. Consumer skills;

k. Planning for living and leisure expenses;

l. Banking transactions;

m. Credit and loan functions;

n. Role of insurance in risk management;

o. Income earning, taxes, and reporting;

p. Personal financial planning;

q. Investment and savings planning; and

r. Financing postsecondary education (including the Free Application for Federal Student Aid (FAFSA); and

2. Understanding and knowledge of teaching in an online or blended learning environment.

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Fast-Track Regulation

Titles of Regulations: **8VAC20-671. Regulations Governing the Operation of Private Schools for Students with Disabilities (amending 8VAC20-671-10).**

8VAC20-750. Regulations Governing the Use of Seclusion and Restraint in Public Elementary and Secondary Schools in Virginia (amending 8VAC20-750-20).

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

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: March 2, 2022.

Effective Date: April 1, 2022.

Agency Contact: Jim Chapman, Regulatory and Legal Coordinator, Department of Education, James Monroe Building, 101 North 14th Street, 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, or email jim.chapman@doe.virginia.gov.

Basis: The State Board of Education's overall regulatory authority is found in § 22.1-16 of the Code of Virginia, which authorizes the board to promulgate such regulations as may be necessary to carry out its powers and duties. The board's regulatory authority over schools for students with disabilities is found in § 22.1-321 of the Code of Virginia.

Purpose: The regulatory change is essential to maintain consistency across the public and private school contexts in both the application of regulations and the protections afforded to students with disabilities. The goal of the regulatory change is to maintain consistency across the public and private school contexts in both the application of regulations and the protections afforded to students with disabilities. The regulatory change is essential to protect the health, safety, and welfare of students because it maintains consistency across the public and private school contexts in both the application of regulations and the protections afforded to students with disabilities.

Rationale for Using Fast-Rulemaking Process: The board expects that this action will be noncontroversial and therefore appropriate for the fast-track rulemaking process because it is important that the classification of students and the application of regulations remains consistent across the public and private school contexts.

Substance: This regulatory action will amend the definition of "traumatic brain injury" in 8VAC20-671-10 to conform to the definition of the same term in 8VAC20-81-10 and add a definition of "traumatic brain injury" to 8VAC20-750-20 to mirror the definition set by the General Assembly for 8VAC20-81-10.

Issues: The primary advantages to the regulatory change to the public and the agency or Commonwealth are that the board will ensure consistency across the public and private school contexts in both the application of its regulations and the protections afforded to children with disabilities. There are no disadvantages to the regulatory change nor are there other pertinent matters of interest to the regulated community, government officials, or the public.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. The Board of Education (Board) proposes to amend the definition of "traumatic brain injury" (TBI) in 8VAC20-671 Regulations Governing the Operation of Private Schools for Students with Disabilities, and create a definition of TBI in 8VAC20-750 Regulations Governing the Use of Seclusion and Restraint in Public Elementary and Secondary Schools in Virginia.

Background. Chapter 170 of the 2021 Special Session I Acts of Assembly[2] directed the Board to amend the definition of TBI in 8VAC20-81 Regulations Governing Special Education Programs for Children with Disabilities in Virginia to add new text (in bold) as follows:

> "Traumatic brain injury" means an acquired injury to the brain caused by an external physical force or by other medical conditions, including stroke, anoxia, infectious disease, aneurysm, brain tumors, and neurological insults resulting from medical or surgical treatments, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. Traumatic brain injury applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. Traumatic brain injury does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma." (34 CFR 300.8(c)(12)).

The Board subsequently amended 8VAC20-81 in this manner via an exempt action to incorporate the new text.[3] Otherwise, the definition remained the same.

The current definition of TBI in 8VAC20-671 is the same as it was in 8VAC20-81 prior to the amendments directed by the legislative mandate.[4] The Board proposes to amend the definition in 8VAC20-671 so that it is identical to the newly-amended definition in 8VAC20-81.[5]

The current 8VAC20-750 does not have a definition of TBI. The Board proposes to add the post-mandate definition in 8VAC20-81 to 8VAC20-750.

Estimated Benefits and Costs. The Department of Education (DOE) believes that the proposed change to the definition of TBI in 8VAC20-671 Regulations Governing the Operation of Private Schools for Students with Disabilities would result in more students being identified under the TBI category for special education services. Additionally, the agency believes that many of the students that would be identified under the new TBI definition are already receiving services under another classification (such as "other health impairment"). The nature of this disability often requires significant and customizable supports, and so it is thought that many students are already receiving them under a different classification. DOE believes this would result in the re-designation and classification of students already receiving services, and only a very small number of students, if any, would be newly identified as needing services. The agency does not know if there would be a difference in costs of having students newly identified under the TBI category for special education services.

The proposed addition of the definition of TBI to 8 VAC 20-750 Regulations Governing the Use of Seclusion and Restraint in Public Elementary and Secondary Schools in Virginia provides information for the reader of the regulation, but DOE does not believe it otherwise would have a substantive impact.

The Regulations Governing the Operation of Private Schools for Students with Disabilities apply to both private day schools for students with disabilities and schools in private residential facilities for students with disabilities (including group homes). The costs for students at both the private day schools and the schools in private residential facilities are covered by the Children's Services Act (CSA). For the private day schools, approximately 63% of the CSA funds are provided by the Commonwealth; the remaining 37% are provided by local government. For the schools in private residential facilities, approximately 65%of the CSA funds are provided by the Commonwealth; the remaining 35% are provided by local government. If there are differences in costs for re-designation and classification of students due to the proposal, it would thus affect expenditures by the Commonwealth and local governments commensurately.

Businesses and Other Entities Affected. The proposed amendments would affect the 87 private day schools for students with disabilities and the 31 schools in private residential facilities for students with disabilities (including group homes) in the Commonwealth that are licensed by DOE,[6] as well as students with an injury to the brain caused by medical conditions, including stroke, anoxia, infectious disease, aneurysm, brain tumors, and neurological insults resulting from medical or surgical treatments, resulting in total or partial functional disability or psychosocial impairment.

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[7] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. As noted above, DOE does not know whether the proposal would affect cost (or in which direction). Thus, an adverse impact indication cannot be determined.

Small Businesses[8] Affected.[9] The proposed amendments do not appear to adversely affect small businesses.

Localities[10] Affected.[11] Because local governments pay part of the cost for students to go to private day schools for students with disabilities and schools in private residential facilities for students with disabilities, local governments may be affected by the proposal. It would be the locality/public school district where the student's family resides, not the location of the private school, which would be paying. So, it could apply to any locality. Officially, the students are only supposed to be sent to the private schools when the public schools lack the resources to sufficiently serve the student's disability. Since DOE cannot determine whether the cost of paying for services would increase, decrease or stay the same, it cannot be determined whether there would be an adverse impact for local governments.

Projected Impact on Employment. The proposal is unlikely to substantively affect total employment.

Effects on the Use and Value of Private Property. Since DOE cannot determine how services would change under the proposal, it cannot be determined how demand for services from private day schools for students with disabilities and schools in private residential facilities would change. Thus, the effects on the use and value of these private entities cannot be determined.

The proposal does not affect real estate development costs.

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[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]See https://lis.virginia.gov/cgi-bin/legp604.exe?212+ful+CHAP0170

[3]See https://townhall.virginia.gov/L/viewstage.cfm?StageID=9433

[4]There is one exception. The definition in 8VAC20-81 ends with a federal citation, (34 CFR 300.8(c)(12)). The definition in 8VAC20-671 does not.

[5]Ibid.

[6]Data source: DOE

[7]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[8]Pursuant to § 2.2-4007.04, 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."

[9]If the proposed regulatory action may have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to § 2.2-4007.1 of the Code of Virginia, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[10]"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.

[11]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

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

Summary:

The amendments (i) update the definition of "traumatic brain injury" in 8VAC20-671 and (ii) add the definition of "traumatic brain injury" to 8VAC20-750 to be consistent with 8VAC20-81, which was amended pursuant to Chapter 170 of the 2021 Acts of Assembly, Special Session I.

8VAC20-671-10. Definitions.

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

"504 Plan" means a written plan required under § 504 of the Rehabilitation Act of 1973 (29 USC § 701 et seq.), as amended. A student's 504 Plan details modifications, accommodations, and services that are needed for the student with a disability to participate in and enjoy the benefits of school programs at the same level as his peers without disabilities.

"Applicant" means the person, partnership, corporation, or association that has completed and submitted an application to the department for approval for a license to operate a school for students with disabilities in Virginia.

"Autism" means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three~~,~~ that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance. A child who manifests the characteristics of autism after age three could be identified as having autism if the criteria in this definition are satisfied.

"Aversive stimuli" means any action used to punish a student or to eliminate, reduce, or discourage the problem behavior by use of any of the following or any other actions that are painful, humiliating, degrading, or abusive:

1. Noxious odors and tastes.

2. Water and other mists or sprays.

3. Blasts of air.

4. Corporal punishment as defined in § 22.1-279.1 of the Code of Virginia.

5. Verbal and mental abuse.

6. Placement of a student alone in a room, where the door is locked or held shut and the student is prevented from leaving the room.

7. Forced exercise where:

a. The student's behavior is related to his disability;

b. The exercise would have a harmful effect on the student's health; or

c. The student's disability prevents participation in activities.

8. Deprivation of necessities, including:

a. Food or liquid at a time when it is customarily served;

b. Medication; or

c. Use of restroom.

"Behavioral intervention plan" means a plan that utilizes positive behavioral interventions and supports to address (i) behaviors that interfere with the learning of students with disabilities or with the learning of others or (ii) behaviors that require disciplinary action.

"Board" means the State Board of Education.

"Business day" means Monday through Friday, 12 months of the year, exclusive of federal and state holidays (unless holidays are specifically included in the designation of business days).

"Calendar days" means consecutive days, inclusive of Saturdays and Sundays. Whenever any period of time fixed by this chapter shall expire on a Saturday, Sunday, or federal or state holiday, the period of time for taking such action under

this chapter shall be extended to the next day that is not a Saturday, Sunday, or federal or state holiday.

"Complaint" means an accusation that a school has violated one or more of the requirements of this chapter or other applicable regulation.

"Consent" means:

1. The ~~parent(s)~~ parent or eligible student has been fully informed of all information relevant to the activity for which consent is sought in the parent's or eligible student's native language or other mode of communication;

2. The ~~parent(s)~~ parent or eligible student understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records (if any) that will be released and to whom; and

3. The ~~parent(s)~~ parent or eligible student understands that the granting of consent is voluntary on the part of the ~~parent(s)~~ parent or eligible student and may be revoked any time.

If a parent or eligible student revokes consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked.) Revocation ceases to be relevant after the activity for which consent was obtained was completed.

The meaning of the term "consent" is not the same as the meaning of the term "agree" or "agreement." "Agree" or "agreement" refers to an understanding between the parent or eligible student and the school about a particular matter and as required in this chapter. There is no requirement that an agreement be in writing, unless stated in this chapter. The school should document its agreement.

"Controlled substance" means a drug or other substance identified under ~~Schedules~~ Schedule I, II, III, IV, or V of the Controlled Substances Act, 21 USC § 812(c).

"Corrective action plan" means the school's plan of action to correct a finding of noncompliance applicable to this chapter or other applicable regulations. The plan must identify specific timelines and the ~~person(s)~~ person responsible for implementation.

"Deaf-blindness" means simultaneous hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.

"Deafness" means a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, that adversely affects the child's educational performance.

"Department" means the Virginia Department of Education.

"Developmental delay" means a disability affecting a child age two by September 30 through six, inclusive:

1. Who (i) is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development; or (ii) has an established physical or mental condition that has a high probability of resulting in developmental delay;

2. The delay is not primarily a result of cultural factors, environmental or economic disadvantage, or limited English proficiency; and

3. The presence of one or more documented characteristics of the delay has an adverse effect on educational performance and makes it necessary for the student to have specially designed instruction to access and make progress in the general educational activities for this age group.

"Disability category" means a listing of special education eligibility classifications for students served including: autism, deaf-blindness, developmental delay, emotional disability, hearing impairment (including deafness), intellectual disability, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, traumatic brain injury, and visual impairment (including blindness).

"Education records" means those records that are directly related to a student and maintained by the school or by a party acting for the school. Education records may be recorded in any manner including, but not limited to, handwriting, print, computer media, video or audiotape, film, microfilm, or microfiche. Education records include discipline and medical records. Education records include electronic exchanges between school personnel and ~~parent(s)~~ the parent regarding matters associated with the child's educational program.

"Eligible student" means a student who has reached 18 years of age.

"Emotional disability" or "emotional disturbance" means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:

1. An inability to learn that cannot be explained by intellectual, sensory, or health factors;

2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

3. Inappropriate types of behavior or feelings under normal circumstances;

4. A general pervasive mood of unhappiness or depression; or

5. A tendency to develop physical symptoms or fears associated with personal or school problems.

Emotional disability or emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance or emotional disability as defined in this section.

"Funding agency" means a community policy and management team under the Children's Services Act, Chapter 52 (§ 2.2-5200 et seq.) of Title 2.2 of the Code of Virginia; local school division; or local department of social services.

"Guaranty instrument" means a surety bond, irrevocable letter of credit, or certificate of deposit.

"Hearing impairment" means an impairment in hearing in one or both ears, with or without amplification, whether permanent or fluctuating, that adversely affects a child's educational performance but that is not included under the definition of deafness in the Regulations Governing Special Education Programs for Children with Disabilities in Virginia (8VAC20-81).

"Illegal drug" means a controlled substance or a prescription drug not prescribed for the person but does not include a controlled substance that is legally possessed or used under the supervision of a licensed health care professional or that is legally possessed or used under any other authority under the Controlled Substances Act, 21 USC § 812(c), or under any other provision of federal law.

"Individualized Education Program" or "IEP" means a written statement for a child with a disability that is developed, reviewed, and revised at least annually in a team meeting in accordance with the Regulations Governing Special Education for Children with Disabilities in Virginia (8VAC20-81). The IEP specifies the individual educational needs of the child and what special education and related services are necessary to meet the child's educational needs.

"Individualized Instruction Plan" or "IIP" means a written statement for a child who is privately placed or for a child who has not been determined eligible for special education services that is developed, reviewed, and revised at least annually in a team meeting that includes the parent and student when appropriate. The IIP specifies the student's academic level, course of study, individual educational needs, and the educational services the child will receive.

"Intellectual disability" means the definition formerly known as "mental retardation" and means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational performance.

"Licensee," also known as the sponsor, means the person, partnership, corporation, or association to whom a license is issued and who is legally responsible for compliance with this chapter.

"License to operate" or "license" means a document issued by the state Superintendent of Public Instruction that authorizes approval to operate a school for students with disabilities.

"Mechanical restraint" means the use of any device or equipment to restrict a student's freedom of movement. This term does not include devices implemented by trained school personnel or utilized by a student that have been prescribed by an appropriate medical or related services professional and are used for the specific and approved purposes for which such devices were designed, such as:

1. Adaptive devices or mechanical supports used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such devices or mechanical supports;

2. Vehicle safety restraints when used as intended during the transport of a student in a moving vehicle;

3. Restraints for medical immobilization; or

4. Orthopedically prescribed devices that permit a student to participate in activities without risk of harm.

"Multiple disabilities" mean simultaneous impairments (such as intellectual disability with blindness or intellectual disability with orthopedic impairment), the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blindness.

"Orthopedic impairment" means a severe orthopedic impairment that adversely affects a child's educational performance. The term includes impairments caused by congenital anomaly, impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).

"Other health impairment" means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome, and that adversely affects a child's educational performance.

"Paraprofessional," also known as paraeducator, means an appropriately trained employee who assists and is supervised by qualified professional staff in meeting the requirements of this chapter.

"Parent" means:

1. A person who is:

a. A biological or adoptive parent of a child;

b. A foster parent, even if the biological or adoptive parent's rights have not been terminated, but subject to subdivision 3 of this definition;

c. A guardian generally authorized to act as the child's parent or make educational decisions for the child (but not the Commonwealth if the child is a ward of the Commonwealth);

d. An individual acting in the place of a biological or adoptive parent (including grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or

e. If no party qualified under subdivisions 1 a through 1 d of this definition can be identified, or those parties are unwilling to act as parent, a surrogate parent who has been appointed in accordance with 8VAC20-81-220.

2. The biological or adoptive parent, when attempting to act as the parent pursuant to this section and when more than one party is qualified under subdivision 1 of this definition to act as a parent, must be presumed to be the parent for purposes of this section unless the biological or adoptive parent has had his residual parental rights and responsibilities terminated pursuant to § 16.1-277.01, 16.1-277.02, or 16.1-283 of the Code of Virginia or a comparable law in another state.

3. The local school division shall provide written notice to the biological or adoptive parents at their last known address that a foster parent is acting as the parent pursuant to this section, and the local school division is entitled to rely upon the actions of the foster parent pursuant to this section until such time that the biological or adoptive parent attempts to act as the parent.

4. If a judicial decree or order identifies a specific person ~~or persons~~ among subdivisions 1 a through 1 e of this definition to act as the "parent" of a child or to make educational decisions on behalf of a child, then such person ~~or persons~~ shall be determined to be the "parent" for purposes of the special education identification, evaluation, and placement of a child and the provision of a free appropriate public education to a child.

"Pat down" means a thorough external body search of a clothed student.

"Personally identifiable information" means information that includes, but is not limited to:

1. The student's name, the child's parent, or other family member;

2. The address of the child;

3. A personal identifier, such as the child's social security number or student number; or

4. A list of personal characteristics that would make the student's identity easily traceable.

"Pharmacological restraints" means a drug or medication used on a student to control behavior or restrict freedom of movement that is not (i) prescribed by a licensed physician or other qualified health professional acting under the scope of the professional's authority for the standard treatment of a student's medical or psychiatric condition and (ii) administered as prescribed by the licensed physician or other qualified health professional acting under the scope of the professional's authority.

"Physical restraint" means the use of approved physical interventions or "hands-on" holds by trained staff to prevent a student from moving his body to engage in a behavior that places him or others at risk of physical harm. Physical restraint does not include:

1. Briefly holding a student in order to calm or comfort the student; or

2. Holding a student's hand or arm to escort the student safely from one area to another.

"Placing agency" means the community policy and management team under the Children's Services Act, Chapter 52 (§ 2.2-5200 et seq.) of Title 2.2 of the Code of Virginia; the local school division; or the local department of social services.

"Privately placed student" means a student placed in a private school for students with disabilities by the parent.

"Publicly placed student" means a student placed in a private school for students with disabilities by a local school division, family assessment and planning team under the Children's Services Act, or court order.

"Qualified personnel" or "qualified staff" means personnel who have met the state-approved or state-recognized certification, licensing, or other comparable requirement applicable to a specific discipline.

"Regular basis" means more than twice a month.

"Related services" means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education and includes speech-language pathology and audiology services; interpreting services; psychological services; physical and occupational therapy; recreation, including therapeutic recreation; early identification and assessment of disabilities in children; counseling services, including rehabilitation counseling; orientation and mobility services and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services; social work services in schools; and parent counseling and training. Related services do not include

a medical device that is surgically implanted including cochlear implants, the optimization of device functioning (e.g., mapping), maintenance of the device, or the replacement of that device. The list of related services is not exhaustive and may include other developmental, corrective, or supportive services (such as artistic and cultural programs, and art, music, and dance therapy, if they are required to assist a child with a disability to benefit from special education).

"School" means a school for students with disabilities that has a license to operate issued by the Superintendent of Public Instruction.

"School for students with ~~disabilities "~~ disabilities" or "schools" means a privately owned and operated preschool, school, or educational organization, no matter how titled, maintained, or conducting classes for the purpose of offering instruction, for a consideration, profit or tuition, to persons determined to have autism, deaf-blindness, developmental delay, a hearing impairment including deafness, intellectual disability, multiple disabilities, orthopedic impairment, other health impairment, an emotional disturbance, a specific learning disability, a speech or language impairment, a traumatic brain injury, or a visual impairment including blindness.

"Seclusion" means the confinement of a student alone in a room from which the student is physically prevented from leaving.

"Serious incident" means:

1. Any accident or injury requiring medical attention by a licensed physician;

2. Any illness that requires hospitalization;

3. Any runaway; or

4. Any event that affects, or potentially may affect, the health, safety, or welfare of any student being served at the school or school-related activity.

"Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician.

"Special education" means specially designed instruction to meet the unique needs of a child with a disability.

The term includes:

1. Speech-language pathology services or any other related service, if the service is considered special education rather than a related service under state standards;

2. Vocational education; and

3. Travel training.

"Specially designed instruction" means adapting, as appropriate, to the needs of an eligible child under this chapter, the content, methodology, or delivery of instruction to:

1. Address the unique needs of the child that result from the child's disability; and

2. Ensure access of the child to the general curriculum so that the child can meet the educational standards that apply to all children within the jurisdiction of the local educational agency.

"Specific learning disability" means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Specific learning disability does not include learning problems that are primarily the result of (i) visual, hearing, or motor disabilities; (ii) intellectual disabilities; (iii) emotional disabilities; or (iv) environmental, cultural, or economic disadvantage.

Dyslexia is distinguished from other learning disabilities due to its weakness occurring at the phonological level. Dyslexia is a specific learning disability that is neurobiological in origin. It is characterized by difficulties with accurate ~~and/or~~ or fluent word recognition and by poor spelling and decoding abilities. These difficulties typically result from a deficit in the phonological component of language that is often unexpected in relation to other cognitive abilities and the provision of effective classroom instruction. Secondary consequences may include problems in reading comprehension and reduced reading experience that can impede growth of vocabulary and background knowledge.

"Speech or language impairment" means a communication disorder, such as stuttering, impaired articulation, expressive or receptive language impairment, or voice impairment, that adversely affects a child's educational performance.

"Standard precautions" mean universal precautions designed to prevent transmission of HIV, hepatitis B virus (HBV), and other bloodborne pathogens when providing first aid or health care. Standard precautions apply to blood; all body fluids, secretions, and excretions except sweat, regardless of whether or not they contain blood; nonintact skin; and mucous membranes. The precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection when providing first aid or health care. Standard precautions include protective barriers such as gloves, gowns, aprons, masks, or protective eye wear that can reduce the risk of exposure with materials that may contain infectious microorganisms.

"Standards of Learning" or "SOL" means Virginia's rigorous academic standards established by the Board of Education.

"Strip search" means a visual inspection of the body of a student when that student's outer clothing or total clothing is removed, and there is an inspection of the removed clothing. Strip searches are conducted for the detection of contraband.

"Substantial compliance" means that while there may be noncompliance with one or more regulations that represent minimum risk, compliance clearly and obviously exists with most of the regulations as a whole.

"Superintendent" means the state Superintendent of Public Instruction.

"Teacher of record" means the teacher who is responsible for the delivery of instruction. The teacher of record shall hold a license issued by the Virginia Board of Education.

"Time-out" means assisting a student to regain control by removing the student from his immediate environment to a different open location until the student is calm or the problem behavior has subsided.

"Traumatic brain injury" means an acquired injury to the brain caused by an external physical force or by other medical conditions, including stroke, anoxia, infectious disease, aneurysm, brain tumors, and neurological insults resulting from medical or surgical treatments, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. Traumatic brain injury applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. Traumatic brain injury does not apply to brain injuries that are congenital or degenerative or to brain injuries induced by birth trauma.

"Visual impairment including blindness" means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness.

"Volunteer" means any individual who of his own free will and without compensation provides goods or services to the school.

"Virtual learning" means the delivery of instruction through emerging technologies such as satellite, streaming video, or the Internet.

8VAC20-750-20. General definitions.

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

"Behavioral intervention plan" or "BIP" means a plan that utilizes positive behavioral interventions and supports to address (i) behaviors that interfere with a student's learning or that of others or (ii) behaviors that require disciplinary action.

"Board" means the Virginia Board of Education.

"Business day" means Monday through Friday, 12 months of the year, exclusive of federal and state holidays (unless holidays are specifically included in the designation of business days).

"Chapter" means these regulations, that is, Regulations Governing the Use of Seclusion and Restraint in Public Elementary and Secondary Schools in Virginia, 8VAC20-750.

"Calendar days" means consecutive days, inclusive of Saturdays and Sundays. Whenever any period of time fixed by this chapter expires on a Saturday, Sunday, federal holiday, or state holiday, the period of time for taking such action shall be extended to the next day that is not a Saturday, Sunday, federal holiday, or state holiday.

"Child with a disability" or "student with a disability" means a public elementary or secondary school student evaluated in accordance with the provisions of 8VAC20-81 as having an intellectual disability, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disability (referred to in 8VAC20-81 as an emotional disability), an orthopedic impairment, autism, traumatic brain injury, other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities who, by reason thereof, requires special education and related services. This also includes developmental delay if the school division recognizes this category as a disability under 8VAC20-81-80 M 3. If it is determined through an appropriate evaluation that a child has one of the disabilities identified but only needs related services and not special education, the child is not a child with a disability under 8VAC20-81. If the related service required by the child is considered special education rather than a related service under Virginia standards, the child would be determined to be a child with a disability. As used in this chapter, the disability categories set forth in this definition and the terms "special education" and "related services" shall have the meanings set forth in 8VAC20-81-10.

"Day" means calendar day unless otherwise designated as business day or school day.

"Department" means the Virginia Department of Education.

"Evaluation" means procedures used in accordance with 8VAC20-81 to determine whether a child has a disability and the nature and extent of the special education and related services the child needs.

"Functional behavioral assessment" or "FBA" means a process to determine the underlying cause or functions of a student's behavior that impede the learning of the student or the learning of the student's peers. A functional behavioral assessment may include a review of existing data or new testing data or evaluation as determined as set forth in 8VAC20-750-70.

"Individualized education program" or "IEP" means a written statement for a child with a disability that is developed, reviewed, and revised at least annually in a team meeting in

accordance with the Regulations Governing Special Education Programs for Children with Disabilities in Virginia (8VAC20-81). The IEP specifies the individual educational needs of the child and what special education and related services are necessary to meet the child's educational needs.

"Individualized education program team" or "IEP team" means a group of individuals described in 8VAC20-81-110 that is responsible for developing, reviewing, or revising an IEP for a child with a disability.

"School day" means any day, including a partial day, that students are in attendance at school for instructional purposes. The term has the same meaning for all students in school, including students with and without disabilities.

"School personnel" means individuals employed by the school division on a full-time or part-time basis or as independent contractors or subcontractors as instructional, administrative, and support personnel and include individuals serving as a student teacher or intern under the supervision of appropriate school personnel.

"Section 504 plan" means a written plan of modifications and accommodations under Section 504 of the Rehabilitation Act of 1973 (29 USC § 794).

"Student" means any student, with or without a disability, enrolled in a public elementary or secondary school as defined in § 22.1-1 of the Code of Virginia.

1. For purposes of this chapter, the term "student" shall also include those students (i) attending a public school on a less-than-full-time basis, such as those students identified in § 22.1-253.13:2 N of the Code of Virginia; (ii) receiving homebound instruction pursuant to 8VAC20-131-180 and as defined in 8VAC20-81-10, without regard to special education status; (iii) receiving home-based instruction pursuant to 8VAC20-81-10; and (iv) who are preschool students enrolled in a program operated by a school division or receiving services from school personnel.

2. As used in this chapter, "student" shall not include children meeting compulsory attendance requirements of § 22.1-254 of the Code of Virginia by (i) enrollment in private, denominational, or parochial schools; (ii) receipt of instruction by a tutor or teacher of qualifications prescribed by the Board of Education and approved by the relevant division superintendent; ~~[~~] (iii) receipt of home instruction pursuant to § 22.1-254 of the Code of Virginia ~~]~~ or (iv) receipt of instruction in a secure facility or detention home as defined in § 16.1-228 of the Code of Virginia or in a facility operated by the Virginia Department of Behavioral Health and Developmental Services ~~]~~. With regard to restraint and seclusion, students placed through public or private means in a private day or residential school for students with -disabilities shall be afforded the protections set forth in 8VAC20-671.

"Traumatic brain injury" means an acquired injury to the brain caused by an external physical force or by other medical conditions, including stroke, anoxia, infectious disease, aneurysm, brain tumors, and neurological insults resulting from medical or surgical treatments, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. "Traumatic brain injury" applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. "Traumatic brain injury" does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.

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STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

Proposed Regulation

Title of Regulation: **8VAC40-31. Regulations Governing Certification of Certain Institutions to Confer Degrees, Diplomas and Certificates (adding 8VAC40-31-125).**

Statutory Authority: § 23.1-215 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: April 1, 2022.

Agency Contact: Beverly Rebar, Senior Associate for Academic and Legislative Affairs, State Council of Higher Education for Virginia, 101 North 14th Street, 9th Floor, Monroe Building, Richmond, VA 23219, telephone (804) 371-0571, or email beverlyrebar@schev.edu.

Basis: Section 23.1-215 of the Code of Virginia authorizes the State Council of Higher Education for Virginia (SCHEV) to adopt, pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia), such regulations as may be necessary to implement the provisions for standards for certain private and out-of-state institutions of higher education. Section 23.1-215 of the Code of Virginia authorizes the State Council of Higher Education for Virginia to adopt, pursuant to the Administrative Process Act, such regulations as may be necessary to implement the provisions of Chapter 2 (§ 23.1-200 et seq.) of Title 23.1 of the Code of Virginia.

Purpose: This regulation is essential to protect the welfare of citizens who are enrolled in programs by out-of-state distance education providers. The national education landscape has changed such that online education programs have proliferated. While it may once have been a common operational model to offer distance learning through telecommunications equipment that was located at a site within the state, technological advancements have rendered that model obsolete. Out-of-state postsecondary schools can and do

conduct business with Virginia citizens from locations entirely outside of Virginia. Those citizens are entitled to the same protections afforded to Virginia students enrolled in Virginia schools through SCHEV certification processes.

The regulation will not have any effect on institutions that are members in good standing of the National State Authorization Reciprocity Agreement (NC-SARA) it imposes no certification requirements on State Authorization Reciprocity Agreement (SARA) members from other states. The NC-SARA framework ensures adequate consumer protections for students of SARA schools nationwide. Certification for schools that are not members of NC-SARA is more complex and will require a separate process that has been outlined in the proposed language.

Substance: The regulation will provide that any degree-granting postsecondary school providing distance learning to residents of the Commonwealth from a location outside of the Commonwealth shall be certified to operate in the Commonwealth or shall be a participant in a reciprocity agreement to which the Commonwealth belongs. Schools that are members of the NC-SARA reciprocity agreement are not subject to the regulation as according to NC-SARA, Virginia reciprocally honors their home states' authorization.

The regulation provides criteria that must be fulfilled by schools that are not members of NC-SARA in order to be certified to operate, addressing (i) aspects of the school's current status, such as accreditation, being in good standing in its home state, and providing certain disclosures to the public and (ii) the school's obligations to the Commonwealth regarding maintenance of student records and payment of fees.

Issues: The primary advantage to the public and the Commonwealth is that SCHEV will be able to protect Virginia citizens who are enrolled in out-of-state postsecondary schools in distance education programs. There are no disadvantages to the public or the Commonwealth from the regulation.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 380 of the 2020 Acts of Assembly, the State Council of Higher Education for Virginia (SCHEV) proposes to add certification requirements for out-of-state schools offering distance learning in Virginia. Out-of-state schools that are members of the National Council for State Authorization Reciprocity Agreements (NC-SARA) would be exempt from these certification requirements. The proposed amendments would require out-of-state schools that are not members of NC-SARA to: (i) apply for SCHEV authorization by demonstrating authorization and good standing in the state where the school has legal domicile, (ii) provide certain disclosures to Virginia students seeking to enroll in a distance learning program, and (iii) pay a certification fee.

Background. Chapter 380 of the 2020 Acts of Assembly added a definition of "distance learning" and amended § 23.1-219 of the Code of Virginia to add: Any degree-granting postsecondary school providing distance learning to residents of the Commonwealth from a location outside of the Commonwealth shall be certified to operate in the Commonwealth or shall be a participant in a reciprocity agreement to which the Commonwealth belongs for the purpose of consumer protection.[1] Accordingly, out-of-state schools that are part of NC-SARA would not require certification. Schools that do require certification would have to demonstrate that they meet the following criteria: (i) the institution is authorized to operate by the appropriate entity in the state where the institution has legal domicile, (ii) the institution is accredited by an accrediting body approved by the U.S. Department of Education with a scope of authority that includes distance learning, (iii) the institution is in good legal standing, including having no current or pending show cause or probationary actions against it, and (iv) the institution demonstrates minimum financial stability to qualify for certification.

Upon receiving certification, out-of-state schools seeking to enroll Virginia students would be required to provide prospective enrollees with a notification that the school is certified, a notification outlining the procedures a student may follow to file a complaint against the school, including contacting SCHEV as a last resort, and a notification stating that the transferability of credits earned at the school is at the sole discretion of the receiving institution. Further, institutions offering programs leading to professional licensure would be required to provide prospective students with a notification regarding whether completion of the program would be sufficient to meet licensure requirements in Virginia. Lastly, the institution would be required to inform SCHEV and enrolled students in Virginia of "any adverse action by the U.S. Department of Education or by its accrediting agency that threatens a disruption of the operation of the institution and/or exposes students to a loss of course or degree credit or financial loss."

Institutions would have to pay SCHEV a nonrefundable initial and renewal authorization fee as provided in 8VAC40-31-260.[2] The proposed amendments include a requirement that applications for annual renewal be submitted at least 90 days prior to the expiration date specified on the certificate of authorization.

Estimated Benefits and Costs. The proposed changes to fees would increase costs for out-of-state institutions providing distance learning programs in Virginia while providing greater protections to students in Virginia seeking to enroll in distance learning programs from out-of-state institutions. As long as the demand for distance learning programs from out-of-state schools remains robust, these institutions would most likely absorb the costs of the application and renewal fees. Schools may also pass on all or part of these costs to students, either spreading out the cost across all students, or specifically across Virginia residents. Out-of-state schools that choose not to apply for certification would have two options: they may join

NC-SARA instead of going through the certification process, or choose not to enroll students from Virginia.[3]

Virginia students and their families would benefit from greater oversight of distance learning programs, particularly those not part of NC-SARA. In particular, the proposed amendments would require that distance learning programs provide notifications to prospective students regarding the certification status, transferability of credits, and if applicable, whether the program meets licensing requirements in Virginia. Students and families would benefit from greater transparency and SCHEV could take action if certified schools are found to not provide these notifications. However, such consumer protection benefits would be limited if uncertified schools are able to enroll Virginia students undetected, and if students and their families are unaware of the certification and notification requirements.

Businesses and Other Entities Affected. The proposed amendments would not impact any postsecondary educational institutions in Virginia; they apply only to out-of-state schools that do not participate in NC-SARA. The number of such schools is unknown. Virginia students seeking to enroll in distance learning programs would benefit from greater oversight of out-of-state schools' distance learning programs.

An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. The proposal would increase costs for out-of-state schools offering distance learning in Virginia that are not members of NC-SARA. Thus, an adverse impact is indicated.

Small Businesses[4] Affected. The proposed amendments would not affect small businesses in Virginia.

Localities[5] Affected.[6] 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 unlikely to affect employment in Virginia since they only apply to certain out-of-state schools.

Effects on the Use and Value of Private Property. The proposed amendments increase costs for out-of-state private schools offering distance learning in Virginia that are not members of NC-SARA. The value of such private schools may be modestly reduced. Real estate development costs are not affected.

[1]See https://lis.virginia.gov/cgi-bin/legp604.exe?201+ful+CHAP0380+hil.

[2]In a separate regulatory action, SCHEV has set the initial fee and renewal fee at $10,000. See https://townhall.virginia.gov/l/ViewAction.cfm?actionid=5391 for details.

[3]This applies for schools with legal domicile in 49 states (all but California), the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. California schools would not have the option of joining NC-SARA since their state is not party to the agreement. See https://www.nc-sara.org/sara-states.

[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."

[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.

Agency's Response to Economic Impact Analysis: The State Council of Higher Education for Virginia concurs with the economic impact analysis submitted by the Department of Planning and Budget.

Summary:

Pursuant to Chapter 380 of the 2020 Acts of Assembly, the proposed amendments require out-of-state postsecondary schools offering distance education to Virginia citizens to be certified by the State Council of Higher Education for Virginia or be participants in a reciprocity agreement to which the Commonwealth belongs. This action establishes certification requirements for schools that do not participate in a reciprocity agreement.

8VAC40-31-125. Certification required for schools offering distance learning in Virginia.

A. Any degree-granting postsecondary school providing distance learning to residents of the Commonwealth from a location outside of the Commonwealth shall be certified to operate in the Commonwealth or shall be a participant in a reciprocity agreement to which the Commonwealth belongs, in accordance with council's authority pursuant to § 23.1-211 of the Code of Virginia, for the purpose of consumer protection.

B. Any degree-granting postsecondary institution seeking initial or renewal authorization to offer distance education programs or courses to residents of the Commonwealth from a location outside of the Commonwealth that is not a participant in a reciprocity agreement to which the Commonwealth belongs must demonstrate that it meets the following eligibility criteria:

1. The institution is properly authorized to operate by and in good standing with the appropriate entity in the state where the institution has legal domicile.

2. The institution is a United States degree-granting institution that is accredited by an accrediting agency that is recognized by the U.S. Department of Education with a scope of authority, as specified by the U.S. Department of Education, that includes distance education.

3. The institution is in good standing, including having no current or pending show cause or probation actions against it.

4. The institution demonstrates minimum financial stability to qualify for certification defined as a federal Financial Responsibility Composite Score of 1.5 or better.

C. An institution certified pursuant to this section shall provide proof of the following disclosures to Virginia residents:

1. A notification that the school is certified to operate by council.

2. A notification outlining the procedures a student may follow to file a complaint against the school. The disclosure must include a statement that if the complaint is not resolved to the student's satisfaction, the student may contact the council as a last resort. The school must provide contact information for council and must ensure that the student will not be retaliated against for filing a complaint.

3. A notification stating that the transferability of credits earned at the school is at the sole discretion of the receiving institution.

4. For institutions offering programs or courses leading to or advertised as leading to professional licensure, a notification regarding whether completion of the program is sufficient to meet licensure requirements in Virginia. If the institution is unable to determine whether a program will meet the professional licensure requirements in Virginia, the notification shall provide current contact information for any applicable licensing boards and advise the student or applicant to determine whether the program meets requirements for licensure in Virginia prior to enrollment.

D. An institution certified pursuant to this section shall pay a nonrefundable initial and renewal authorization fee as provided in 8VAC40-31-260.

E. An institution certified pursuant to this section shall immediately inform the council and current enrolled students who are residents of the Commonwealth of any adverse action by the U.S. Department of Education or by its accrediting agency that threatens a disruption of the operation of the institution or exposes students to a loss of course or degree credit or financial loss.

F. The certificate of authorization for an institution certified pursuant to this section shall expire on the stated expiration date. Applications for annual renewals must be submitted to council at least 90 days prior to the expiration date of the current authorization.

VA.R. Doc. No. R21-5770; Filed December 29, 2021, 2:30 p.m.

TITLE 9. ENVIRONMENT

VIRGINIA WASTE MANAGEMENT BOARD

Proposed Regulation

Titles of Regulations: **9VAC20-120. Regulated Medical Waste Management Regulations (repealing 9VAC20-120-10 through 9VAC20-120-1000).**

9VAC20-121. Regulated Medical Waste Management Regulations (adding 9VAC20-121-10 through 9VAC20-121-420).

Statutory Authority: § 10.1-1402 of the Code of Virginia; 42 USC § 6941 et seq.; 40 CFR Part 257.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: April 18, 2022.

Agency Contact: Priscilla D. Rohrer, Guidance and Regulation Coordinator, Department of Environmental Quality, P.O. Box 3000, Harrisonburg, VA 22801, telephone (540) 574-7852, FAX (804) 698-4178, or email priscilla.rohrer@deq.virginia.gov.

Basis: Section 10.1-1402 of the Code of Virginia authorizes the Virginia Waste Management Board to supervise and control waste management activities in the Commonwealth and to promulgate regulations necessary to carry out its powers and duties.

Purpose: The purpose of this regulatory action is to modernize the standards for general handling and treatment of regulated medical waste (RMW) based on current industry best management practices. This regulatory action is necessary in order to update the requirements for RMW transfer stations and RMW treatment facilities, provide clarity for the regulated universe, remove redundancies, and eliminate overlap with other regulations. The goals of this action are to clarify the requirements for generators and permitted facilities, improve permitting procedures, and streamline the regulation for ease of use while still protecting the health, safety, and welfare of citizens. Proposed validation and operating parameters for treatment technologies were evaluated during the regulatory development phase.

Substance: This regulation is for the general handling, storage, transfer, treatment, and disposal of regulated medical waste. Rules for packaging, labeling and transporting RMW, as well as exemptions from regulation, are also included. Additional substantive revisions include (i) providing conditional exemptions to encourage safe collection and proper management of specific types of regulated medical waste, such as sharps; (ii) clarifying RMW storage requirements for generators and permitted facilities; (iii) streamlining the permit structure and clarifying activities exempt from permitting; (iv) specifying the siting, design, operation, recordkeeping, and reporting requirements of RMW transfer stations and treatment facilities; (v) requiring validation and periodic challenge testing for treatment technologies; (vi) clarifying procedures for the management of Category A wastes; (vii) improving the alternate treatment technology petition process; and (viii) improving regulatory structure, procedures, and use. Currently, Virginia has 14 regulated medical waste management facilities that have transfer stations or that treat regulated medical waste.

Issues: The primary advantage of this regulatory action is that the proposed regulatory action will provide for clarity and

certainty for the management and treatment of RMW. This is an advantage to the regulated community, the public, and the Commonwealth as proper management and treatment of RMW will provide protections for human health and the environment. In working with the regulatory advisory panel to develop the proposed regulation, the agency was careful to provide for greater clarity for those that implement the regulation. This proposed regulatory action should pose no disadvantages to the public or to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Virginia Waste Management Board (Board) proposes numerous changes to the Regulated Medical Waste Management Regulations, including how the chapter is organized. Due to the length and complexity of the proposed changes, instead of amending the current chapter the Board proposes to repeal chapter 9VAC20-120 and promulgate new chapter 9VAC20-121, keeping the name Regulated Medical Waste Management Regulations.

Significant changes include: 1) introducing best management practices for Category A Waste, 2) requiring that all regulated medical waste (RMW) transfer stations and treatment facilities submit new permit applications within six months of the effective date of the regulation, 3) eliminating the option for an on-site permit-by-rule, 4) eliminating expiration dates for permits and renewal requirements, 5) requiring the installation of a fixed radiation detector, 6) new specification requirements for cart tippers, slides, or conveyors, 7) new validation testing[1] requirements prior to operation of treatment systems or devices, 8) enhanced periodic challenge testing[2] requirements, 9) requiring periodic self-inspection of RMW treatment facilities, 10) requiring RMW generators to maintain shipping records, 11) eliminating requirement to shred treated RMW, 12) increasing flexibility for treatment facilities to establish operating parameters specific to the treatment unit and waste stream rather than defaulting to general regulatory performance standards for a particular treatment method, 13) increasing the allowed options for cleaning and disinfection of reusable containers, 14) increasing the allowed options for packaging of treated RMW, and 15) longer storage timeframes for RMW without refrigeration.

Background. The Regulated Medical Waste Management Regulations establish standards and procedures pertaining to RMW management, including permit requirements for the storage, transfer, treatment and disposal of RMW. Rules for packaging, labeling and transporting RMW, as well as exemptions from regulation, are also included. Standards for approved treatment processes are provided as well as provisions for establishing alternate treatment technologies.

During and after the 2014-2015 Ebola virus disease outbreak, the Department of Environmental Quality (DEQ) assisted healthcare facilities and other state and local agencies with planning for the management of Ebola-contaminated waste, which is considered a Category A waste. "Category A waste" means wastes that are contaminated with a Category A infectious substance and must be packaged and transported in accordance with the United States Department of Transportation (USDOT) Hazardous Materials Regulations (HMR) or an applicable USDOT special permit. "Category A infectious substance" means an infectious substance in a form capable of causing permanent disability or life-threatening or fatal disease in otherwise healthy humans or animals when exposure to the substance occurs. Category A infectious substances are defined by 49 CFR 173.134 of the USDOT HMR.[3]

Category A waste must be managed in accordance with more stringent handling, storage, transport, and treatment requirements than other types of RMW in order to prevent the spread of highly infectious disease. The existing Regulated Medical Waste Management Regulations do not specifically address the management of Category A waste. Therefore, during the 2014-2015 Ebola virus disease outbreak DEQ relied on interim guidance from the Centers for Disease Control (CDC), the federal Environmental Protection Agency, USDOT, and other entities while working one-on-one with facilities to ensure that management would protect human health and the environment.

Following the Ebola virus disease outbreak, the CDC awarded a grant to the Virginia Department of Health (VDH). Under a memorandum of understanding, VDH administered the grant funds to DEQ in 2016 to contract subject matter experts to perform a systematic review of the Regulated Medical Waste Management Regulations in order to identify existing regulatory gaps and propose revisions to address current industry best management practices for Category A waste and other types of RMW. The subject matter experts proposed changes to streamline RMW management requirements for generators and permitted facilities, update performance standards for treatment technologies, and clarify specific protocols for validation and periodic challenge testing. DEQ received a report with proposed regulatory revisions in 2017 and formed an internal RMW workgroup to evaluate the proposal prior to submitting the current action.

Estimated Benefits and Costs.

Management of Category A waste. According to DEQ, no Category A waste has been known to be present in the Commonwealth, including during the Ebola virus disease outbreak. The proposed new regulation includes a section, 9VAC20-121-160, on the management of Category A waste. In addition to stating that, "Every effort shall be made to minimize the amount of Category A waste generated," the proposed section delineates the procedures to be followed if it is present. The proposed text does not introduce substantive cost, and is beneficial in that facilities would likely be more knowledgeable on how to most safely handle Category A waste if it is present.

Permits. The Board proposes to require that all RMW transfer stations and treatment facilities in Virginia submit new permit applications within six months of the effective date of the regulation. There are four RMW transfer stations and ten RMW treatment facilities in the Commonwealth. Each of these 14 entities would be required to pay a $390 permit fee. DEQ estimates that it would take each entity from 24 to 40 hours to assemble the information necessary to submit the application. The agency estimates that it would spend approximately 12 hours of staff time per permit application for review and processing. The Board believes that given the magnitude of proposed changes, a full review associated with permit application is necessary.

The current regulation includes a permitting option called on-site permit-by-rule. The Board proposes to eliminate this option, which would affect nine of the 14 permitted facilities. As a result, these facilities would incur additional costs from the staff time needed to compile additional submission documents for the permit application. According to DEQ the facilities should already have all of the information needed to complete and submit the additional documents. The agency believes that by eliminating the on-site permit-by-rule option it would receive better information on treatment units. Improved information would allow DEQ to better ensure that RMW is treated effectively and appropriately, and thereby provide better protections for the public and consistency in permitting procedures for all fourteen facilities.

Under the current regulation, permits expire and need to be renewed every ten years. Under the proposed regulation, permits do not expire and do not need to be renewed. For each of the 14 RMW facilities and any other future RMW facilities, this would save $390 in fees and approximately 24 to 40 hours of staff time in application preparation every ten years. It would also save approximately 12 hours of DEQ staff time in application review and processing for each facility every ten years as well.

Other New Requirements. The proposed regulation requires that RMW transfer stations and treatment facilities have fixed radiation detectors in a location as close as practicable to the incoming waste loads and in proximity to monitor all waste prior to storage, transfer, or treatment. The fixed radiation detectors are not required at captive regulated medical waste management facilities[4] if the facility demonstrates that there is no potential for generation or management of radioactive materials or wastes. Radiation detectors cost from $6,000 to $8,000 for fixed devices depending on the configuration (floor mounted or door mounted).[5] According to DEQ, a number of permitted facilities (including at least two state university hospitals) have already installed fixed radiation detectors.

The proposed regulation includes new specification requirements for cart tippers, slides, or conveyors to ensure that movement of RMW is controlled to maintain the integrity of the RMW packaging (i.e. to avoid damage to packaging that could cause releases of RMW). Based on a DEQ survey of treatment facilities, modifications to existing cart tippers, if needed, may cost anywhere from a nominal maintenance charge (to adjust hydraulic pressure) up to $2,000 (to install a non-porous barrier).

"Validation testing" means procedures conducted at the site of a regulated medical waste treatment facility prior to initial operation of a treatment system or device, the purpose of which is to demonstrate, through established operating parameters, the effective treatment of regulated medical waste. The proposed regulation includes new validation requirements prior to operation, with criteria for when repeat validation is to occur (at least once every five years) to ensure treatment units are operating effectively. The additional costs for the initial validation include costs for four to 12 biological indicators for each of three validation test runs (at $3 to $4 per indicator) and approximately 8 hours of staff time to complete the testing (usually 30 to 90 minutes per test plus incubation time for biological indicators).[6] These are costs per treatment unit. Of the ten RMW treatment facilities in the Commonwealth, five have one unit ($36 to $144 in indicators and 8 hours of staff time), one has two units ($72 to $288 in indicators and 16 hours of staff time), two have three units ($108 to $432 in indicators and 24 hours of staff time), one has four units ($144 to $576 in indicators and 32 hours of staff time), and one has nine units ($324 to $1,296 in indicators and 72 hours of staff time).

"Challenge Testing" means periodic monitoring or testing of a regulated medical waste treatment device or system that employs the use of biological indicators to demonstrate continued, effective operation of the device or system. The proposed regulation includes enhanced periodic challenge testing requirements. The proposed enhanced challenge testing includes the costs of zero to three additional biological indicators ($3 to $4 per indicator) per month beyond the current requirement, depending on the volume of waste treated. The number of biological indicators required per month corresponds to the volume of waste treated per load. Staff time for performing challenge tests is not anticipated to be lengthened by the use of additional biological indicators.

The proposed regulation also requires that each facility conduct monthly inspections of all major aspects of facility operations necessary to ensure compliance with the regulation. Records of the self-inspections are required to be kept and be available for review. DEQ estimates that this would take one hour of one employee's time per month.

Not all generators of RMW are required to maintain records under the current regulation. The Board proposes to require that all RMW generators maintain records, including copies of all shipping papers, specifying the date of shipment, amount of waste removed from the site, and the names, addresses, and telephone numbers of the transporter and the destination facility receiving the shipment for treatment or disposal. Under both the current and proposed regulations, the records are to be kept for a minimum of three years following treatment or shipment.

All of these new requirements are intended to reduce risk to health and safety.

Other Eliminated Requirements or Increased Flexibility. The current regulation requires RMW waste to be shredded to indicate that it has been treated. According to DEQ, this is no longer necessary and the Board proposes to eliminate this requirement. Some facilities have already obtained a variance from the requirement. For those that still are shredding this change would be beneficial in that they will not be affected by down time or the repairs that are required by the shredding units, including the cost to replace blades and other components damaged by clogging. In addition, this would eliminate unnecessary safety and health risks posed to workers who repair shredders, which typically fail mid-cycle and could expose workers to pathogens from untreated RMW no longer contained in intact packaging.

The proposed regulation also introduces potential cost savings in time and materials by: a) increasing the flexibility for treatment facilities to establish operating parameters specific to the treatment unit and waste stream rather than defaulting to general regulatory performance standards for a particular treatment method, b) increasing the allowed options for cleaning and disinfection of reusable containers, c) increasing the allowed options for packaging of treated RMW, and d) allowing RMW to be stored for longer timeframes without refrigeration. All of the above were deemed safe, while potentially reducing costs.

Businesses and Other Entities Affected. The proposed amendments primarily affect the ten permitted RMW treatment facilities and the four permitted RMW transfer stations in the Commonwealth. RMW generators are also affected. The ten permitted RMW treatment facilities consist of four public universities, three hospitals, one state agency, one private laboratory, and one private treatment business. All four permitted RMW transfer stations are private entities. RMW generators include hospitals, doctors' offices, dentists' offices, clinics, and other healthcare facilities as well as veterinary establishments, laboratories, research facilities, etc.

Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. While the benefits to public health may be large, there would likely be some increases in net costs for some of the affected entities as described in the section above. Thus, adverse impact is indicated for this action.

Small Businesses[7] Affected.

Types and Estimated Number of Small Businesses Affected.

Section 2.2-4007.04 of the Code of Virginia defines small business 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." One or two of the ten permitted RMW treatment facilities may qualify as a small business. Employment and revenue data is not available for those entities or the four permitted RMW transfer stations. Thus it is not known which if any qualify as a small business. Many, but not all of the health care facilities are likely small business, but specific data are not available.

Costs and Other Effects. The costs and other effects as described in the Estimated Benefits and Costs section of this report would apply to the affected entities that qualify as small businesses.

Alternative Method that Minimizes Adverse Impact. There are no clear alternative methods that both reduce adverse impact and meet the intended policy goals.

Localities[8] Affected.[9] The proposed regulation affects all localities in that all localities have healthcare facilities. The 14 permitted RMW facilities are located in Arlington, Charlottesville, Chesterfield, Fairfax, Fredericksburg, Norfolk, Petersburg, Prince William, Richmond, Roanoke, Sandston, Sterling, and Warrenton. The proposed amendments do not introduce costs for local governments.

Projected Impact on Employment. The proposed changes associated with the repeal of 9VAC20-120 and promulgation of 9VAC20-121 are not likely to substantially affect total employment.

Effects on the Use and Value of Private Property.[10] The proposed changes associated with the repeal of 9 VAC 20-120 and promulgation of 9 VAC 20-121 increase some costs and reduce other costs for the two privately-owned permitted RMW treatment facilities and four privately-owned permitted RMW transfer stations. There would likely be some increase in net costs for some of these firms, which may moderately reduce their net value.

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[1]"Validation testing" means procedures conducted at the site of a regulated medical waste treatment facility prior to initial operation of a treatment system or device, the purpose of which is to demonstrate, through established operating parameters, the effective treatment of regulated medical waste.

[2]Challenge Testing" means periodic monitoring or testing of a regulated medical waste treatment device or system that employs the use of biological indicators to demonstrate continued, effective operation of the device or system.

[3]See https://www.law.cornell.edu/cfr/text/49/173.134

[4]"Captive regulated medical waste management facility" means a regulated medical waste management facility that is located on property owned or controlled by the generator of all waste managed or disposed of at that facility.

[5]Source: DEQ

[6]Ibid

[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."

[8]"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.

[9]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[10]Private property is interpreted to include all private assets including private businesses.

Agency's Response to Economic Impact Analysis: The department has reviewed the economic impact analysis prepared by the Department of Planning and Budget and has no comment.

Summary:

The proposed regulatory action repeals and replaces Regulated Medical Waste Management Regulations (9VAC20-120), which provides for the general handling, storage, transfer, treatment, disposal of, packaging, labeling, transporting, and exemptions from all of these provisions for regulated medical waste (RMW). Substantive revisions included in the new chapter (i) provide conditional exemptions to encourage safe collection and proper management of specific types of regulated medical waste, such as sharps; (ii) clarify RMW storage requirements for generators and permitted facilities; (iii) streamline the permit structure and clarifying activities exempt from permitting; (iv) specify the siting, design, operation, recordkeeping, and reporting requirements of RMW transfer stations and treatment facilities; (v) require validation and periodic challenge testing for treatment technologies; (vi) clarify procedures for the management of Category A wastes; (vii) improve the alternate treatment technology petition process; and (viii) improve regulatory structure, procedures, and use.

Chapter 121
Regulated Medical Waste Management Regulations

Part I
Definitions

9VAC20-121-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise. Chapter 14 (§ 10.1-1400 et seq.) of Title 10.1 of the Code of Virginia defines words and terms that supplement those in this chapter. The Solid Waste Management Regulations (9VAC20-81) define additional words and terms that supplement those in the statutes and this chapter. When the statutes, as cited, and the solid waste management regulations, as cited, conflict, the definitions of the statutes are controlling.

"Approved sanitary sewer system" means a network of sewers serving a facility that has been approved in writing by the Virginia Department of Health, including affiliated local health departments. Such sewer systems may be approved septic tank or drainfield systems and onsite treatment systems, or they may be a part of a collection system served by a VPDES permitted treatment works.

"Ash" means the residual waste material produced from an incineration process or any combustion.

"ASTM" means the American Society for Testing and Materials.

"Autoclave" means a wet thermal sterilization process that uses saturated steam under a specified amount of pressure for a specified exposure time and at a specific temperature.

"Bioaerosol" means a suspension of airborne particles, generally comprised of microorganisms (e.g., bacteria, viruses) or materials of biological origin released from humans, animals, plants, soil, water, or other sources. Particles range in size from very small to very large, and could include liquid droplets and materials left behind after such droplets evaporate (known as "droplet nuclei").

"Bioburden" means the degree of microbial contamination, including the type and total population of organisms, the number of spore formers present, and their resistance on any material and in a given amount of waste material prior to undergoing treatment.

"Biohazard" means biological substances that pose a threat to the health of living organisms, primarily that of humans, but can include substances harmful to animals.

"Biological indicator" means a preparation of a specific microorganism of a known concentration and resistance to a specific treatment process or to a known physical or chemical condition and is used to evaluate the capability of a process to effectively treat regulated medical waste. "Biological indicators" include bacterial spores or other microorganisms inoculated onto carriers (such as spore strips), spore suspensions, and self-contained biological indicators.

"Biological toxin" or "toxin" means a poison, especially a protein or conjugated protein produced by certain animals, plants, and pathogenic bacteria that is highly poisonous for other living organisms.

"Biologicals" means any preparations (sera, nonviable vaccines, vaccines attenuated in a manner that prevents propagation, antigens, toxins, and antitoxins) derived from a living organism or its products for use in diagnosis, immunization, or treatment of human beings or animals.

"Blood" means human blood, human blood components (e.g., serum and plasma), and products made from human blood.

"Bloodborne pathogen" means pathogenic microorganisms that are present in human blood (including human blood components and products made from human blood) that can cause disease in humans.

"Board" means the Virginia Waste Management Board.

"Body fluids" means liquid emanating or derived from humans, including blood; cerebrospinal, synovial, pleural, peritoneal, and pericardial fluids; semen and vaginal secretions; amniotic fluid; and any other body fluids that are contaminated with blood, mixed or combined with body fluids, or suspected by the health care professional in charge of being capable of producing an infectious disease in humans. This term does not include toenail and skin clippings, breast milk,

sputum, semen, teeth, sweat, tears, urine, vomitus, or saliva that are not contaminated with visible blood unless transmission of an infectious disease is possible as determined by a health care professional.

"Calibration" means the demonstration that a measuring device produces accurate results within specified limits of its operating range.

"Captive regulated medical waste management facility" means a regulated medical waste management facility that is located on property owned or controlled by the generator of all waste managed or disposed of at that facility.

"Category A infectious substance" means an infectious substance in a form capable of causing permanent disability or life-threatening or fatal disease in otherwise healthy humans or animals when exposure to the substance occurs. Category A infectious substances are defined by 49 CFR 173.134 of the U.S. Department of Transportation Hazardous Materials Regulations.

"Category A waste" means wastes that are contaminated with a Category A infectious substance and must be packaged and transported in accordance with the U.S. Department of Transportation Hazardous Materials Regulations or an applicable DOT special permit.

"Challenge testing" means periodic monitoring or testing of a regulated medical waste treatment device or system that employs the use of biological indicators to demonstrate continued, effective operation of the device or system.

"Closure" means the act of securing a regulated medical waste management facility and terminating use of the facility for management of regulated medical waste pursuant to the requirements of this chapter.

"Container" means any portable enclosure in which a material is stored, transported, treated, or otherwise handled.

"Contaminated" means the presence or the reasonably anticipated presence of blood or other body fluids, infectious agent, biohazard, or biological toxin on an item or surface.

"Cremains" means the ash or bone shadows that remain after cremation.

"Culture" means an infectious substance containing a pathogen that is intentionally propagated. "Culture" does not include a human or animal patient specimen.

"Cultures and stock" means materials derived from the management (e.g., the systems used to grow and maintain infectious agents in vitro, including nutrient agars, gels, broths, and cell lines) of agents infectious to humans, and associated biologicals, from medical or pathological laboratories, from research and industrial laboratories, or from the production of biologicals and includes discarded live or attenuated vaccines capable of propagation, or culture dishes and devices used to transfer, inoculate, or mix cultures.

"Cycle" means the total operating time required for a device to treat regulated medical waste, and for an autoclave, includes warm-up, residence time, and cool down time.

"D-value" or "decimal reduction value" means the thermal resistance or time in minutes at a specific temperature that is required for a one-log or 90% reduction of a specific microbial population under specified treatment conditions.

"Decontamination" means the use of physical or chemical means to remove, inactivate, or destroy human pathogens on a surface or item to the point where they are no longer capable of transmitting disease and the surface or item is rendered safe for handling, use, or disposal.

"Department" or "DEQ" means the Virginia Department of Environmental Quality.

"Director" means the Director of the Department of Environmental Quality or the director's designee.

"Discard" means to throw away or reject. When a material is soiled, contaminated, or no longer usable, and it is placed in a waste receptacle for disposal or treatment prior to disposal, it is considered discarded.

"Discharge" or "waste discharge" means the accidental or intentional spilling, leaking, pumping, pouring, emitting, emptying, or dumping of regulated medical waste into or on any land or state waters.

"Disinfectant" means an antimicrobial product used on hard inanimate surfaces and objects to destroy or irreversibly inactivate infectious agents, such as bacteria, fungi, and viruses, but not necessarily bacterial spores. There are three types of disinfectants registered by EPA based on the type of efficacy data submitted: limited, general or broad-spectrum, and hospital grade.

"Disinfection" means any procedure that involves the application of an antimicrobial agent (disinfectant) registered with EPA that is consistent with its approved use in accordance with the manufacturer's instructions. Disinfection shall not be considered a form of treatment, and appropriate handling of disinfected materials, as well as health and safety precautions, shall still be required to achieve protection of public health and the environment.

"Disposal" means the discharge, deposit, injection, dumping, spilling, leaking, or placing of any solid waste into or on any land or water so that such solid waste or any constituent of it may enter the environment or be emitted into the air or discharged into any waters, including groundwaters.

"Disposal facility" means a facility or part of a facility at which solid waste is intentionally placed into or on any land or water, and at which the solid waste will remain after closure.

"Domestic sewage" means untreated sanitary wastes that pass through a sewer system.

"Efficacy testing" means testing of a treatment method, system, or device, conducted by a laboratory, independent of the system manufacturer, in conformance with generally recognized scientific principles, microbiologic examinations, or other pertinent assessments of waste material to establish operating parameters for effective treatment of regulated medical waste.

"Effluent" means liquid waste such as spills, wash water, and wastewater emanating from regulated medical waste storage, transfer, and treatment areas.

"Empty" means wastes have been removed from a container using the practices commonly employed to remove materials of that type such as pouring, pumping, or aspirating.

"EPA" means the U.S. Environmental Protection Agency.

"Exposure time" or "residence time" means the length of time at which the treatment method is held at a specific temperature, pressure, irradiation level, or chemical concentration for effective treatment of regulated medical waste.

"Federal agency" means any department, agency, or other instrumentality of the federal government, any independent agency, or establishment of the federal government, including any government corporation and the Government Printing Office.

"Generate" means to cause waste to become subject to regulation. At the point a regulated medical waste is discarded, it has been generated. Timeframes associated with storage and refrigeration are linked to the date the waste is placed in storage, not the date the waste is generated.

"Generator" means any person, by site location, whose act or process produces regulated medical waste identified or defined in this chapter or whose act first causes a regulated medical waste to become subject to this chapter.

"Hazardous material" means a substance or material that has been so designated under 49 CFR Parts 171 and 173.

"Hazardous waste" means any solid waste defined as a "hazardous waste" by the Virginia Hazardous Waste Management Regulations.

"Health care professional" means a medical doctor or nurse practicing under a license issued by the Department of Health Professions.

"Household sharps" means any needles, syringes with attached needles, lancets, auto injectors, pen needles, and any other devices that are used to penetrate the skin for the delivery of medications that are derived from households through self-care, rather than under the care of a home health care professional or at a health care facility. "Household sharps" are sharps that, except for the fact that they are derived from a household, would otherwise be classified as a regulated medical waste in accordance with this chapter.

"Household waste" means any waste material, including garbage, trash, and refuse, derived from households. Households include single and multiple residences, hotels and motels, bunkhouses, ranger stations, crew quarters, campgrounds, picnic grounds, and day-use recreation areas. "Household waste" does not include sanitary waste in septic tanks (septage) that is regulated by other state agencies. Waste generated by a health care professional or nonstationary health care provider administering care in a household, mobile unit, or commercially operated residence, or outpatient recovery facility that meets the definition of regulated medical waste is not household waste and must be managed as regulated medical waste.

"Inactivated" or "inactivation" means having reached the point, through autoclaving, incineration, or other validated treatment process, where the waste material is no longer infectious, does not pose an infection risk, and is not considered to be a regulated medical waste.

"Infectious agent" means any organism or agent, including a synthetic agent, that causes disease or an adverse health impact in humans or can be transferred to humans, as well as animals that have an economic impact on human society.

"Infectious substance" means a material known or reasonably expected to contain a pathogen, including bacteria, viruses, rickettsiae, parasites, fungi, or prions, that can cause disease in humans or animals.

"Inner packaging" means a packaging that is the primary container, such as a red bag or sharps container, for which an outer packaging is required for transport.

"Nonstationary health care provider" means those persons who routinely provide health care at locations that change each day or frequently. This term includes traveling doctors, nurses, midwives, and others providing care in patients' homes, first aid providers operating from emergency vehicles, and mobile blood service collection stations.

"Offsite" means any site that does not meet the definition of onsite, as defined in this part, including areas of a facility that are not on geographically contiguous property or outside of the boundary of the site.

"Onsite" means the same or geographically contiguous property, which may be divided by public or private right-of-way, provided the entrance and exit to the facility are controlled by the owner or the operator of the facility. Noncontiguous properties owned by the same person but connected by a right-of-way that he controls and to which the public does not have access are also considered onsite property.

"Operating parameters" means the specific conditions of pressure, temperature, residence time, chemical concentration, and other physical or engineering condition established through efficacy testing of a treatment method and verified

through validation testing to be effective for treatment of regulated medical waste.

"Outer packaging" means packaging that is the secondary container or the outermost enclosure, such as a disposable or reusable rigid pail, fiberboard carton, drum, or portable bin that is under normal conditions of use leak-resistant, strong enough to prevent tearing or bursting, puncture resistant, impervious to moisture, has leak proof sides and bottom, has a tight fitting cover or is otherwise closable, and is in good repair, of a composite or combination packaging together with any absorbent materials, cushioning and any other components necessary to contain and protect inner packaging.

"Overpack" means an enclosure that is used to provide protection or convenience in handling of a package or to consolidate two or more packages. "Overpack" does not include a vehicle, freight container, or aircraft unit load device. Examples of overpacks are one or more packages (i) placed or stacked onto a load board such as a pallet and secured by strapping, shrink wrapping, stretch wrapping, or other suitable means; or (ii) placed in a protective outer packaging such as a box or crate.

"Packaging" means the assembly of one or more containers and any other components necessary to assure compliance with minimum packaging requirements under Regulations Governing the Transportation of Hazardous Materials (9VAC20-110) or this chapter.

"Parametric controls" or "parametric monitoring device" means real time monitoring instrumentation integral to the treatment unit that is designed to quantitatively measure operational parameters, such as temperature, pressure, or other parameter, and provide an electronic or paper record of measurements that can be correlated to treatment. Parametric controls may be used to regulate or maintain preset operating parameters.

"Pathogen" means a microorganism, including bacteria, viruses, rickettsiae, parasites or fungi, or other agent, such as a proteinaceous infectious particle (prion), that can cause disease in humans or animals.

"Patient specimen" means human or animal materials collected directly from humans or animals and transported for research, diagnosis, clinical or investigational activities, or disease treatment or prevention. "Patient specimen" includes excreta, secreta, blood and its components, tissue and tissue swabs, body parts, and specimens in transport media (e.g., transwabs, culture media, and blood culture bottles) until such time that the patient specimen is discarded.

"Prion" means a pathogenic agent that is able to cause abnormal folding of specific normal cellular proteins called "prion proteins," which are found most abundantly in the brain. This abnormal folding is associated with neurological disease. Prions are proteinaceous infectious particles that are highly resistant to all but the most destructive methods of inactivation. They require specific inactivation, disposal, and containment procedures.

"Process rate" means the maximum rate of waste acceptance that a regulated medical waste management facility can process for transfer, treatment, or storage. This rate is limited by the capabilities of equipment, personnel, and infrastructure.

"Processing" means preparation, treatment, or conversion of regulated medical waste by a series of actions, changes, or functions that bring about a decided result.

"Regulated medical waste" or "RMW" means solid wastes defined to be regulated medical wastes in Part II (9VAC20-121-90) this chapter.

"Regulated medical waste management facility" means a site used for planned transfer, treatment, or disposal of regulated medical waste. A regulated medical waste management facility may consist of more than one transfer, treatment, or disposal unit. A regulated medical waste management facility is a type of solid waste management facility.

"Regulated medical waste transfer station" means a regulated medical waste management facility where regulated medical waste is received for the purpose of its subsequent consolidation, over-packing, storage, trans-loading, or subsequent transfer to another regulated medical waste management facility for further processing, treatment, transfer, or disposal. Parking a vehicle containing regulated medical waste during transportation for 24 hours or more is considered a regulated medical waste transfer station.

"Regulated medical waste treatment facility" means a regulated medical waste management facility where regulated medical waste is treated so that it no longer constitutes a threat to public health and the environment, and the waste is subsequently managed as solid waste.

"Reusable medical device" means a device, including surgical forceps, endoscopes, and stethoscopes, that is designed and labeled for multiple uses and is reprocessed by thorough cleaning followed by high-level disinfection or sterilization between patients.

"Sanitizer" means a substance, or mixture of substances, that reduces the bacterial population in the inanimate environment by significant numbers, (e.g., 3 log10 reduction) or more but does not destroy or eliminate all bacteria.

"Select agent or toxin" means a subset of biological agents and toxins that the U.S. Department of Health and Human Services and U.S. Department of Agriculture have determined have the potential to pose a severe threat to public health and safety, to animal or plant health, or to animal or plant products. Select agents and toxins are specified under 42 CFR §§ 73.3 and 73.4, 9 CFR §§ 121.3 and 121.4, and 7 CFR § 331.3.

"Sharps" means needles, scalpels, knives, lancets, syringes with attached needles, suture needles, pasteur pipettes, broken

glass, broken rigid plastic, and similar items having a point or sharp edge or that are likely to cause percutaneous injury or break during transportation and result in a point or sharp edge that may puncture or compromise the integrity of the container.

"Sharps drop box" means a secure, tamper-proof sharps container for the temporary storage of only household sharps provided for the convenience of individual home generators who choose to transport their own household sharps to the collection point and where collected sharps are packaged, labeled, and managed as regulated medical waste.

"Shipment" means the movement or quantity conveyed by a transporter of a regulated medical waste between a generator and a designated facility or a subsequent transporter.

"Shipping paper" means a shipping order, bill of lading, manifest, or other shipping document serving a similar purpose and containing the information required by the U.S. Department of Transportation Hazardous Materials Regulations.

"Site" means all land or water and structures, other appurtenances, and improvements on them used for treating, storing, and disposing of regulated medical waste. This term includes adjacent land within the facility boundary used for the utility systems such as repair, storage, shipping or processing areas, or other areas incident to the management of regulated medical waste.

"Solid waste" means any of those materials defined as "solid waste" in 9VAC20-81-95 of the Virginia Solid Waste Management Regulations. Regulated medical waste that has been treated in accordance with this chapter is considered solid waste.

"Spill" means any accidental or unpermitted discharge, leaking, pumping, pouring, emitting, or dumping of wastes or materials that, when spilled, become wastes.

"Spore" means a dormant form of a microorganism that is more resistant to adverse conditions.

"Sterilize" means to inactivate all microorganisms on materials or waste.

"Storage" means the holding, including during transportation, of regulated medical waste.

"Surrogate waste load" means a load of noninfectious material used in validation test runs of treatment units that represents materials and packaging that would be found in the regulated medical waste stream to be treated by the facility.

"Transportation" or "transport" means the movement of regulated medical waste by air, rail, highway, or water.

"Transporter" means a person authorized in accordance with federal and state regulations and engaged in transportation or movement of regulated waste.

"Treatment" means any method, technology, or process designed to change the character or composition of any regulated medical waste so that it is inactivated and no longer constitutes a threat to public health and the environment. Treatment does not include compaction or disinfection.

"Treatment method" means a process including wet thermal sterilization (such as autoclaving) or dry thermal sterilization, chemical sterilization, combustion or incineration, and alternate technologies used to treat regulated medical waste.

"Thermochemical indicator" means a device (e.g., tape, paper strips, integrators, or small ampoules) that responds to the treatment process parameters in some measurable fashion, such as changing color or becoming striped when subjected to temperatures intended to provide sterilization of materials.

"Thermochemical recording device" means a device (e.g., thermocouple, wireless data loggers, or chemical monitoring probes) that reacts in response to one or more critical treatment parameters (such as temperature) and yields a quantifiable value that correlates to microbial lethality or predictable inactivation of microbial spore populations.

"Unauthorized waste" means waste that is not authorized by the department to be managed by a regulated medical waste management facility. Examples are dependent upon the treatment technology and permit but may include chemotherapeutic, pathological, pharmaceutical, radioactive, chemical, hazardous, or other wastes.

"Used health care product" means a medical, diagnostic, or research device or piece of equipment, or personal care product used by consumers, medical professionals, or pharmaceutical providers that does not otherwise meet the definition of patient specimen, biological product, or regulated medical waste, but is contaminated with potentially infectious body fluids or materials and is not decontaminated or disinfected to remove or mitigate the infectious hazard prior to transportation.

"Validation testing" means procedures conducted at the site of a regulated medical waste treatment facility prior to initial operation of a treatment system or device, the purpose of which is to demonstrate, through established operating parameters, the effective treatment of regulated medical waste.

"Vector" means a living animal, insect, or other arthropod that is capable of transmitting a pathogen or infectious disease from one organism to another.

"VPDES" means Virginia Pollutant Discharge Elimination System, the Virginia system for the issuance of permits pursuant to the Permit Regulation (9VAC25-31), the State Water Control Law (§ 62.1-44.2 et seq. of the Code of Virginia), and § 402 of the Clean Water Act (33 USC § 1251 et seq.).

"Waste management" means the entire process of managing waste from the point of generation to final disposition. For regulated medical waste, the process includes collection and

segregation, characterization, classification, packaging, labeling, processing, staging, storing, decontamination, treatment, transportation, and disposal, as well as monitoring of waste management operations and sites to ensure that the management of these wastes is protective of human health and the environment.

"Waste management facility" means all contiguous land and structures, other appurtenances, and improvements on them used for treating, storing, or disposing of waste.

"Z-value" means the temperature change required for the D-value to change by 1 log (i.e., by a factor of 10) for a specific microbial population under specified treatment conditions.

Part II
General Information

9VAC20-121-20. Purpose.

The purpose of this chapter is to establish standards and procedures pertaining to regulated medical waste management in the Commonwealth of Virginia in order to protect the public health and public safety, and to enhance the environment and natural resources.

9VAC20-121-30. Administration.

A. The Virginia Waste Management Board promulgates and enforces regulations that it deems necessary to protect the public health and safety, the environment, and natural resources.

B. The director is authorized and directed to administer this chapter in accordance with the Virginia Waste Management Act (§§ 10.1-1400 through 10.1-1457 of the Code of Virginia).

C. Nothing in this chapter shall limit or affect the power of the director, by the director's order, to prohibit storage, transfer, treatment, or disposal of any waste or require special handling requirements the director determines are necessary to protect the public health or the environment.

9VAC20-121-40. Applicability.

A. This chapter applies (i) to all persons who generate or transport, store, transfer, process, treat, dispose, or otherwise manage regulated medical waste; own or operate a regulated medical waste management facility; or allow a regulated medical waste management facility to be operated on their property in the Commonwealth of Virginia; and (ii) to those who seek approval to engage in these activities, except those specifically exempted or excluded elsewhere in this chapter. A "person" may include an individual, firm, company, corporation, partnership, association, state or federal government and any agency thereof, municipality, commission, political subdivision of a state, or any interstate body.

B. All existing regulated medical waste management facilities must comply with this chapter. Existing facilities, including those with an existing permit, must submit a complete permit application by (insert date six months after the effective date of this regulation) to come into compliance with this chapter.

9VAC20-121-50. Prohibitions.

A. No person shall operate any regulated medical waste management facility for the transfer, treatment, or disposal of regulated medical waste without a permit from the director.

B. No person shall allow regulated medical waste to be stored, disposed, or otherwise managed on the person's property except in accordance with this chapter.

C. It shall be the duty of all persons to manage their regulated medical waste in a legal manner. Untreated regulated medical waste, including its packaging, shall not be used, reused, or reclaimed.

D. No person shall:

1. Allow regulated medical waste to drain or discharge into surface waters except when treated onsite and discharged into surface water as authorized under a Virginia Pollutant Discharge Elimination System (VPDES) Permit (9VAC25-31).

2. Cause the discharge of pollutants into waters of the United States, including wetlands, that violates any requirements of the Clean Water Act (33 USC § 1251 et seq.), including the VPDES requirements and Virginia Water Quality Standards (9VAC25-260).

3. Cause the discharge of a nonpoint source of pollution to waters of the United States, including wetlands, that violates any requirement of an area wide or statewide water quality management plan that has been approved under § 208 or 319 of the Clean Water Act (33 USC § 1251 et seq.) or violates any requirement of the Virginia Water Quality Standards (9VAC25-260).

4. Allow regulated medical waste to be deposited in or to enter any surface waters, groundwaters, or storm drains.

E. Any person who violates subsection A, B, C, or D of this section shall immediately cease the activity of improper management and shall initiate waste removal, cleanup, or closure.

9VAC20-121-60. Enforcement and appeal.

A. All administrative enforcement and appeals taken from actions of the director relative to the provisions of this chapter shall be governed by the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

B. The Virginia Waste Management Board or the director may enforce the provisions of this chapter utilizing all applicable procedures under the law. The powers of the board and the director include those established under Chapter 11.1 (§ 10.1-1182 et seq. of the Code of Virginia); in Article 8 (§ 10.1-1455 et seq.) of Chapter 14 of Title 10.1 of the Code of Virginia; and particularly in § 10.1-1186 of the Code of

Virginia. These sections describe the right of entry for inspections; the issuance of orders, penalties, injunctions; and other provisions and procedures for enforcement of this chapter.

9VAC20-121-70. Public participation and information.

A. All permits for regulated medical waste management facilities are subject to public participation, as specified in Part V (9VAC20-121-300 et seq.) of this chapter.

B. Modifications to regulated medical waste management facility permits shall be subject to public participation in accordance with Part V (9VAC20-121-300 et seq.) of this chapter.

C. Dockets of all permitting actions, enforcement actions, and administrative actions relative to this chapter shall be available to the public for review, consistent with the Virginia Administrative Process Act, Virginia Freedom of Information Act (§ 2.2-3700 of the Code of Virginia), and the provisions of this chapter.

D. Public participation in the compliance evaluation and enforcement programs is encouraged. The department will:

1. Investigate all citizen complaints and provide written responses to all signed, written complaints from citizens, concerning matters within the board's purview;

2. Not oppose intervention by any citizen in a suit brought before a court by the department as a result of the enforcement action; and

3. Provide notice on the department's internet website and provide at least 30 days of public comment on proposed settlements of civil enforcement actions, except where the settlement requires some immediate action. Where a public comment period is not held prior to the settlement of an enforcement action, public notice will still be provided following the settlement.

9VAC20-121-80. Relationship to other bodies of regulation.

A. The Solid Waste Management Regulations (9VAC20-81) address other requirements for solid waste management. If there is a conflict between the provisions of this chapter and the solid waste management regulations, this chapter is controlling.

B. Regulated medical waste management facilities must also comply with any applicable sections of the Hazardous Waste Management Regulations (9VAC20-60). If there is a conflict between the provisions of this chapter and the hazardous waste management regulations, 9VAC20-60 is controlling.

C. Intrastate shipment of hazardous materials is subject to the Regulations Governing the Transportation of Hazardous Materials (9VAC20-110). If there is a conflict between the provisions of this chapter and the hazardous materials transportation regulations, 9VAC20-110 is controlling.

D. Generators of regulated medical waste and regulated medical waste management facilities may be subject to the general industry standard for occupational exposure to bloodborne pathogens in 16VAC25-90-1910.1030 (29 CFR 1910.1030).

E. Persons transporting regulated medical waste are subject to the federal requirements in the U.S. Department of Transportation Hazardous Material Regulations at 49 CFR Parts 171 through 180.

F. Facilities managing select agents or toxins are subject to the Regulations for Disease Reporting and Control (12VAC5-90) as administered by the Virginia Department of Health. Facilities that possess, use, or transfer select agents or toxins are also subject to registration, reporting, inactivation, destruction, and compliance with the U.S. Department of Health and Human Services and U.S. Department of Agriculture's Federal Select Agent Program and the federal select agent regulations at 7 CFR Part 331, 9 CFR Part 121, and 42 CFR Part 73.

G. If there is a conflict between provisions of this chapter and adopted regulations of another agency of the Commonwealth, the provisions of these regulations are set aside to the extent necessary to allow compliance with the regulations of the other agency. If neither regulation controls, the more stringent standard applies.

H. Nothing in this chapter either precludes or enables a local governing body to adopt ordinances. Compliance with one body of regulation does not ensure compliance with the other, and normally, both bodies of regulation must be fully complied with.

I. The Financial Assurance Regulations for Solid Waste Disposal, Transfer, and Treatment Facilities (9VAC20-70) shall be applicable in all parts to regulated medical waste management facilities. Nothing in this chapter governing regulated medical waste management shall be considered to delete or alter any requirements of the department as set out in Financial Assurance Regulations for Solid Waste Facilities.

J. The U.S. Nuclear Regulatory Commission, 10 CFR, regulates management of radioactive materials. The Virginia Department of Health has established other requirements in accordance with Title 32.1 of the Code of Virginia. No regulated medical waste containing radioactive materials, regardless of amount or origin, shall be treated unless its management and treatment are in full compliance with these two bodies of regulations and are deemed by both regulations to represent no threat to public health and the environment.

9VAC20-121-90. Identification of regulated medical waste.

A. A solid waste is a regulated medical waste subject to this chapter if it meets the criteria under subsection B of this section, unless specifically excluded or exempted by subsection C or D of this section. Claims that materials are not

regulated medical wastes or are conditionally exempt from regulation shall demonstrate that the material meets the terms of an exemption. In doing so, appropriate documentation shall be provided to demonstrate that the material is not a regulated medical waste or is exempt from regulation.

B. A solid waste is a regulated medical waste if it meets either of the two criteria of this subsection:

1. The solid waste is suspected by the health care professional in charge of being capable of producing an infectious disease in humans. A solid waste shall be considered to be capable of producing an infectious disease if it has been or is likely to have been contaminated by an organism likely to be pathogenic to healthy humans, such organism is not routinely and freely available in the community, and if such organism has a significant probability of being present in sufficient quantities and with sufficient virulence to transmit disease. If the exact cause of a patient's illness is unknown, but the health care professional in charge suspects a contagious disease is the cause, the likelihood of pathogen transmission shall be assessed based on the pathogen suspected of being the cause of the illness.

2. The solid waste or solid waste stream is identified in the following list:

a. Discarded cultures, stocks, specimens, vaccines, and associated items likely to have been contaminated by them are regulated medical wastes if they are likely to contain organisms likely to be pathogenic to healthy humans. Wastes from the production of biologicals and antibiotics likely to have been contaminated by organisms likely to be pathogenic to healthy humans are regulated medical wastes;

b. Wastes consisting of human blood or body fluids, containers of human blood or body fluids, and items contaminated with human blood or body fluids are regulated medical waste. Human blood and body fluids solidified by absorbent gel, powder, or similar means are also regulated medical waste.

c. Human pathological and anatomical waste, including tissues, organs, body parts, and other pathological or anatomical wastes;

d. Sharps likely to be contaminated with organisms that are pathogenic to healthy humans, and all needles, scalpels, lancets, syringes with attached needles, suture needles, regardless of whether they have been used in patient care, are regulated medical wastes. This also includes sharps generated through veterinary practice, acupuncture needles, and household sharps collected in a sharps drop box;

e. When animals are intentionally infected with organisms likely to be pathogenic to healthy humans for the purposes of research, in vivo testing, production of biological materials, or any other reason, the animal carcasses, body parts, bedding material, and all other wastes likely to have been contaminated are regulated medical wastes when discarded, disposed of, or placed in storage;

f. Wastes that are contaminated with a Category A infectious substance are regulated medical waste that shall be managed in accordance with 9VAC20-121-160;

g. Any residue or contaminated soil, water, or other debris resulting from the cleanup of a spill of any regulated medical waste; and

h. Any solid waste contaminated by or mixed with regulated medical waste, including solid wastes that are packaged as regulated medical wastes.

C. The following materials are not solid wastes or regulated medical wastes:

1. Domestic sewage, including wastes that are not stored and are disposed of in a sanitary sewer system (with or without grinding).

2. Any mixture of domestic sewage and other wastes that pass through a sewer system to a wastewater treatment works permitted by the State Water Control Board or the Virginia Department of Health.

3. Sanitary waste from septic tanks (septage) and sewage holding tanks that is regulated by other state agencies.

4. Human remains when:

a. Under the control of a licensed physician or dentist, when the remains are being used or examined for medical purposes and are not solid wastes;

b. Provided to qualified educational programs as anatomical gifts;

c. Removed during a medical procedure and retained by the patient for religious or other purposes provided that the remains are not a source of disease transmission, as determined by a health care professional; and

d. Properly interred in a cemetery or in preparation by a licensed funeral director or embalmer for such interment or cremation.

5. Individual human and animal cremains.

6. Dead or diseased animals subject to regulation by the Virginia Department of Agriculture and Consumer Services.

7. Bed linen, instruments, medical care equipment, and other materials that are routinely cleaned and reused for their original purpose are not subject to this chapter until they are discarded and are a solid waste unless a health care professional has determined these items to be to be capable of producing an infectious disease in humans in accordance with 9VAC20-121-90 B 1. These items do not include reusable carts or containers used in the management of regulated medical waste, which shall be managed in accordance with 9VAC20-121-130.

8. Used health care products and reusable medical devices, being returned to a manufacturer or third party for reprocessing (cleaning and disinfecting or sterilizing) and reuse if packaged and labeled in accordance with 49 CFR 173.134(b)(12)(ii)(A) through (D) and reprocessed in accordance with applicable U.S. Food and Drug Administration requirements. Used health care products and contaminated medical devices or equipment being sent offsite for recycling or disposal are regulated medical waste and shall be managed in accordance with this chapter. These items do not include reusable carts or containers used in the management of regulated medical waste, which shall be managed in accordance with 9VAC20-121-130.

9. The following items while in use: samples for laboratory tests, patient specimens, and criminal evidence items taken during enforcement procedures that meet the definition of regulated medical waste. Once these items are no longer needed for their intended purpose, they shall be managed as regulated medical waste unless exempt under 9VAC20-121-90 D.

10. Tissue blocks of organs or tissues (except those associated with prions) that have been fixed in paraffin or similar embedding materials for cytological or histological examinations. Once these items are no longer needed for their intended purpose, they shall be managed as solid waste.

D. The following solid wastes are not regulated medical wastes for purpose of this chapter:

1. Wastes that have been treated in accordance with this chapter are no longer regulated medical waste and may be used, reused, or reclaimed in accordance with the provisions of the Virginia Solid Waste Management Regulations (9VAC20-81), provided the following requirements are met:

a. Treated waste that was once regulated but is no longer regulated medical waste shall not be packaged as regulated medical waste. Solid waste packaged as regulated medical waste is regulated medical waste.

b. If the solid waste is no longer regulated medical waste because of treatment, the generator and the permitted treatment facility shall maintain a record of the treatment for three years after treatment. Generators treating regulated medical waste onsite shall maintain records in accordance with applicable provisions of Part V (9VAC20-121-300 et seq.) of this chapter. Generators shipping regulated medical waste offsite for treatment shall maintain records in accordance with 9VAC20-121-100 I.

c. The generator or proposed user of treated regulated medical waste may request that the department make a case-specific determination that the solid waste may be beneficially used in a manufacturing process to make a product or as an effective substitute for a commercial product. The requestor shall submit a beneficial use demonstration in accordance with the requirements of 9VAC20-81-97.

2. Household waste, including household sharps. Household sharps shall be placed in an opaque, leak proof, puncture resistant container that is closed, tightly sealed, and labeled for home use before being mixed with other solid wastes or disposed. Household sharps may be placed in U.S. Food and Drug Administration-cleared sharps containers if specifically designed and labeled for home use. Household sharps containers shall be labeled "HOUSEHOLD SHARPS – DO NOT RECYCLE" or "HOME GENERATED SHARPS – DO NOT RECYCLE" printed in large legible text and permanent ink. Household sharps centrally collected in a sharps drop box shall be managed as regulated medical waste in accordance with 9VAC20-121-300 E 1. Medical waste generated by a health care professional administering care in a household is regulated medical waste and must be managed in accordance with this chapter.

3. Toenail and skin clippings, breast milk, sputum, semen, teeth, sweat, tears, urine, vomitus, or saliva, unless contaminated with visible blood or a health care professional has determined these items to be capable of producing an infectious disease in humans in accordance with 9VAC20-121-90 B 1.

4. Dental amalgam managed in accordance with the Dental Rule (40 CFR Part 441).

5. Meat or other food items being discarded because of spoilage, contamination, or recall.

6. The following discarded items, when they are unused or expired: health care products, medical equipment, medical devices, or other materials, unless a health care professional has determined these items to be to be capable of producing an infectious disease in humans in accordance with 9VAC20-121-90 B 1. This does not apply to unused or expired sharps, which are a regulated medical waste in accordance with 9VAC20-121-90 B 2 d.

7. Used products for personal hygiene, such as diapers, facial tissues, underpads, adult incontinence products, sanitary napkins, and feminine hygiene items, unless a health care professional has determined these items to be capable of producing an infectious disease in humans in accordance with 9VAC20-121-90 B 1.

8. The following discarded items when they are empty: urine collection bags and tubing, suction canisters and tubing, IV solution bags and tubing, colostomy bags, ileostomy bags, urostomy bags, plastic fluid containers, enteral feeding containers and tubing, hemovacs, urine bottles, and urine specimen cups, unless the items are subject to regulation under 16VAC25-90-1910.1030 (29 CFR 1910.1030) or a comparable state or federal standard.

9. The following discarded items: urinary catheters, suction catheters, plastic cannula, IV spikes, nasogastic tubes, oxygen tubing and cannula, ventilator tubing, enema bags and tubing, enema bottles, thermometer probe covers, irrigating feeding syringes, and bedpans or urinals, unless the items are subject to 16VAC25-90-1910.1030 (29 CFR 1910.1030) or a comparable state or federal standard.

10. Items such as bandages, gauze, or cotton swabs or other similar absorbent materials, unless at any time following use the items are saturated or would release human blood or human body fluids in a liquid or semiliquid state if compressed. Items that contain or that are caked with dried human blood or human body fluids and are capable of releasing these materials during handling are regulated medical waste. An item would be considered caked if it could release flakes or particles when handled.

11. Human blood and body fluids when solidified by absorbent gel, powder, or similar means as part of a spill cleanup at establishments engaged in operations other than health care or management of regulated medical waste. This category includes waste generated by stores, markets, office buildings, restaurants, businesses, schools, manufacturers, and commercial or industrial operations.

12. Waste generated from the care of an animal at a household or a farm when care is provided by the owner of the animal. Waste generated by a veterinarian, such as sharps, must be managed as regulated medical waste.

13. Waste from cosmetology, ear and body piercing, nail salons, and tattoo establishments, except for sharps and unabsorbed human blood or body fluids.

14. Plant or animal wastes, such as bat guano, removed from construction or demolition projects when actions are taken to avoid worker exposure, including use of appropriate personal protective equipment, and the waste is managed in accordance with any applicable best management practice, special handling, and other precautions for processing or disposal.

15. Waste from food, drug, and cosmetics testing laboratories (except research laboratories) using microbiological methods for the detection of human infectious agents, microbial toxins, or chemical residuals as part of routine quality assurance testing of food, drugs, or cosmetic products.

16. Wastes regulated by the Virginia Department of Health, the State Water Control Board, the Air Pollution Control Board, Department of Agriculture and Consumer Services, Federal Drug Administration, U.S. Department of Agriculture, or any other state or federal agency with such authority.

Part III
Standards for Management of All Regulated Medical Waste

9VAC20-121-100. General handling and generator requirements.

A. Any person or facility handling, generating, storing, transporting, transferring, treating, or disposing of regulated medical waste shall comply with the general management requirements of this section.

B. Regulated medical waste shall be identified and segregated from other waste, including radioactive waste, hazardous waste, and other solid waste, at the point of origin or as soon as practicable after generation. If practical, regulated medical waste shall also be segregated based on the anticipated treatment method.

C. All generators must comply with the packaging, labeling, storage, reusable container, spill cleanup, transportation, and Category A waste management requirements for regulated medical waste outlined in Part III (9VAC20-121-100 et seq.) of this chapter, as applicable.

D. Anyone handling or packaging regulated medical waste and loading, unloading, or handling containers of regulated medical waste shall wear appropriate personal protective equipment in accordance with the standards for occupational exposure to bloodborne pathogens in the general industry standard in 16VAC25-90-1910.1030 (29 CFR 1910.1030).

E. All regulated medical waste shall be handled in a manner that maintains the integrity of the packaging at all times, prevents damage, leakage, and spills and provides protection from the elements, vectors, and trespassers.

F. Trash chutes shall not be used to manage regulated medical waste. If slides, cart tippers, conveyors, or similar equipment are used to move regulated medical waste from the point of generation to storage areas, between containers, or to vehicles or treatment devices, the movement and impact shall be controlled to maintain the integrity of the regulated medical waste packaging and prevent damage, leaks, and spills. Waste shall not be thrown, dumped, walked upon, or handled in any other manner that could result in spills or releases of regulated medical waste or damage to the packaging.

G. Except in accordance with 9VAC20-121-240 B, regulated medical waste shall not be manually or mechanically compacted, compressed, or subjected to violent mechanical stress prior to treatment; however, after regulated medical waste is fully treated and is no longer regulated medical waste, it may be compacted in a closed container in a safe and sanitary manner.

H. All regulated medical waste generated shall either be treated onsite in accordance with Part IV (9VAC20-121-200 et seq.) of this chapter or packaged, labeled, and transported offsite to a facility permitted to receive the waste for transfer, treatment, or disposal.

I. Generators of regulated medical waste are subject to the following recordkeeping requirements:

a. The generator shall maintain all records of onsite treatment or shipment offsite for a minimum of three years following treatment or shipment. All records shall be available for review by the department upon request.

b. Generators treating regulated medical waste onsite, regulated medical waste transfer stations, and all other regulated medical waste treatment or disposal facilities shall maintain records in accordance with applicable provisions of Part V (9VAC20-121-300 et seq.) of this chapter.

c. Generators shipping regulated medical waste offsite for transfer, treatment, or disposal shall maintain records, including copies of all shipping papers, specifying the date of shipment, amount of waste removed from the site, and the names, addresses, and telephone numbers of the transporter and the destination facility receiving the shipment for treatment or disposal.

d. If regulated medical waste is received from offsite, records shall be maintained for three years following receipt of the waste and shall include the date of receipt, name of each offsite generator (except for generators of household sharps using sharps drop boxes), amount of waste received, and dates of subsequent treatment or shipment offsite.

9VAC20-121-110. Packaging and labeling of regulated medical waste.

A. All regulated medical waste shall be appropriately packaged, labeled, and managed as required by this section.

B. The generator of regulated medical waste is responsible for the packaging and labeling of regulated medical waste. Contractors or other agents may provide services to the generator, including packaging and labeling of regulated medical waste; however, no contract or other relationship shall relieve the generator of the responsibility for packaging and labeling the regulated medical waste as required by this chapter.

C. No person shall receive for transportation, transfer, storage, or treatment any regulated medical waste that is not packaged and labeled in accordance with this chapter. Contractors or other agents may package or label regulated medical wastes to comply with this chapter, so long as the packaging and labeling is performed onsite where the regulated medical waste was generated and no transportation, storage, treatment, or disposal occurs prior to the packaging. Nothing in this section shall prevent the proper repackaging and further transportation of regulated medical waste that has spilled during transportation.l

D. All regulated medical waste shall be packaged and labeled onsite prior to storage, treatment, transport, or other management and at a minimum must conform with the following:

1. When regulated medical wastes are first discarded, they shall be placed directly in bags or containers meeting the requirements of the standards for occupational exposure to bloodborne pathogens in the general industry standard in 16VAC25-90-1910.1030 (29 CFR 1910.1030). The general industry standard requires the packaging to be closable, constructed to contain all contents and prevent leakage of fluids, labeled, and closed prior to removal. Red bags shall be used for the packaging of all regulated medical waste except as provided in subdivision 2 of this subsection.

2. Sharps shall be placed directly in puncture resistant containers as required by the general industry standards in 16VAC25-90-1910.1030(d)(4)(iii)(A). Sharps containers must not be filled beyond the fill line indicated on the container.

3. Waste packages must not be overfilled. As a bag or container becomes full at the point of generation, and prior to moving, it shall be closed, capped, or sealed so that no waste materials can leak, spill, or protrude during handling, storage, or transport.

4. Once closed, capped, and sealed, bags and containers of regulated medical waste shall not be opened, unsealed, unpackaged, or repackaged. If damage, spills, or outside contamination of the regulated medical waste packaging occurs, the bag or container shall be placed in a secondary packaging that meets all requirements of this subsection.

5. All regulated medical waste packaging shall be labeled. The label shall be securely attached to or printed on packaging. The label may be a tag or sticker securely affixed to the package. Permanent ink shall be used to complete the information on the label. The label and the information provided on the label must be clearly legible. The following information shall be included:

a. The name, address, and business telephone number of the generator. For hospitals, the label shall identify the specific department or lab where the waste originated;

b. The words "Regulated Medical Waste," "Biohazard," or "Infectious Waste" in large print; and

c. The universal biohazard symbol.

E. When regulated medical waste is conveyed in reusable carts or containers, the waste in the cart or container shall be packaged and labeled in accordance with this section.

F. When not being filled and prior to moving, wheeled carts and other items used to move regulated medical waste shall be secured, locked, or sealed so that no waste materials can leak

and labeled with the universal biohazard symbol or color-coded red to indicate that the contents contain regulated medical waste.

G. Wheeled carts and roll-off containers shall not be used for the holding of liquids, sharps, animal carcasses or body parts, and human anatomical waste, including tissues, organs, or body parts, unless the regulated medical waste is:

1. Properly contained in rigid containers capable of retaining liquids with enough absorbent material to absorb all liquid present, and

2. Separated from other types of regulated medical waste by a leak-proof rigid barrier, divider, or separate compartment.

H. Prior to transporting regulated medical waste offsite for treatment, transfer, or disposal, waste shall be packaged and labeled for transportation in accordance with the standards of 49 CFR Part 173 of the U.S. Department of Transportation Hazardous Materials Regulations or packaged in accordance with an exemption approved by the U.S. Department of Transportation.

9VAC20-121-120. Storage of regulated medical waste.

A. The requirements of this section apply to storage of regulated medical waste, including storage (i) in soiled utility rooms and other accumulation areas; (ii) at a generating facility; (iii) during transportation; (iv) at a regulated medical waste transfer stations; and (v) at a regulated medical waste treatment or disposal facility. This section also applies to areas used to transfer a load of regulated medical waste from one vehicle to another or when a vehicle containing regulated medical waste is parked for 24 hours or more during transportation.

B. All regulated medical waste shall be stored in a manner that:

1. Maintains the integrity of the packaging at all times, prevents damage, leakage, and spills and provides protection from the elements, vectors, and trespassers;

2. Maintains the packaging in an upright and stable configuration to minimize the potential for spills. If packages or containers are stacked, except during transport, the top of the stacked containers must not be more than six feet above the level of the floor. The integrity of the containers must not be compromised by the stacking arrangement;

3. Is clean and orderly and located in areas free of standing liquid and debris;

4. Provides security from unauthorized access and protects workers and the general public. Regulated medical waste shall be stored in areas where access is limited to only those persons specifically designated to manage regulated medical waste;

5. Meets the packaging and labeling requirements of 9VAC20-121-110; and

6. Meets the requirements of 9VAC20-121-130 when regulated medical waste is stored in reusable carts or containers.

C. Regulated medical waste transfer stations, treatment facilities, and generators of 250 gallons or more of regulated medical waste per calendar month are subject to the following storage requirements:

1. All regulated medical waste shall be stored on surfaces that are cleanable and impermeable to liquids. Carpets and floor coverings with cracks or gaps shall not be used in storage areas. Where tile floors are used and seams are present in the tile, the floor must be sealed with wax or other floor coatings in order to meet this requirement.

2. In areas used to store regulated medical waste, all floor drains shall discharge directly to an approved sanitary sewer system, and all ventilation shall discharge so as to minimize human exposure to the waste.

3. Signage shall be displayed to indicate any areas used to store regulated medical waste.

D. All regulated medical waste shall be stored in accordance with the following timeframes:

1. Generators of less than 250 gallons of regulated medical waste per calendar month shall arrange for the removal of all regulated medical waste stored onsite at least once per calendar month and provide shipment to a facility permitted to receive it for transfer, treatment, or disposal. No regulated medical waste shall be stored onsite for more than 45 calendar days, and no more than 250 gallons of regulated medical waste shall be stored onsite at any given time. Records shall be maintained in accordance with 9VAC20-121-100 I.

2. Generators of 250 gallons or more of regulated medical waste per calendar month shall arrange for the removal of all regulated medical waste stored onsite at least once per calendar week and provide shipment to a facility permitted to receive it for transfer, treatment, or disposal. No regulated medical waste shall be stored onsite for more than 10 calendar days. Records shall be maintained in accordance with 9VAC20-121-100 I.

3. Regulated medical waste treatment facilities shall provide treatment or removal of all regulated medical waste stored onsite on at least a weekly basis. No regulated medical waste shall be stored onsite for more than 10 calendar days. Records shall be maintained in accordance with 9VAC20-121-340.

4. Regulated medical waste transfer stations shall store unrefrigerated regulated medical waste onsite for no more than seven calendar days. All regulated medical waste stored

for more than seven calendar days must be refrigerated and stored in an ambient temperature between 35°F and 45°F (2°C and 7°C). No regulated medical waste shall be stored onsite for more than a total of 15 calendar days. Records shall be maintained in accordance with 9VAC20-121-340.

5. Regulated medical waste transfer stations and treatment facilities shall clearly demonstrate the length of time that regulated medical waste is accumulated onsite by marking the outer packaging in permanent ink or maintaining an inventory, barcode, or other recordkeeping system.

E. Except in accordance with a permit:

1. No more than 25% of the regulated medical waste stored onsite each month shall be generated or received from offsite, except for emergency cleanups conducted in accordance with 9VAC20-121-300 E 5 and household sharps collected at sharps drop boxes in accordance with 9VAC20-121-300 E 1;

2. Regulated medical waste shall not be treated onsite; and

3. Regulated medical waste that is stored on a loading dock or in areas designated for loading shall be packaged, marked, and labeled for transport and shall not be stored in loading areas for more than 24 hours.

9VAC20-121-130. Reusable container requirements.

A. The requirements of this section shall be implemented whenever regulated medical waste is conveyed in reusable carts or containers.

B. The waste in the cart or container shall be packaged and labeled in accordance with 9VAC20-121-110.

C. Reusable carts and containers must be constructed of smooth, easily cleanable materials that are impervious to liquids and made of materials designed to withstand exposure to hot water or chemical disinfectants. A plastic bag shall not be reused.

D. Use of reusable carts and containers and any automated or mechanical cleaning and disinfection systems shall maintain the integrity of the packaging at all times, prevent damage, leakage, and spills and provide protection from the elements, vectors, and trespassers.

E. Persons cleaning and disinfecting reusable carts and containers shall wear appropriate personal protective equipment.

F. Immediately following each time a container is emptied and prior to being reused, all reusable carts and containers, including reusable suction canisters and fluid carts that receive blood, shall be both thoroughly cleaned and disinfected. Cleaning shall be conducted with detergent and water using an agitation method or by pressure and movement to remove all waste and visible contamination from all inner and outer surfaces of the container. At least one of the following methods shall be used for disinfection:

1. Utilizing an EPA-registered general or broad-spectrum disinfectant following manufacturer's label instructions;

2. Exposure to heated rinse water at a minimum of 180°F (82°C) and a maximum 195°F (90°C) for a minimum of 15 seconds, or until the surface reaches a temperature of 160°F (71°C); or

3. Immersion in or rinsing with, one of the following chemical sanitizers for a minimum of three minutes:

a. Hypochlorite solution (500 ppm available chlorine);

b. Phenolic solution (500 ppm active agent);

c. Iodophor solution (100 ppm available iodine);

d. Quaternary ammonium solution (400 ppm active agent); or

e. Other organic, plant-based, or nonchemical disinfectant registered by EPA.

G. All wash water from cleaning and disinfection shall be contained and discharged directly to an approved sanitary sewer system.

H. Reusable carts and containers shall not be reused if there are cracks, holes, damage, or other defects, including to a lid or locking mechanism or if contamination or waste residuals are present.

I. Reusable carts or containers used for the holding or storage of regulated medical waste shall not be used for any other purpose.

J. When reusable carts or containers containing regulated medical waste are used for offsite transport, all aspects of the cart or container management shall comply with federal Department of Transportation Hazardous Material Regulations, 49 CFR Parts 171 through 180, as applicable.

K. Reusable carts or containers that are damaged, defective, or ready to be discarded shall not be disposed of as solid waste unless they are cleaned and disinfected in accordance with this section, and all regulated medical waste labeling is removed or covered, prior to disposal. Containers unable to be cleaned and disinfected must be treated as regulated medical waste.

9VAC20-121-140. Management of spills of regulated medical waste.

A. Any person or facility handling, generating, storing, transporting, transferring, treating, or disposing of regulated medical waste shall immediately address all spills of regulated medical waste, incidents or emergencies, maintenance events, and nonconformances that could have an impact on the management of regulated medical waste at the facility.

B. Anyone handling regulated medical waste shall maintain a spill containment and cleanup kit onsite within the vicinity of

any area where regulated medical waste is managed, and the location of the kit shall provide for rapid and efficient cleanup of spills anywhere within the area. All vehicles transporting regulated medical wastes are required to carry a spill containment and clean up kit in the vehicle whenever regulated medical wastes are conveyed. A spill containment and cleanup kit shall consist of at least the following items:

1. Material designed to absorb spilled liquids, and the amount of absorbent material shall be that having a capacity, as rated by the manufacturer, of one gallon of liquid for every cubic foot of regulated medical waste that is normally managed in the area for which the kit is provided or 10 gallons, whichever is less;

2. In a sprayer capable of dispersing its charge in a mist and a stream at a distance, at least one gallon of an EPA-registered hospital grade disinfectant effective against mycobacteria, unless it can be demonstrated that an alternate EPA-registered disinfectant is protective of human health and the environment and is appropriate for the type of regulated medical waste managed and surfaces being disinfected;

3. Enough red plastic bags to double enclose at least 150% of the maximum load managed (up to a maximum of 500 bags) that meet the applicable requirements of 49 CFR Part 173, including the ASTM 125 pound drop test for filled bags (D959) or an exemption approved by the U.S. Department of Transportation and are accompanied by seals and labels. These bags shall be large enough to overpack any box or container normally used for regulated medical waste management by that generator, handler, or facility;

4. Appropriate personal protective equipment, such as puncture and leak resistant gloves, safety glasses or face shield, protective coveralls or bib, protective footwear, and mask or respiratory protection as needed; and

5. For vehicles only, a first aid kit, fire extinguisher, boundary marking tape, lights, and other appropriate safety equipment.

C. Following any spill or release of regulated medical waste or its discovery, the following procedures shall be implemented:

1. Take appropriate precautions to ensure personnel do not come into contact with any contaminants by wearing appropriate personal protective equipment.

2. Repackage spilled regulated medical waste in accordance with the packaging requirements in 9VAC20-121-110.

3. Transport any regulated medical waste by a transporter that meets the requirements of 9VAC20-121-150.

4. Clean and disinfect all areas and materials having been contacted by regulated medical waste using an EPA-registered hospital grade disinfectant effective against mycobacteria in accordance with manufacturer's label instructions, unless it can be demonstrated that an alternate EPA-registered disinfectant is protective of human health and the environment and is appropriate for the type of regulated medical waste managed and surfaces being disinfected.

5. Take necessary steps to replenish the spill containment and cleanup kit.

9VAC20-121-150. Transportation of regulated medical waste.

A. The requirements of this section apply to the transportation of regulated medical waste including by intermediate transporters and generators who transport their own waste offsite.

B. All transporters of regulated medical waste must comply with the general handling requirements in 9VAC20-121-100.

C. Regulated medical waste shall be transported in accordance with the applicable requirements for shipping papers, packaging, labeling, marking and vehicle placarding in accordance with the U.S. Department of Transportation Hazardous Materials Regulations, 49 CFR Parts 171 through 180. No person shall transport or receive for transport any regulated medical waste that is not packaged and labeled fully in accordance with the U.S. Department of Transportation Hazardous Materials Regulations. Reusable carts or containers used to transport regulated medical waste shall meet the requirements of the U.S. Department of Transportation Hazardous Materials Regulations and must be sealed, puncture resistant, and leak proof.

D. Transportation of regulated medical waste shall maintain the packaging in an upright and stable configuration to minimize the potential for spills. The integrity of the containers must not be compromised by the stacking arrangement.

E. All vehicles and equipment used in the transportation of regulated medical waste must have access control that limits access to those persons specifically designated to manage regulated medical waste, and the cargo carrying body must be secured except when loading and unloading.

F. Surfaces of vehicles and equipment used to transport regulated medical waste must be clean and impermeable to liquids if those areas are involved with the management of the waste. Carpets and floor coverings with cracks or gaps shall not be used. Vehicles used to transport regulated medical waste shall be clean and maintained in an orderly condition, free of standing liquid and debris, in those areas involved with the management of the waste.

G. Storage, transport, and transfer to, from, and between vehicles and equipment shall be under a cover or packaged in a container that protects the waste from the elements and over a floor or bermed pavement that will contain leaks and spills of liquid from the waste. All effluent, wash water, and other

runoff shall discharge directly to or through a holding tank to an approved sanitary sewer system. A cover, floor, or pavement is not required if the activity is transient in nature, such as in the case of spill cleanup or collection of waste packages from professional offices for transport.

H. All vehicles transporting regulated medical waste must carry a spill containment and cleanup kit in the vehicle as specified in 9VAC20-121-140 B, whenever regulated medical wastes are conveyed. Following a spill of regulated medical waste or its discovery, the procedures specified in 9VAC20-121-140 C shall be implemented.

I. Any vehicle parked 24 hours or more during transport will be considered a regulated medical waste transfer station subject to the requirements of Part IV (9VAC20-121-200 et seq.) of this chapter. Unless exempt under 9VAC20-121-300 E, no storage during transport will be allowed without a permit issued in accordance with the procedures in Part V (9VAC20-121-300 et seq.) of this chapter.

J. All vehicles and equipment used to transport regulated medical waste must be thoroughly cleaned and disinfected before being used for any other purpose and prior to any transfer of ownership. Disinfection shall include using an EPA-registered hospital grade disinfectant effective against mycobacteria in accordance with manufacturer's label instructions, unless it can be demonstrated that an alternate EPA-registered disinfectant is protective of human health and the environment and is appropriate for the type of regulated medical waste managed and surfaces being disinfected. Any areas of vehicles or equipment that are visibly contaminated, or that become contaminated as a result of a spill, must be immediately decontaminated in accordance with 9VAC20-121-140.

K. Transport of regulated medical waste by the United States Postal Services that fully complies with 39 CFR 111 shall be considered to be transportation in compliance with this chapter if:

1. The generator maintains a complete and legible copy of the manifest or mail disposal service shipping record for a period of three years. Disposer's certification and other tracking items must be completed and shown on the copy;

2. The addressee is a facility permitted by all the appropriate agencies of the Commonwealth or the host state; and

3. No package shall be more than 35 pounds by weight.

L. Category A waste shall be managed in accordance with the requirements of 9VAC20-121-160.

9VAC20-121-160. Management of Category A waste.

A. Category A waste shall be managed in accordance with the requirements of this section.

B. Overarching Planning Considerations and Waste Generator Information and Responsibilities for Category A waste are specified in Sections 3 and 5 of Managing Solid Waste Contaminated with a Category A Infectious Substance. In addition to the general management requirements for regulated medical waste in Part III (9VAC20-121-100 et seq.), all Category A waste shall be handled in accordance with the following additional requirements:

1. Every effort shall be made to minimize the amount of Category A waste generated. Category A waste shall be physically separated, if practical, from other types of waste at the point of origin. When other types of regulated medical waste are mixed with Category A waste, the mixture shall be managed as Category A waste. Category A waste not suitable for conventional treatment methods, such as batteries, electronics, and oxygen cylinders, shall be segregated from other waste at the point of generation for special handling.

2. All handling, storage, transfer, and treatment of Category A waste must be conducted in areas with cleanable and impermeable surfaces. Carpets and floor coverings with cracks or gaps shall not be used. Where tile floors are used and seams are present in the tile, the floor must be sealed with wax or other floor coatings in order to meet this requirement.

3. Equipment and handling techniques that could potentially cause bioaerosols, such as cart tipping, slides, conveyors, and mechanical cleaning or disinfection systems, shall not be used for Category A waste unless the movement and impact is controlled to maintain the integrity of the packaging, prevent exposure to the waste, and any aerosol, bioaerosol, or mist caused by the process is collected and treated or filtered.

4. Category A waste shall not be conveyed in reusable carts or containers unless the containers are subsequently cleaned and disinfected in accordance with 9VAC20-121-130 using an EPA-registered disinfectant appropriate for the type of Category A waste managed and materials being disinfected.

5. All spills of Category A waste shall be cleaned and disinfected in accordance with 9VAC20-121-140 using an EPA-registered disinfectant appropriate for the type of Category A waste managed and materials being disinfected.

6. Category A waste shall be stored in accordance with the requirements of 9VAC20-121-120 B and C. Packages or containers of Category A waste shall not be stacked.

7. A generator storing 250 gallons or more of Category A waste shall notify the department within 24 hours of exceeding 250 gallons. At least once per calendar week, accumulated Category A waste shall be treated onsite in accordance with this section or shipped offsite to a facility permitted to receive it for treatment or disposal. No Category A waste shall be stored onsite for more than 10 calendar days unless an extended storage timeframe is approved by the

department. Records shall be maintained in accordance with 9VAC20-121-100 I.

8. The regulated medical waste transfer station or treatment facility shall notify DEQ of receipt of any Category A waste in accordance with 9VAC20-121-340.

C. Waste Transporter Information and Responsibilities for Category A waste are specified in Section 6 of Managing Solid Waste Contaminated with a Category A Infectious Substance. Packaging and labeling of Category A waste for transport must comply with the more stringent packaging standards of 49 CFR Parts 171 through 180 of the HMR, or may require a DOT special permit for an exception to the HMR requirements to allow for alternative packaging to accommodate the waste.

D. Waste Treatment Information and Responsibilities for Category A waste are specified in Section 7 of Managing Solid Waste Contaminated with a Category A Infectious Substance. In addition to the general treatment requirements for regulated medical waste in Part IV (9VAC20-121-200 et seq.), all Category A waste shall be treated in accordance with the following additional requirements:

1. A facility shall only receive Category A waste for processing or treatment upon specific approval from the director or by specific provisions within the facility's permit.

2. Prior to treatment of any Category A waste, the facility shall notify DEQ and conduct additional validation testing in accordance with 9VAC20-121-260 and an approved treatment plan that is specific to the Category A waste stream and packaging types that will be received.

3. The treatment method and operating parameters shall be appropriate and effective for the type of Category A waste being managed. Treatment units that employ a mechanical process, such as grinding or shredding, prior to treatment or integral to the treatment unit, may not be appropriate for Category A waste streams. The facility shall demonstrate that the process prevents employee exposure to the waste; contains any aerosol, bioaerosol, or mist caused by the process; and treats or filters any air evacuated from the chamber during processing.

4. The facility shall not receive or treat Category A waste until the department has reviewed and approved the validation results, operating parameters, and protocols to be used for the treatment unit.

5. Treatment of Category A waste shall only be in accordance with the operating parameters and protocols approved by the department.

6. Challenge testing shall be performed and documented for every load containing Category A waste. The facility may request an alternate challenge test frequency once a high level of confidence is established that the Category A waste is being effectively treated.

7. The owner or operator shall provide a certification that the regulated medical waste management plan demonstrates protocols specific to the Category A waste stream to be treated and meets all additional standards of Part III (9VAC20-121-100 et seq.) and Part IV (9VAC20-121-200 et seq.), as applicable, in accordance with 9VAC20-121-330. The plan shall specify if and how management protocols for Category A waste differ from existing protocols for routinely received regulated medical waste, including how treated wastes will be disposed. The certification shall also include a statement that the emergency contingency plan has been provided to the local police and fire departments, local emergency manager, and local emergency health coordinator.

E. Final Disposal Information and Responsibilities for Category A waste are specified in Section 8 of Managing Solid Waste Contaminated with a Category A Infectious Substance. Category A waste shall be disposed of in accordance with the following requirements:

1. Category A waste that has been treated in accordance with the special requirements of this section is no longer Category A waste or regulated medical waste. Category A waste treated in accordance with this section is solid waste and shall be disposed of at a permitted solid waste disposal facility, provided the disposal is in accordance with the Solid Waste Management Regulations (9VAC20-81) and the facility's permit.

2. Category A waste not treated in accordance with this chapter shall not be transported to, received for transport, or disposal by, or disposed of in, any solid waste management facility.

Part IV
Standards for Regulated Medical Waste Transfer Stations and Treatment Facilities

9VAC20-121-200. General and applicability.

A. Any person who designs, constructs, or operates any regulated medical waste transfer station or treatment facility not otherwise exempt under 9VAC20-121-300 E shall obtain a permit-by-rule pursuant to this chapter prior to operation and comply with the requirements of this part. Further, all applications pursuant to this chapter shall demonstrate specific means proposed for compliance with requirements set forth in this part.

B. All facilities, except exempted facilities, shall be maintained and operated in accordance with the permit-by-rule status pursuant to this chapter. All facilities shall be maintained and operated in accordance with the approved design and intended use of the facility.

C. Hazardous wastes shall not be managed or disposed in facilities subject to this regulation unless specifically authorized by the facility permit or the director and managed in accordance with 9VAC20-60. Any material from a state

other than Virginia that is classified as a hazardous waste in that state shall be managed as hazardous waste in accordance with 9VAC20-60.

9VAC20-121-210. Siting requirements.

A. The siting of all regulated medical waste transfer stations or treatment facilities shall be governed by the standards as set forth in this section. These facilities shall:

1. Be adjacent to or have direct access to roads that are paved or surfaced and capable of withstanding anticipated load limits;

2. Not be sited or constructed in areas subject to base floods;

3. Shall not be closer than:

a. 50 feet to any property boundary;

b. 50 feet to any perennial stream or river;

c. 200 feet to any residence or recreational park area; or

d. 200 feet to any health care facility, school, or similar type public institution, unless the facility is located at the health care facility, school, or similar type public institution.

B. The site of a regulated medical waste transfer station or treatment facility shall provide room to minimize traffic congestion and allow for safe management of regulated medical waste and safe operation of the facility.

9VAC20-121-220. Design and construction requirements.

A. The design and construction of all regulated medical waste transfer stations or treatment facilities shall be governed by the standards as set forth in this section. These facilities shall have:

1. An access road suitable for loaded collection vehicles in all weather conditions from the entrance to the unloading or receiving area of the facility.

2. Onsite queuing capacity for the expected traffic so that the waiting collection vehicles do not back up onto the public road.

3. Unloading and loading areas of an adequate size and design to facilitate efficient transfer of regulated medical waste to and from collection vehicles and the unobstructed movement of vehicles.

4. Access controls such as perimeter security fencing, gates, locks, badge systems, or other controls to limit access to areas used to store, transfer, or treat regulated medical waste to only those persons specifically designated to manage regulated medical waste.

5. Adequate lighting so that operating personnel can exercise site control. Lighting may be provided by portable equipment as necessary.

6. Covered areas with cleanable and impermeable surfaces for handling, storage, transfer, and treatment of regulated medical waste and the cleaning and disinfection of reusable containers. These areas shall not be carpeted or have floor coverings with cracks or gaps. Where tile floors are used and seams are present in the tile, the floor must be sealed with wax or other floor coatings in order to meet this requirement.

7. Bermed pavement, a liquid retaining lip, or equivalent controls at loading docks and near rolling or bay doors to contain potential leaks and spills of regulated medical waste or other liquids.

8. Floors sloped or graded to drain such that all effluent, wash water, and other runoff from storage and processing areas, treatment equipment, waste compactors, and reusable container cleaning and disinfection areas is contained and discharged directly to an approved sanitary sewer system.

9. Ventilation that discharges to minimize human exposure to the waste.

10. A water supply shall be provided for cleaning purposes.

11. Fire alarm and protection systems capable of detecting, controlling, and extinguishing any and all fires.

12. Fixed radiation detectors in a location as close as practicable to the incoming waste loads and in an appropriate geometry to monitor all waste prior to storage, transfer, or treatment. A fixed radiation detector is not required at captive regulated medical waste management facility if the facility demonstrates that there is no potential for generation or management of radioactive materials or wastes. Demonstration shall include a certification that there is no radiation producing equipment or material onsite.

B. Effluent, wash water, and other runoff from the facility shall not be permitted to drain or discharge into surface waters except when authorized under a VPDES permit issued pursuant to 9VAC25-31.

C. Slides, cart tippers, conveyors, and similar equipment used to move regulated medical waste must be designed and constructed such that the movement and impact is controlled to maintain the integrity of the packaging at all times and prevent damage, leakage, and spills. Trash chutes shall not be used to manage regulated medical waste.

D. Any areas used for the storage of regulated medical waste shall be designed in accordance with 9VAC20-121-120 and have sufficient storage capacity for the maximum anticipated storage amount based on the amount of daily incoming waste and maximum length of time in storage.

E. All facilities that manage reusable containers or carts for regulated medical waste shall have designated areas for manual or mechanical cleaning and disinfection that comply with the requirements of 9VAC20-121-130.

9VAC20-121-230. Operation requirements.

A. The operation of regulated medical waste transfer stations or treatment facilities shall be governed by the standards as set forth in this section.

B. The regulated medical waste transfer station or treatment facility shall maintain and operate in accordance with a regulated medical waste management plan that meets all requirements of 9VAC20-121-330. This plan shall be reviewed and recertified annually, within one year from the date of the last certification, to ensure consistency with current operations and regulatory requirements, and shall be made available for review by the department upon request. If the applicable standards of this chapter and the facility's operations plan conflict, this chapter shall take precedence.

C. The facility must operate to comply with the general handling requirements of 9VAC20-121-100.

D. All regulated medical waste shall be packaged, labeled in accordance with 9VAC20-121-110 and managed in accordance with the storage conditions and timeframes required by 9VAC20-121-120. The facility shall employ methods to track and document specific incoming waste throughout the duration of storage, treatment or transfer, and shipment offsite.

E. All facilities that manage reusable carts or containers for regulated medical waste shall comply with the requirements of 9VAC20-121-130 and maintain onsite an adequate water supply and sufficient quantity of detergent and EPA-registered disinfectant or other approved materials, as applicable.

F. Except for reusable containers authorized by the department to be opened, regulated medical waste containers must not be opened or unpackaged unless approved as part of the consolidation or treatment process.

G. The facility shall immediately address all spills of regulated medical waste, incidents or emergencies, maintenance events, and nonconformances that could have an impact on the management of regulated medical waste. Spill containment and cleanup kits shall be maintained as required by 9VAC20-121-140 B, and immediately following a spill of regulated medical waste or its discovery, the procedures specified in 9VAC20-121-140 C shall be implemented.

H. Damaged or leaking packages of regulated medical waste shall either be properly repackaged prior to storage and subsequent shipment offsite or contained and treated onsite within 24 hours if the facility is permitted for treatment operations.

I. Transportation of regulated medical waste is subject to the requirements of 9VAC20-121-150.

J. Waste must not be accepted unless it is allowed in accordance with the permit-by-rule issued and the regulated medical waste management plan and there is sufficient storage, transfer, or treatment capacity. The amount of regulated medical waste received and stored at the facility shall not exceed the permit process rate and designed storage capacity.

K. Regulated medical waste transfer stations and treatment facilities regulated under this part shall implement an unauthorized waste control program in accordance with their written plan as required by 9VAC20-121-330 and the following provisions:

1. Prior to managing regulated medical waste or using process equipment, and at least annually, within one year from the date of the last training, the facility shall provide training to staff to recognize, segregate, properly manage, document, and report receipt of waste not authorized to be managed by the facility's permit.

2. If unauthorized waste is observed in the waste delivered to the facility prior to unloading, the owner or operator must refuse to accept the waste.

3. If the unauthorized waste is observed in the waste at the facility or delivered to the facility, the owner or operator shall segregate it, notify the generator (if applicable), document the incident in the operating record, make necessary arrangements to have the material managed in accordance with applicable federal and state laws, and notify the department of the incident to include the means of proper handling, in accordance with the reporting procedures of 9VAC20-121-340.

4. Any unauthorized waste accepted by the owner or operator shall be managed in accordance with applicable federal or state laws and regulations. The facility must carefully store the waste in a designated storage area within the facility separate from untreated regulated medical waste and treated regulated medical waste. Unauthorized waste that has been segregated and stored shall be adequately secured and contained to prevent leakage or contamination to the environment. The facility shall have the unauthorized waste removed or properly managed as soon as practicable, but no later than 10 calendar days after discovery or an alternate timeframe as approved by the department for certain waste types. Handling and management of the unauthorized waste, including segregation, removal, and transportation, shall be by a person authorized to manage such waste and shall be transferred, treated, or disposed of at a permitted waste management facility approved to receive it.

5. The facility must maintain a record of all unauthorized waste accepted at the facility, the date accepted, the type of waste, date of transfer, treatment, or disposal, management method, and the name, address, and telephone number of the final treatment or disposal facility.

L. Radiation detection equipment shall be operated and maintained in a manner that ensures all incoming waste is screened and the measurements are meaningful and fulfill the

objectives for detecting radiologically contaminated waste. If fixed radiation detectors become inoperable, repairs shall be made as soon as practicable, and appropriate portable equipment shall be used to screen incoming waste loads until the equipment is repaired.

M. Untreated waste, radioactive waste, hazardous waste, and any unauthorized waste must be segregated and stored in clearly identified containers. Category A waste shall be managed in accordance with the requirements of 9VAC20-121-160.

N. The facility shall be operated to maintain the design and construction standards as required by 9VAC20-121-220.

O. All areas used to transfer or treat regulated medical waste shall have prominent signage or markings displayed on the door or access point to indicate that the space is used to manage regulated medical waste, and those areas shall be secured to prevent unauthorized access.

P. Floors and areas used for the handling, tipping, storage, transfer, or treatment of regulated medical waste and reusable container cleaning must be kept clean, in an orderly condition, and free of standing liquid and debris.

Q. Effluent, wash water, and other runoff from facility floors, storage and processing areas, treatment equipment, waste compactors, and reusable container cleaning and disinfection areas shall be contained and discharged directly to an approved sanitary sewer system. Effluent, wash water, and other runoff from the facility shall not be permitted to drain or discharge into surface waters except when authorized under a VPDES permit issued pursuant to 9VAC25-31.

R. All infrastructure and equipment shall be properly maintained and operated as designed and approved in the facility's permit. Facility maintenance must include annual calibrations of parametric controls, including recording devices and temperature and pressure gauges; overall cleaning (the facility, vehicles, and processing systems); servicing of exhaust lines and drains; ensuring the proper functioning of pressure and safety valves, and water, steam, disinfectant and electrical lines; replacing gaskets as needed to ensure a complete seal at all times; ensuring floor drains are maintained such that liquid is free-draining at all times; and maintaining proper functioning of mechanical waste handling systems, conveyors and shredders, HEPA, and other ventilation and filtration devices, and radiation monitoring devices, as applicable.

S. Adequate numbers and types of properly maintained equipment shall be available for operation. Provision shall be made for substitute equipment to be available, except for treatment units which must be approved by the department, or the emergency contingency plan implemented to achieve compliance with this chapter, as applicable, within 24 hours should the former become inoperable or unavailable. Operators with training appropriate to the tasks they are expected to perform and in sufficient numbers for the complexity of the site shall be on the site whenever it is in operation.

T. Safety hazards to operating personnel shall be controlled through an active safety program consistent with the requirements of 29 CFR Part 1910, as amended.

U. Each facility shall conduct monthly inspections of all major aspects of facility operations necessary to ensure compliance with the requirements of this chapter. Records of these inspections must be maintained in the operating record and available for review in accordance with 9VAC20-121-340. If a deficiency or release is identified during an inspection, the owner or operator must document it on the self-inspection checklist, provide a remedy for the issue as soon as feasible, and document repairs and remedial actions, including the date implemented. The following aspects of the facility shall be inspected on a monthly basis whenever the facility is in operation:

1. Each component of the processing equipment, treatment system, and infrastructure;

2. Spill containment and cleanup kit and any other decontamination materials;

3. Safety and emergency equipment, including radiation detection equipment, fire alarm and protection systems, fire extinguishers, eyewash stations, or other equipment;

4. Waste storage areas and loading and unloading areas;

5. All floors and floor drains and any areas and inventory for managing, cleaning, and disinfecting reusable carts or containers;

6. Proper use of personal protective equipment by all employees;

7. Monitoring for pests and vermin, litter, blowing debris, odor, dust, breached containers, and spills; and

8. Any areas in which significant adverse environmental or health consequences may result if breakdown occurs.

V. Prior to managing regulated medical waste or using process equipment, and at least annually, within one year from the date of the last training, the facility shall provide all operators with training on the procedures for managing regulated medical waste specific to the transfer or treatment process used, including:

1. General handling of regulated medical waste and use of personal protective equipment;

2. Packaging, labeling, and storage of regulated medical waste;

3. Cleaning and disinfection of reusable containers;

4. Facility housekeeping and management of spills;

5. Overall process and mechanical operation of any equipment used, including operation of any treatment units and procedures for conducting periodic challenge testing; and

6. Emergency contingency plan procedures, in case of system failure or other emergency.

W. The facility shall retain records in accordance with 9VAC20-121-340. Records shall be retained for three years and available for review as requested by the department.

9VAC20-121-240. Treatment standards.

A. Prior to disposal or recycling, all regulated medical waste, including its packaging, must be treated by a department approved regulated medical waste treatment process. Any method used for the treatment of regulated medical waste must be verifiable to render the waste noninfectious in a manner that is protective of human health and the environment. Untreated regulated medical waste shall not be recycled or disposed of in a solid waste landfill or other solid waste management facility.

B. The requirements in this subsection are applicable to all treatment methods. Additional requirements are provided in subsections C through I of this section and are dependent on the type of treatment used.

1. The treatment method and operating parameters shall be appropriate and effective for the type of waste being managed.

a. Human pathological and anatomical waste, including tissues, organs, body parts, and other related waste and animal carcasses shall not be treated by a noncombustion process unless approved by the department. Alkaline hydrolysis is an alternative treatment process that may be considered for treatment. Pathological waste in a liquid fixative may require special management, such as decanting the liquid for separate disposal, incineration, or management as hazardous waste if applicable.

b. Thermally resistant waste, including solidified liquids and bulk animal bedding, requires approval of treatment operating parameters on a case-by-case basis.

c. Category A waste shall be managed in accordance with the requirements of 9VAC20-121-160.

d. Waste contaminated with toxins and toxin waste solutions (depending on the toxin) can be inactivated by incineration or extensive autoclaving, or by soaking in suitable decontamination solutions. Toxin inactivation procedures shall not be assumed to be 100% effective without validation using specific toxin bioassays.

2. Treatment equipment shall include built-in automatic controls and fail safe mechanisms to ensure the waste cannot bypass the treatment process.

3. Size reduction, grinding, shredding, or puncturing of containers is permissible if integral to the treatment unit and shall be done with safe and sanitary methods. Nothing in this section shall prevent the use of devices that grind, shred, or compact to reduce volume at the point of generation and prior to enclosing the regulated medical waste in plastic bags and other required packaging; however, the waste remains regulated medical waste. The facility shall demonstrate that devices are constructed and operated in a manner that prevents employee exposure to the waste; contains any aerosol, bioaerosol, or mist caused by the process; and treats or filters any air evacuated from the chamber during processing. Appropriate means must be employed to appropriately protect workers and contain the waste when unloading regulated medical wastes from such a device.

4. If grinding, shredding, or size reduction or puncturing of packaging takes place prior to treatment, it shall occur in a closed unit immediately preceding the treatment unit. If grinding, shredding, or size reduction takes place following treatment, it must occur within 24 hours of leaving the treatment unit. Transfer from a grinder or shredder to or from a treatment unit shall be under forced draft ventilation that removes fumes from the operations area to a safe discharge.

5. All process units for the preparation or treatment of regulated medical waste shall be in closed vessels designed to operate under a negative pressure atmospheric control that filters all vents, discharges, and fugitive emissions of air from the process units through a high efficiency particulate air (HEPA) filter with efficiency of 99.97% for 0.3 microns. Proper installation of filters shall be documented. Air and gases which have themselves been sterilized by the process are not required to pass through a filter.

6. All effluent must be discharged to an approved sanitary sewer system. Effluent from the facility shall not be permitted to drain or discharge into surface waters except when authorized under a VPDES permit issued pursuant to 9VAC25-31.

7. Only the types of regulated medical waste specified in the facility's permit shall be treated using the approved treatment unit. Treatment methods include:

a. Autoclaves (steam sterilization);

b. Microwaves;

c. Dry heat treatment;

d. Chemical treatment;

e. Alkaline hydrolysis;

f. Incineration; and

g. Alternate treatment technologies as reviewed and approved by the department in accordance with this chapter.

8. Prior to operation of any treatment unit, the facility must conduct validation testing in accordance with 9VAC20-121-260 and an approved treatment plan to establish the appropriate operating parameters for effective treatment of

regulated medical waste. The results of the testing must be submitted to the department for review and approval in accordance with 9VAC20-121-320. The facility shall not receive or treat regulated medical waste until the department has approved the validation results, operating parameters, and protocols to be used for the treatment unit. Revalidation shall be conducted as required by 9VAC20-121-260.

9. Treatment units shall operate in accordance with the specified operating parameters and protocols set forth in subsections C through I of this section or alternate standards established through validation testing and approved by the department. Records of treatment shall be maintained in accordance with 9VAC20-121-340.

10. Periodic challenge testing shall be performed under full loading in accordance with 9VAC20-121-270 to evaluate the effectiveness of each treatment unit and treatment method.

11. Effective treatment of regulated medical waste must achieve a 6 log10 or greater reduction of the viable spore concentrations of the most appropriate bacterial species for the treatment method. Effective treatment is demonstrated by no growth in all treated biological indicators and growth in all untreated biological indicators during validation and periodic challenge testing.

12. The selection of the most appropriate biological indicator to utilize during validation and challenge testing of a treatment process shall be supported by referenced standards, guidelines, or information from peer reviewed journals related to the process.

a. Biological indicators shall utilize spores from one of the following bacterial species:

(1) Geobacillus stearothermophilus (G.s.);

(2) Bacillus atrophaeus (B.a.);

(3) Bacillus subtilis (B.s.);

(4) Other Bacillus species or spore forming bacteria from domestic or international culture collections; or

(5) Organisms that demonstrate the necessary resistance for the treatment method, as approved by the department.

b. The facility shall use commercially prepared biological indicators, such as spore strips, spore suspensions, and self-contained biological indicators.

c. Biological indicators shall be placed in the most challenging location during validation and periodic challenge testing. Indicator ports, chambers, or other mechanisms shall be used for placement of the biological indicator when placement directly into the waste may be compromised by the treatment method, such as when shredding, grinding, or other mechanism is used. Ports and chambers shall be accessible by the operator.

d. When using the appropriate biological indicator, the number to be used shall be based upon the amount of waste to be processed in accordance with 9VAC20-121-260 D 7 (for validation) and 9VAC20-121-270 B (for periodic challenge testing).

13. Parametric controls shall be used to monitor critical operational treatment parameters and provide a record of measurements that can be correlated to effective treatment.

14. Door alignment, gaskets, locking mechanisms, and other components of any treatment unit that utilizes a pressure vessel (such as an autoclave) shall achieve a complete seal during operation to prevent leaking of steam, liquid, or waste and avoid decreases in pressure or temperature that could cause isolated cold spots inside the unit.

15. In the event of power failure, interrupted, or incomplete treatment cycle, the facility shall investigate the cause of the failure and make any necessary repairs to resolve the issue prior to the next treatment cycle. Any waste in the treatment unit shall either be removed and managed as regulated medical waste or subjected to another full treatment cycle once repairs are made.

16. Reusable treatment carts and containers (such as autoclave carts) shall be clean and free of treated waste residuals before reuse.

C. The requirements in this subsection are applicable to autoclave treatment methods.

1. All autoclaves shall be operated at 100% saturated steam conditions at a minimum operating temperature of 250°F (121°C) at no less than 15 pounds per square inch of gauge pressure. Autoclaves shall maintain the minimum operating temperature and pressure for an uninterrupted cycle of 90 minutes. Alternate combinations of operating temperatures, pressures, and cycle times may be demonstrated through validation testing to achieve a reliable and complete kill of all microorganisms in regulated medical waste at design capacity. Longer steam sterilization times are required when a load contains a large quantity of liquid.

2. All autoclaves shall be equipped with continuous time, temperature, and pressure monitoring and recording.

3. For vacuum autoclaves, pre-vacuum cycles shall be conducted such that all system air is fully evacuated a minimum of three times at the beginning of each treatment cycle and held with all air evacuated to ensure adequate steam exposure throughout the waste.

4. For gravity autoclaves, pressure pulsing must be performed to evacuate all air in the unit.

5. Validation and periodic challenge testing shall be performed using biological indicators utilizing spores from the bacterial species Geobacillus stearothermophilus.

D. The requirements in this subsection are applicable to microwave treatment methods.

1. Microwaving treatment shall incorporate pretreatment by shredding and steam injection or induction.

2. All microwaves shall be operated between 203ºF and 212ºF (95ºC and 100ºC) for a minimum of 45 minutes. Alternate operating temperatures and cycle times may be demonstrated through validation testing.

3. Microwave radiation power of the treatment process shall be at least six units each having a power of 1,200 watts or the equivalent power output.

4. Each microwave treatment unit shall be equipped to sense, display, and continuously record the temperature at the start, middle, and end of the treatment chamber.

5. Process temperatures at the exposure chamber entry and exit and the waste flow rate shall be continuously monitored, displayed, and recorded.

6. Validation and periodic challenge testing shall be performed using biological indicators utilizing spores from the bacterial species Bacillus atrophaeus.

E. The requirements in this subsection are applicable to dry heat treatment methods.

1. Dry heat systems shall be operated per the following operational standards:

a. Temperature of not less than 320ºF (160°C) for 120 minutes;

b. Temperature of not less than 340ºF (170°C) for 60 minutes; or

c. Temperature of not less than 360ºF (180°C) for 30 minutes.

Alternate operating temperatures and cycle times may be demonstrated through validation testing.

2. Each treatment unit shall be equipped to sense, display, and continuously record the temperature of the treatment chamber.

3. Unless otherwise approved by the department, no treatment unit employing dry heat as the main treatment process shall have a treatment chamber capacity greater than 1.0 cubic foot in volume.

4. Validation and periodic challenge testing shall be performed using biological indicators utilizing spores from the bacterial species Bacillus atrophaeus.

F. The requirements in this subsection are applicable to chemical treatment methods.

1. Operating standards for chemical treatment systems are dependent on the chemical concentration and exposure time. Facilities wishing to employ a chemical treatment system shall submit an alternate treatment technology petition per 9VAC20-121-250 to justify the proposed operating parameters. Once the petition is approved, chemical concentration and treatment time operating parameters shall be demonstrated through validation testing in the presence of the maximum anticipated organic waste content.

2. The facility shall maintain registration for the chemical used in the treatment system in accordance with the Federal Insecticide, Fungicide, and Rodenticide Act, if required.

3. Containers holding chemicals shall be labeled in accordance with 40 CFR 156 (Labeling Requirements for Pesticides and Devices), and the facility shall maintain Safety Data Sheets for all chemicals related to the chemical treatment system.

4. Validation and periodic challenge testing shall be performed using biological indicators utilizing spores from the bacterial species Bacillus subtilis or Bacillus atropheus.

G. The requirements in this subsection are applicable to alkaline hydrolysis treatment methods. Alkaline hydrolysis is a process by which heat and pressure dissolve and sterilize regulated medical waste in a strong solution of sodium or potassium hydroxide (NaOH or KOH, respectively).

1. Alkaline hydrolysis shall only be used for treatment of human pathological and anatomical waste, including tissues, organs, body parts, other related waste, and animal carcasses.

2. Systems that operate above atmospheric pressure must employ a dissolution chamber that is a certified pressure vessel by the American Society of Mechanical Engineers' (ASME).

3. Operating parameters for alkaline hydrolysis systems vary depending on the amount of regulated medical waste to be treated and the type of contamination:

a. To inactivate microbial pathogens, the waste must be heated to 212ºF (100ºC), and pressurized at 15 pounds per square inch for three hours;

b. To destroy transmissible spongiform encephalopathy (TSE), including bovine spongiform encephalopathy, the waste must be heated to 300ºF (150ºC) and pressurized at 70 pounds per square inch for six to eight hours.

c. Chemical concentration and treatment time shall be demonstrated through validation testing in the presence of the worst case organic material waste content.

4. Treatment shall ensure the complete dissolution of all tissue remains, if applicable, and any solids left shall be disposed of at a solid waste management facility permitted to receive it.

5. Validation and periodic challenge testing shall be performed using biological indicators utilizing spores from the bacterial species Geobacillus stearothermophilus.

H. The requirements in this subsection are applicable to incineration treatment methods.

1. All incinerators shall be permitted under regulations of the State Air Pollution Control Board and be in compliance with the regulations of that body.

2. All combustible regulated medical waste shall be converted by the incineration process into ash that is not recognizable as to its former character.

3. Analysis of ash and air pollution control residues:

a. Incinerator bottom ash and residues collected from air pollution control equipment shall be collected separately in leak resistant containers with runoff controls to prevent releases from the ash storage. Incinerator bottom ash and air pollution control residues shall be stored separately until sample testing per subdivision 3 b of this subsection is performed and the waste streams are determined to be a solid waste.

b. Testing requirements:

(1) Representative samples consisting of 250 milliliters of each waste stream shall be collected once every eight hours of operation of a continuously fed incinerator and once every batch or 24 hours of operation of a batch fed incinerator. Samples shall be collected during each 1,000 hours of operation or quarterly, whichever is more often, and samples shall be thoroughly mixed and seven random portions of equal volume shall be composited into one sample for laboratory analysis. This sample shall be tested in accordance with the methods established by the Virginia Hazardous Waste Management Regulations (9VAC20-60) for determining if a solid waste is a hazardous waste.

(2) In addition to subdivision 3 b (1) of this subsection, composite samples of incinerator bottom ash shall be tested for total organic content.

c. If ash or air pollution control residues are found to be hazardous waste (based on a sample and a confirmation sample) the waste ash shall be managed of as a hazardous waste in accord with the Virginia Hazardous Waste Management Regulations (9VAC20-60). The operator shall notify the department within 24 hours. No later than 15 calendar days following, the permittee shall submit a plan for treating and disposing of the waste on hand at the facility and all unsatisfactorily treated waste that has left the facility. The permittee shall include with the plan a description of the corrective actions to be taken to prevent further unsatisfactory performance. No ash or air pollution control residues subsequently generated from the incinerator waste stream found to be hazardous waste shall be sent to a nonhazardous solid waste management facility in the Commonwealth unless written approval of the director is obtained in accordance with Solid Waste Management Regulations (9VAC20-81).

d. If ash or air pollution control residues are found not to be hazardous waste by analysis, they may be disposed of in a solid waste landfill that is permitted to receive municipal solid waste or incinerator ash, provided the disposal is in accordance with the Solid Waste Management Regulations (9VAC20-81).

e. A log shall document the ash sampling, to include the date and time of each sample collected; the date, time, and identification number of each composite sample; and the results of the analyses, including laboratory identification. Results of analyses must be returned from the laboratory and recorded within four weeks following collection of the composite sample. The results and records described in this part shall be maintained for a period of three years, and shall be available for review.

I. Alternate treatment technologies as reviewed and approved by the department. All alternate treatment technologies approved by the director shall conform to the general treatment standards in subsection B of this section and any additional requirements the department imposes at the time of approval.

1. Any person who desires to use a chemical treatment technology per subsection F of this section or treatment technology, other than those described in subsections C, D, and E or subsections G and H of this section, shall petition the director for a review under 9VAC20-121-250.

2. If the director finds that the technology and application is in accordance with this part, the department may consider the facility for permitting.

9VAC20-121-250. Alternate treatment technologies.

A. In accordance with 9VAC20-121-240 I, chemical treatment and other alternate treatment technologies may be approved for permitting if the department reviews the process and determines that the technology provides treatment in accordance with this chapter and protects public health and the environment, and if the department establishes appropriate conditions for their siting, design, and operation. This section establishes the criteria, protocols, procedures, and processes to be used to petition the director for review and to demonstrate the suitability of the proposed technology for the treatment of regulated medical waste.

B. Alternate treatment technologies are subject to the general treatment standards of 9VAC20-121-240 and the additional requirements of this section. To ensure effectiveness of the proposed chemical or alternate treatment technology, the applicant must demonstrate effective microbial and bacterial inactivation at a 6 log10 or greater reduction for the microorganisms and spores listed in subsections C and D of this section through validation testing that meets the requirements of 9VAC20-121-260.

C. Microbial inactivation shall be demonstrated using one or more representative microorganisms from each microbial group:

1. For vegetative bacteria: either Staphylococcus aureus (ATCC 6538) or Pseudomonas aeruginosa (ATCC 15442).

2. For fungi: either Candida albicans (ATCC 18804), Penicillium chrysogenum (ATCC 24791), or Aspergillus niger.

3. For viruses: either Polio 2 or Polio 3, or MS-2 Bacteriophage (ATCC 15597-B1).

4. For parasites: either Cryptosporidium spp. oocysts or Giardia spp. Cysts.

5. For Mycobacteria: either Mycobacterium terrae, Mycobacterium phlei, Mycobacterium bovis (BCG) (ATCC 35743).

D. Bacterial inactivation shall be demonstrated for chemical, thermal, and irradiation treatment systems using spores from either B. stearothermophilus (ATCC 7953) or B. subtilis (ATCC 19659).

E. For those treatment processes that can maintain the integrity of the biological indicator carrier (i.e., ampules, plastic strips) of the desired microbiological test strain, biological indicators of the required strain and concentration shall be used to demonstrate effective treatment. Effective treatment is demonstrated by no growth in all treated biological indicators and growth in all untreated biological indicators during validation and periodic challenge testing.

F. For those treatment mechanisms that cannot ensure or provide integrity of the biological indicator (i.e., chemical inactivation or grinding), quantitative measurement of effective treatment requires a two-step approach: Step 1, "Control"; Step 2, "Test." The purpose of Step 1 is to account for the reduction of test microorganisms due to loss by dilution or physical entrapment.

1. Step 1 is:

a. Use microbial cultures of a predetermined concentration necessary to ensure a sufficient microbial recovery at the end of this step.

b. Add suspension to a standardized medical waste load that is to be processed under normal operating conditions without the addition of the microbial inactivation agent (i.e., heat, chemicals).

c. Collect and wash waste samples after processing to recover the biological indicator organisms in the sample.

d. Plate recovered microorganism suspensions to quantify microbial recovery. (The number of viable microorganisms recovered serves as a baseline quantity for comparison to the number of recovered microorganisms from wastes processed with the microbial inactivation agent).

e. The required number of recovered viable indicator microorganisms from Step 1 must be equal to or greater than the number of microorganisms required to demonstrate a 6 log10 or greater reduction.

2. Step 2 is:

a. Use microbial cultures of the same concentration as in Step 1.

b. Add suspension to the standardized medical waste load that is to be processed under normal operating conditions with the addition of the microbial inactivation agent.

c. Collect and wash waste samples after processing to recover the biological indicator organisms in the sample.

d. Plate recovered microorganism suspensions to quantify microbial recovery.

3. From data collected from Step 1 and Step 2, the level of microbial and bacterial inactivation shall be calculated based on the:

a. Number of viable "Test" microorganisms (in colony forming units per gram of waste solids) introduced into the treatment unit,

b. Number of "Control" microorganisms (in colony forming units per gram of waste solids) that were not recovered after processing, and

c. Number of viable "Test" microorganisms (in colony forming units per gram of waste solids) recovered in treated processed waste residue.

G. To initiate the technology review process the applicant shall complete and submit DEQ Form RMWTP-01, Application for Evaluation and Approval of Regulated Medical Waste Treatment Technology to the department. The application shall be accompanied by:

1. A detailed description of the chemical or alternate treatment technology. The description must include:

a. A discussion of operating procedures and conditions, including, as applicable, treatment times, pressure, temperatures, chemical concentrations, irradiation doses, feed rates, and wasteload composition;

b. A discussion of parametric controls, verifying effective treatment, and ensuring operator noninterference; and

c. A discussion of waste residues and by-products generated and methods of disposal or recycling.

d. The description shall be accompanied by the manufacturer's operations manual or equipment usage instructions, equipment specifications, and maintenance manual.

2. Documentation demonstrating the chemical or alternate treatment technology meets microbial and bacterial inactivation criteria specified under subsections B through F of this section. The documentation must include a description of the test procedures and calculations used in fulfilling required performance standards verifying effective treatment, of user verification methodology, and of microbial culturing protocols that ensure traceability, purity and concentration, and copy of all test results.

3. A chemical management plan describing all chemicals to be stored on site and include copies of Safety Data Sheets for all chemicals used for regulated medical waste treatment and EPA pesticide registration, if applicable.

4. Documentation providing occupational safety and health assurance.

H. The applicant shall demonstrate that all required surrogate pathogens and resistant bacterial endospores are inactivated to criteria specified in subsections B through F of this section under the representative surrogate waste load compositions.

I. The applicant shall demonstrate where the relationship between effective treatment, biological indicator data, and data procured from real-time parametric monitoring devices for the treatment unit.

J. The review of the application will occur in accordance with this subsection.

1. After receiving an application that includes the information and demonstrations required in subsections A through I of this section, the department will perform an administrative review and determine whether the information received is sufficient to approve the proposed chemical or alternate treatment technology. If the information is deemed to be insufficient, the department will request that additional information be furnished.

2. The applicant may submit the additional information requested or may demonstrate that the additional information should not be required. If the department agrees that the additional information is not required, the department will determine if the application is complete.

3. After the application is deemed complete, the director may then issue a treatment technology approval. The approval shall be issued under the conditions specified in the manufacturer's instructions and equipment specifications, operating procedures, and conditions as outlined in the application, including, as applicable, treatment times, temperatures, pressure, chemical concentrations, irradiation doses, feed rates, and waste load composition. Any significant revision to these conditions will require reapplication for approval in accordance with this section.

4. Following technology approval, any facility wishing to use the approved technology to treat regulated medical waste shall apply for and obtain the necessary permits in accordance with Part V (9VAC20-121-300 et seq.).

9VAC20-121-260. Validation testing.

A. Prior to using any treatment system, the facility must conduct validation testing that employs the use of process controls, biological indicators, and process monitoring to establish operating parameters to demonstrate effective treatment of regulated medical waste.

B. Prior to validation testing, the owner or operator shall submit to the department a treatment plan containing the information required by 9VAC20-121-330 E. The plan shall demonstrate that the validation protocols for each treatment unit meet the standards of this section and shall indicate any additional protocols specific to the regulated medical waste to be treated, such as the use of packaging types that may affect treatment of the waste. Validation testing must be conducted in accordance with an approved treatment plan and the requirements of this section. The validation test results and operating parameters must be submitted to the department for review prior to acceptance of regulated medical waste for treatment.

C. To demonstrate reproducibility, a minimum of three separate treatment runs must be performed on three separate days, using three distinct loads, during which the department is present to witness at least one complete validation test run. All test runs shall meet the following requirements:

1. Operating parameters used during the tests must be consistent with the parameters that will be used during routine operation of the treatment process (e.g., cycle duration, temperature, pressure, chemical concentration, irradiation exposure time, or other treatment parameters as applicable).

2. Surrogate waste load composition (e.g., porosity, liquids, solids, moisture content, organic matter, thermal resistance, and type of packaging or containers) and wasteload configuration (e.g., packing density and orientation) used during the tests must be consistent with the waste properties and loading process that will be used during routine operation. The surrogate waste load shall represent the most difficult waste anticipated to be treated during routine operation.

3. The weight and volume of the surrogate waste loads used during the tests must be consistent with the amount of waste that will be treated during routine operation. Validation testing must be performed at the treatment unit's full capacity unless an alternate load size is approved.

D. To assess treatment performance, the system must employ commercially-prepared biological indicators from the same lot or batch, each containing spores that demonstrate the necessary resistance for the treatment method, as determined by the department. The indicators must:

1. Have a minimum concentration of 6 log10 spores per biological indicator. The concentration must be higher and more thermally resistant than the bioburden routinely associated with the waste;

2. Include a supplier's certificate of performance (or certificate of analysis) that identifies the organism (genus, species, strain, and population) and, for thermal treatment systems (including autoclaves), the D-value and Z-value. The D-value must be 1.5 to 3.0 minutes, unless otherwise

approved by the department, and the Z-value must be no less than 50°F (10°C);

3. Be appropriate for the type of waste and device (i.e., self-contained, suspension, or spore strip), including the shelf life, the carrier material and primary packaging, the culture medium (for self-contained biological indicators) and the media, growth, and culture conditions (for non-self-contained biological indicators);

4. Be compatible with the treatment process and have a resistance relative to the temperature, pressures, conditions, chemicals, or irradiation used in the process; the infectious agents on a substrate; the type and density of the waste to be treated; and its packaging;

5. Be placed in a carrier system (e.g., net bags, wrapped in a paper towel and encased in cotton batting or inside tennis balls, socks, or alloy containers with holes in them) designed to mimic the thermal resistance of the waste before placement into the package to be treated. Materials used to hold biological indicators must be similar to the waste to be treated, provide effective protection from damage or breakage or from otherwise being compromised, be loose in the bulk of the waste, and be easily retrievable at the end of each validation test run. Indicators shall not be placed in carrier systems that would enhance treatment or produce erroneous results (such as metal containers that would conduct heat);

6. Be placed throughout the waste load during each validation test at the coldest or most challenging locations within the treatment unit, where the sum of all influences on the microorganisms results in minimal inactivation for a defined waste load;

7. Be used in accordance with the quantity specified as follows, for each test run:

a. Three biological indicators per cycle for 0 to 110 pounds of waste per load;

b. Five biological indicators per cycle for 111 to 550 pounds of waste per load;

c. Seven biological indicators per cycle for 551 to 1,100 pounds of waste per load;

d. Nine biological indicators per cycle for 1,101 to 1,650 pounds of waste per load;

e. Eleven or more biological indicators per cycle, as determined by the department, for greater than 1,650 pounds of waste per load; and

f. One or more biological indicators from the same lot or batch to be left untreated and used as a control;

8. Be stored in accordance with the manufacturer's specifications when not in use. Expired biological indicators shall not be utilized.

9. Biological indicators in the form of paper strips must not be used in devices or areas where fluids can pool or puddle around the indicator. Self-contained biological indicators with vent caps must not be used where liquids may accumulate and contaminate the indicators.

10. Qualitative or quantitative biological indicators shall be used provided the operator or vendor of the technology provides evidence from such sources as peered reviewed journals that support the use of that particular indicator. Biological indicators requiring microbial bioassay to confirm effective treatment must be quantitatively analyzed after the treatment cycle. All self-contained biological indicators used for test runs must be evaluated for growth (e.g. qualitatively analyzed for color change) following incubation in accordance with the manufacturer's instructions.

E. Concurrent with biological indicators, the process must employ devices or instrumentation that demonstrates the treatment unit is achieving critical operating parameters for effective treatment. Process monitoring shall include:

1. Thermochemical indicators (e.g., tape, paper strips, or integrators) that demonstrate that the waste has been exposed to a certain temperature or chemical concentration;

2. Thermochemical recording devices (e.g., wireless data loggers, thermocouples, or chemical monitoring probes) that are placed in or on waste packages and that provide a measurable record of actual treatment conditions of the waste; and

3. Parametric controls or monitoring devices integral to the treatment system that record critical operational treatment parameters and provide a record of measurements that can be correlated to effective treatment.

F. Effective treatment of regulated medical waste must achieve a 6 log10 or greater reduction of the viable spore concentrations of the most appropriate bacterial species for the treatment method. Effective treatment is demonstrated by no growth in all treated biological indicators and growth in all untreated biological indicators during each test run. In certain situations where the waste poses a greater risk (e.g., a higher bioburden waste), the department may require a greater reduction.

G. The facility shall submit to the department for approval a summary of the validation test results demonstrating the treatment effectiveness and specifying the operating parameters based on the results of all validation test runs. The report shall describe the results of all validation test runs, including:

1. Date and time of all test runs, including the operator's name and cycle start and end times;

2. Surrogate waste load composition, configuration, and size;

3. Number, type, batch or lot number, expiration date, and placement of biological indicators, thermochemical indicators, and thermochemical recording devices; and

4. Results of all methods used to monitor operating parameters achieved throughout the treatment cycle and the accuracy of parametric monitoring devices, including copies of charts, graphs, or other read-outs from the treatment equipment and growth results of all treated indicators and untreated controls.

H. Validation testing must be repeated when any of the following occurs:

1. Failure of any treatment process to achieve operational parameters, such as time, temperature, or pressure during validation testing;

2. Failure to achieve microbial inactivation in any biological indicator during any treatment cycle during validation testing;

3. Failure of the untreated control indicator to show growth of the viable spore concentration;

4. Any modifications to any of the treatment process operational parameters, bioburden, waste mass, chemical type, concentration, irradiation or exposure time, type of waste to be treated, or mechanical or engineering changes to the treatment system from those assessed during the validation testing;

5. A failure identified in subdivision 1, 2, or 3 of this subsection during periodic challenge testing as identified by biological or process monitoring that occurs three or more times in a calendar year or during the first 30 days of actual operation;

6. A treatment device has been operational without a repeat validation for at least five years; or

7. A treatment device has not been used for at least one year.

9VAC20-121-270. Periodic challenge testing.

A. After initial validation testing and during routine operation, a regulated medical waste treatment facility shall perform periodic challenge testing under full loading to evaluate the effectiveness of each treatment device in accordance with procedures outlined in the facility's approved treatment plan.

B. Periodic challenge testing shall be performed in accordance with the following requirements:

1. Biological indicators shall be used to periodically challenge test a load of regulated medical waste and must comply with all requirements of 9VAC20-121-260 D, with the exception of the quantity of biological indicators required under 9VAC20-121-260 D 7.

2. Periodic challenge testing must include at least one-third of the number of appropriate biological indicators that are required for the validation test, or two indicators, whichever is greater, unless otherwise determined by the department. One or more additional biological indicators from the same lot or batch shall be left untreated and used as a control.

3. The results of all periodic challenge testing shall be maintained for three years in accordance with 9VAC20-121-340 and shall include:

a. Date and time of all challenge tests, including the operator's name and cycle start and end times;

b. Number, type, batch or lot number, expiration date, and placement of biological and thermochemical indicators; and

c. Results of all methods used to monitor operating parameters achieved throughout the treatment cycle, including copies of charts, graphs, or other read-outs from the treatment equipment and growth results of all treated indicators and untreated controls.

4. Effective treatment of regulated medical waste must be demonstrated by a 6 log10 or greater reduction of spore concentrations in all biological indicators in each periodic challenge test. A challenge test is considered a failure if any of the following occurs:

a. Failure of any treatment process to achieve operational parameters such as time, temperature, or pressure;

b. Failure to achieve microbial inactivation in any biological indicator during any treatment cycle. All biological indicators must show passing results (no growth in the viable spore concentration) after treatment or the challenge test is considered a failure; or

c. Failure of the untreated control indicator to show growth of the viable spore concentration.

C. Any regulated medical waste treated during or after a challenge test shall be stored temporarily until challenge test results are obtained. Regulated medical waste shall not be shipped offsite until the challenge test is complete and shows passing results for all biological indicators.

D. Unless otherwise approved by the department, for the first 30 days of actual operation, each treatment unit shall undergo challenge testing twice per day. The first load of each day shall be used for one of the required challenge tests.

E. Following the first 30 days of actual operation, periodic challenge testing must be conducted at a minimum of once per week or every 40 hours of operation, whichever is greater.

F. After six months of successful operation with no challenge test failures in weekly or 40- hour testing, challenge testing shall be conducted at least once per month.

G. Any challenge test failures during the first six months of actual operation shall require a return to daily challenge testing

for at least 30 operating days. After the first six months of actual operation, any challenge test failure shall require a return to challenge testing once per week or every 40 hours of operation, whichever is greater.

H. Following any challenge test failure:

1. The waste shall continue to be managed as regulated medical waste and shall be retreated, stored temporarily until retreatment, or diverted to another approved facility for treatment or disposal. Regulated medical waste shall not be considered treated until a subsequent challenge test is conducted with passing results;

2. The facility shall evaluate and correct any issues with the treatment cycle and unit prior to treating any additional waste;

3. The facility shall notify the department of the failure in accordance with 9VAC20-121-340; and

4. The facility shall increase the frequency of challenge testing in accordance with subsection G of this section.

9VAC20-121-280. Disposal of treated regulated medical waste.

A. Regulated medical waste that has been treated in accordance with this part is no longer a regulated medical waste. Treated regulated medical waste is a solid waste. Treated waste may be compacted in a closed container in a safe and sanitary manner.

B. Treated waste shall be disposed of at a permitted solid waste disposal facility in accordance with the Solid Waste Management Regulations (9VAC20-81) and the solid waste disposal facility's permit. Regulated medical waste not treated in accordance with this chapter remains a regulated medical waste and shall not be transported to, received for transport or disposal by, or disposed in any solid waste management facility.

C. Where non-bulk treatment is used, treated waste shall be placed in sealed bags or containers that allow for visible assessment of treatment, such as clear bags or bags marked with sterilization indicators. The bags shall not be red in color. Opaque bags and bags with special labels are permissible if agreed upon in writing by the solid waste management facility receiving the treated waste. Treatment cart liners that are resistant to treatment conditions (such as temperature) may be used to package treated waste. Where bulk treatment is used and the solid waste is immediately placed or compacted in closed bulk solid waste management containers that are more than 64 gallons in volume, the repackaging of the solid waste in bags is not required. Treated waste shall not be repackaged as regulated medical waste.

D. The regulated medical waste treatment facility shall have a written agreement with each permitted solid waste management facility that will transfer, store, or dispose of the treated waste. The agreement shall specify and include the following:

1. A description of how the treated waste will be packaged and transported to each solid waste management facility, including the types and colors of bags or containers used, and any special labeling if applicable;

2. The type of regulated medical waste treated, treatment method, and name, address, and telephone number of the treatment facility; and

3. The name, address, and telephone number of any transfer stations or other intermediate facilities or locations where the treated waste will be transferred or temporarily stored prior to transport to a permitted solid waste disposal facility.

E. If treated residuals are determined to be hazardous, then the waste must be managed in accordance with the Virginia Hazardous Waste Management Regulations (9VAC20-60).

9VAC20-121-290. Closure requirements.

A. The owner or operator of a regulated medical waste management facility shall close the facility in a manner that minimizes the need for further maintenance, and controls, minimizes, or eliminates, to the extent necessary to protect human health and the environment, the post-closure escape of regulated medical waste, uncontrolled effluent, surface runoff, or waste decomposition products to the groundwater, surface water, or atmosphere.

1. When a unit that has been used for regulated medical waste management is to cease operations involving regulated medical waste, the unit and all related equipment, structures, and surfaces shall be thoroughly cleaned and disinfected. Cleaning shall be conducted with detergent and water. At a minimum, disinfection shall include using an EPA-registered hospital grade disinfectant effective against mycobacteria in accordance with manufacturer's label instructions, unless it can be demonstrated to the satisfaction of the department that an alternate EPA-registered disinfectant will be protective of human health and the environment and is appropriate for the type of regulated medical waste managed and surfaces being disinfected.

2. All regulated medical waste, materials contaminated with waste constituents, and treatment residue shall be removed and disposed of in accordance with this chapter.

B. Closure plan and modification of plan.

1. The owner or operator of a regulated medical waste management facility shall have a written closure plan that meets the requirements of 9VAC20-121-330 G.

2. The owner or operator may amend the closure plan at any time during the active life of the facility. The owner or operator shall so amend the plan any time changes in operating plans or facility design affects the closure plan.

The amended closure plan shall be placed in the operating record.

3. The owner or operator shall submit to the department the amended closure plan that was placed in the operating record.

4. At least 180 days prior to beginning closure of each unit, the owner or operator shall notify the director of the intent to close.

5. The owner or operator shall provide to the department a certification that the facility has been closed in accordance with the closure plan.

C. The owner or operator shall complete closure activities in accordance with the closure plan and within six months after receiving the final volume of wastes. The director may approve a longer closure period if the owner or operator can demonstrate that the required or planned closure activities will take longer than six months to complete, and that the owner or operator has taken all steps to eliminate any significant threat to human health and the environment from the unclosed but inactive facility.

D. The owner or operator shall post one sign notifying all persons of the closing and providing a notice prohibiting further receipt of waste materials. The sign shall remain in place until closure activities are complete. Further, suitable barriers shall be installed at former accesses to prevent new waste from being delivered.

E. The department shall inspect the facility to confirm that the closure is complete and adequate in accordance with this chapter. The department shall notify the owner of a closed facility in writing if the closure is satisfactory, or if unsatisfactory, shall require any necessary construction or such other steps as may be necessary to bring unsatisfactory sites into compliance with this chapter. Notification by the department that the closure is satisfactory does not relieve the operator of responsibility for corrective action to prevent or abate problems caused by the facility.

Part V
Permitting of Regulated Medical Waste Management Facilities

9VAC20-121-300. Applicability.

A. Any facility operated for the transfer or treatment of regulated medical waste that is not exempt in accordance with this chapter, must hold a permit-by-rule from the department prior to commencement of operations.

B. Each regulated medical waste management facility permit-by-rule shall be limited to one site and shall be nontransferable between sites.

C. A new permit-by-rule is required when there is:

1. Any new regulated medical waste management facility; or

2. Any change in design or process of a regulated medical waste management facility that will, in the opinion of the department, result in a substantially different type of facility.

D. The director may grant a variance from any provision contained in this part to a permittee provided the requirements of Part VI (9VAC20-121-400 et seq.) of this chapter are met.

E. The following regulated medical waste management activities are conditionally exempt from the requirements of this part provided no open dump, hazard, or public nuisance is created and wastes are managed in accordance with the requirements promulgated by other applicable state or federal regulations or the conditions provided in this section.

1. Household sharps may be collected in a sharps drop box located in a public restroom, airport, train station, health clinic, pharmacy, health department, police or fire station, community organization building, permitted solid waste management facility, or other location as a convenience to the public, as long as the following requirements are met:

a. Sharps drop boxes shall only receive household sharps from individual home generators who choose to transport household sharps to the drop box. Sharps drop boxes shall not receive waste from collection vehicles or other entities that have collected waste from more than one real property owner;

b. All owners and operators of sharps drop boxes must comply with the general handling, packaging and labeling, storage, reusable container, spill cleanup, transportation, and Category A waste management requirements for regulated medical waste outlined in Part III (9VAC20-121-100 et seq.) of this chapter; and

c. Collected sharps shall be treated or disposed of as regulated medical waste in accordance with this chapter. Untreated sharps shall not be recycled or disposed of in a solid waste landfill or other solid waste management facility. Collected sharps that are shipped offsite as part of a mail-back program shall be transported in accordance with the requirements of 39 CFR 111 and 9VAC20-121-150 K.

2. Facilities that employ a treatment method to treat regulated medical waste onsite but subsequently package, label, and transport the waste offsite to be further managed as regulated medical waste are exempt from permitting in accordance with this chapter, but are subject to all other standards outlined in Part III (9VAC20-121-100 et seq.) for the management of regulated medical waste.

3. Treatment systems (such as an effluent decontamination system) used to treat industrial or domestic sewage discharges in compliance with federal, state, or local pretreatment requirements as applicable. If the treatment unit separates solids from liquids prior to discharge, the solids shall be managed as regulated medical waste unless it meets an exemption in accordance with this chapter.

4. Combustion of up to 10% by weight of regulated medical waste in a Virginia Solid Waste Management Regulations (9VAC20-81) permitted solid waste incinerator, thermal treatment, or waste to energy facility. Regulated medical waste must be an approved supplemental waste or included in an approved material review process in accordance with the State Air Pollution Control Board regulations and management of the regulated medical waste prior to addition to the incinerator, thermal treatment, or waste to energy unit must be in accordance with this chapter.

5. Temporary offsite storage of regulated medical waste generated from an emergency cleanup for up to 72 hours, including in a locked vehicle, prior to transporting directly to a regulated medical waste management facility permitted to receive the waste for treatment, transfer, or disposal, provided that all regulated medical waste is:

a. Generated from an emergency or unplanned sudden or nonsudden spill or release of regulated medical waste requiring immediate response in order to protect human health or the environment, and the regulated medical waste was not generated by a health care professional or nonstationary health care provider;

b. Collected from not more than one individual regulated medical waste generator and is not received from collection vehicles or other entities that have collected waste from more than one real property owner;

c. Managed, stored, and transported in accordance with all requirements of Part III (9VAC20-121-100 et seq.) of this chapter, except for the storage timeframe which shall be no more than 72 hours; and

d. Not a Category A waste, hazardous waste, or radioactive waste.

9VAC20-121-310. Permits by rule and emergency permits.

A. This subsection contains the requirements for permits-by-rule. The owner or operator of a facility described in subdivision A 1 of this section shall be deemed to have a regulated medical waste management facility permit if (i) the owner or operator submits the completed DEQ Form RMW PBR, Regulated Medical Waste Management Facility Permit-by-Rule Form, and all required information and attachments as detailed in subdivision A 2 of this section, and (ii) the department acknowledges completeness of the submittal per subdivision A 4 of this section.

1. Except for exempt facilities described in 9VAC20-121-300 E, the owner or operator of the following regulated medical waste management facilities shall apply for a permit-by-rule:

a. Regulated medical waste transfer stations as defined by this chapter, including when a vehicle transporting regulated medical waste will be parked for 24 hours or more during transport;

b. Facilities treating regulated medical waste employing a treatment method described in 9VAC20-121-240; and

c. Facilities treating regulated medical waste employing an alternate treatment method as described in 9VAC20-121-250.

2. The owner or operator of a regulated medical waste management facility shall submit the following information and documentation to the department:

a. To initiate the permit-by-rule application process, any person who proposes to establish a new regulated medical waste management facility, or modify an existing regulated medical waste management facility shall file a notice of intent with the director stating the type of facility for which the permit-by-rule application is made, the precise location of the proposed facility, and the intended use of the facility. The notice shall be in letter form and be accompanied by the following documents:

(1) A disclosure statement (DEQ Forms DISC-01 and DISC-02) identifying all key personnel as required by § 10.1-1408.1 of the Code of Virginia.

(2) A copy of the certification for at least one operator licensed by the Board for Waste Management Facility Operators as required by § 10.1-1408.2 of the Code of Virginia.

(3) A certification (DEQ Form CERT-01) from the governing body of the county, city, or town in which the facility is to be located stating, without qualifications, conditions, or reservations, that the location and operation of the facility are consistent with all applicable ordinances. No certification shall be required for the application for a modification to an existing permit-by-rule.

(4) The results of the public participation effort conducted in accordance with the requirements contained in subdivision A 3 of this section;

b. A certification that the facility meets the siting standards, as applicable, of 9VAC20-121-210;

c. A certificate signed by a professional engineer that the facility has been designed and constructed in accordance with the design and construction standards, as applicable, of 9VAC20-121-220;

d. Design plans certified by a professional engineer consisting of at least the following:

(1) A title sheet indicating the facility name, who prepared the plans, the person for whom the plans were prepared, a table of contents, and a location map showing the location of the site and area to be served.

(2) An exterior site plan identifying building dimensions of the transfer or treatment facility and the location of property boundaries and building setbacks, fencing, loading or unloading areas, vehicle staging and queuing locations, and parking areas.

(3) An interior site plan identifying location and size of all receiving, storage, temporary storage, including storage areas to be used to segregate unauthorized waste, radioactive waste, hazardous waste, and other untreated waste from treated waste, and processing areas, and location of treatment units, reusable container washing stations, and floor drains.

(4) A process flow diagram for all treatment units showing, piping and instrumentation, vents, and liquid discharge locations;

e. Documentation of the authorization to discharge into an approved sanitary sewer system or publicly or privately owned treatment works;

f. A certification that the facility meets the standards of Part III (9VAC20-121-100 et seq.) and Part IV (9VAC20-121-200 et seq.), as applicable, in a regulated medical waste management plan to be maintained in the operating record in accordance with 9VAC20-121-330. The certification shall also include a statement that the emergency contingency plan has been provided to the local police and fire departments, local emergency manager, and local emergency health coordinator;

g. Alternate treatment technologies shall provide a copy of the treatment technology approval;

h. A treatment plan for each treatment unit in accordance with 9VAC20-121-330 E;

i. For treatment facilities, a written agreement in accordance with 9VAC20-121-280 D with each permitted solid waste management facility that will transfer, store, or dispose of treated waste;

j. A closure plan in accordance with 9VAC20-121-330 G;

k. Demonstration of legal control over the site for the permit life;

l. A certification from the State Corporation Commission that the business entity pursing the permit-by-rule status is a valid entity, authorized to transact its business in Virginia. This requirement does not apply to those facilities owned solely by governmental units;

m. Closure cost estimates and proof of financial responsibility as required by the Financial Assurance Regulations for Solid Waste Disposal, Transfer, and Treatment Facilities (9VAC20-70). Proof of financial responsibility must be for the entity identified in subdivision A 2 l of this section. For treatment facilities, proof of financial responsibility is required prior to department approval to begin operation in accordance with 9VAC20-121-320; and

n. The applicable permit fees under the provisions of 9VAC20-90.

3. Public participation.

a. The applicant for a new regulated medical waste transfer station or treatment facility shall publish a notice once a week for two consecutive weeks in a major local newspaper of general circulation of the intent to construct and operate a facility eligible for a permit-by-rule. The notice shall include:

(1) A statement of the applicant's intent to apply for a permit-by-rule to operate a regulated medical waste transfer station or treatment facility;

(2) A brief description of the proposed facility and its location;

(3) A statement that the purpose of the public participation is to identify issues of concern, to facilitate communication and to establish a dialogue between the applicant and persons who may be affected by the facility;

(4) Announcement of a 30-day comment period, in accordance with subdivision A 3 d of this section;

(5) Announcement of the date, time, and location for a public meeting to be held in accordance with subdivision A 3 c of this section;

(6) The name, address, and telephone number of the owner's or operator's representative who can be contacted by interested persons to answer questions or receive comments on the siting and operation of the proposed regulated medical waste facility; and

(7) Location where copies of the documentation to be submitted to the department in support of the permit-by-rule notification can be viewed and copied in accordance with subdivision A 3 b of this section.

b. The owner or operator shall place a copy of the documentation and support documents in a location accessible to the public in the vicinity of the proposed facility.

c. The owner or operator shall hold a public meeting not earlier than 14 days after the publication of the notice required in subdivision A 3 a of this section and no later than seven days before the close of the 30-day comment period. The meeting shall be held to the extent practicable in the vicinity of the proposed facility at a time convenient for the public.

d. The public shall be provided 30 days to comment on the technical and the regulatory aspects of the proposal. The comment period will begin on the date the owner or operator publishes the first notice in the local newspaper.

e. The requirements of this section do not apply to the owners or operators of a regulated medical waste treatment unit that has received a permit from the department based on the regulations promulgated by the State Air Pollution Control Board or State Water Control Board that required facility-specific public participation procedures.

4. Upon receiving the certifications and other required documents, including the results of the public meeting and the applicant's response to the comments received, the

department shall conduct a completeness review and respond within 30 days.

a. If the applicant's submission for a regulated medical waste transfer station is administratively complete, the applicant shall be deemed to operate under permit-by-rule status.

b. If the applicant's submission for a treatment unit is administratively complete, the applicant shall be deemed to operate under permit-by-rule status and granted authorization to initiate validation testing in accordance with an approved validation protocol and 9VAC20-121-320. The facility shall not accept regulated medical waste for treatment until the results of validation testing and operating parameters are submitted and approved by the department.

c. If the applicant's submission is administratively incomplete, the department will respond with a letter stating that the facility will not be considered to have a permit-by-rule or initiate the validation protocol until the missing certifications or other required documentation is submitted. At the time of the initial receipt or at a later date, the director may require changes in the documents designed to assure compliance with this chapter. Should such changes not be accomplished by the facility owner or operator, the facility will not be deemed to have a regulated medical waste management facility permit.

5. A permit-by-rule shall not be transferred by the permittee to a new owner or operator. However, when the property transfer takes place without proper closure, the new owner shall notify the department of the sale and fulfill all the requirements contained in subdivision A 2 of this section. Upon presentation of the financial assurance proof required by Financial Assurance Regulations for Solid Waste Disposal, Transfer, and Treatment Facilities (9VAC20-70) by the new owner, the department will release the former owner from the closure and financial responsibilities and acknowledge existence of the new permit-by-rule in the name of the new owner.

6. The owner or operator of a facility operating under a permit-by-rule may modify its design and operation by furnishing the department a new certificate and applicable permit fees under the provisions of 9VAC20-90. For modifications of design, the new certificate shall be prepared by a professional engineer and shall include new documentation required under subdivision A 2 of this section, as applicable, and subdivision A 3 of this section. For modifications to the operations, the owner or operator shall submit to the department a new certificate and documentation required under subdivision A 2 of this section, as applicable. For treatment units, a new treatment plan and revalidation with department approval to begin operation will be required for design and operation changes that include changing the treatment unit type, changing the treatment unit operating parameters, changes in waste stream, and adding a new treatment unit. Whenever modifications in the design or operation of the facility affect the provisions of the closure plan, the owner or operator shall revise the closure plan and submit to the department a new certificate and documentation required under subdivision A 2 of this section, as applicable. Should there be an increase in the closure costs, the owner or operator shall submit a new proof of financial responsibility as required by 9VAC20-70.

7. The director may terminate a regulated medical waste management facility's coverage under a permit-by-rule and require closure of the facility when the director finds that:

a. As a result of changes in key personnel, the requirements necessary for a permit-by-rule are no longer satisfied;

b. The applicant has knowingly or willfully misrepresented or failed to disclose a material fact in the disclosure statement or any other report or certification required under this chapter or has knowingly or willfully failed to notify the director of any material change to the information in the disclosure statement;

c. Any key personnel have been convicted of any of the crimes listed in § 10.1-1409 of the Code of Virginia, punishable as felonies under the laws of the Commonwealth or the equivalent under the laws of any other jurisdiction or has been adjudged by an administrative agency or a court of competent jurisdiction to have violated the environmental protection laws of the United States, the Commonwealth, or any other state, and the director determines that such conviction or adjudication is sufficiently probative of the permittee's inability or unwillingness to operate the facility in a lawful manner; or

d. The operation of the facility is inconsistent with the facility's regulated medical waste management plan or the requirements of Part IV (9VAC20-121-200 et seq.) of this chapter.

B. Notwithstanding any other provision of this chapter, in the event the director finds an imminent and substantial endangerment to human health or the environment, the director may issue a temporary emergency permit to a facility to allow transfer, treatment, or storage of regulated medical waste. Such permits:

1. May be issued to allow:

a. Transfer, treatment, or storage of regulated medical waste at a nonpermitted facility;

b. Transfer, treatment, or storage of types of regulated medical waste not covered by the permit for a facility with an effective permit;

c. Treatment of regulated medical waste by a new or temporary treatment unit or treatment unit or method not covered by the permit for a facility with an effective permit; or

d. Temporary transfer, treatment, or storage activities not covered by the permit for a facility with an effective permit.

2. If oral, the emergency permit shall be followed within five calendar days by a written emergency permit.

3. Shall not exceed 90 days in duration.

4. Shall clearly specify:

a. The regulated medical wastes to be received;

b. The manner and location of their transfer, treatment, storage, or disposal; and

c. For emergency treatment units, the treatment plan in accordance with 9VAC20-121-330 E.

5. Shall be accompanied by a public notice including:

a. Name and address of the office granting the emergency authorization;

b. Name and location of the facility so permitted;

c. A brief description of the wastes involved;

d. A brief description of the action authorized and reasons for authorizing it; and

e. Duration of the emergency permit.

6. Shall incorporate, to the extent possible and not inconsistent with the emergency situation, all applicable requirements of this chapter, and shall include the applicable permit fees under the provisions of 9VAC20-90.

7. For emergency treatment units, the facility shall not accept regulated medical waste for treatment until the results of validation testing and operating parameters are submitted and approved by the department.

8. Any permit issued under this subsection may be renewed not more than three times if necessary and with appropriate justification. Each such renewal shall be for a period of not more than 90 days.

9VAC20-121-320. Effect of the permit.

A. A regulated medical waste treatment facility will be approved to perform its validation protocol following determination of a complete permit-by-rule application in accordance with the procedures outlined in 9VAC20-121-310. Before receipt of waste by the facility, the permittee must:

1. Arrange for a department representative to inspect the site to observe at least one validation test run and perform validation testing in accordance with approved protocols.

2. Submit to the department for approval a summary of the validation test results demonstrating the treatment effectiveness and specifying the operating parameters based on the results of all validation test runs. The report shall include the results of all validation test runs.

B. Following approval by the department of the validation results, a regulated medical waste treatment facility may begin receiving and treating regulated medical waste as defined in the permit-by-rule. The facility shall comply with the operating parameters necessary to achieve treatment. A regulated medical waste treatment facility shall not receive or treat regulated medical waste until the department has approved the validation results and operating parameters to be used for the treatment unit.

C. Each facility permitted to accept regulated medical waste requires periodic inspection and review of records and reports. By accepting coverage under a permit-by-rule in accordance with 9VAC20-121-310, the owner or operator agree to the specified periodic inspections.

D. Compliance with a valid permit-by-rule and this chapter during its term constitutes compliance for purposes of enforcement with the Virginia Waste Management Act. However, a permit-by-rule may be modified or terminated for cause as set forth in 9VAC20-121-310 A 6 and A 7.

E. A permit-by-rule does not convey any property rights or any sort or any exclusive privilege.

F. A permit-by-rule does not authorize any injury to persons or property or invasion of other private rights or any infringement of federal, state, or local law or regulations.

G. A permit-by-rule may be transferred by the permittee to a new owner or operator only if the permit-by-rule has been terminated and reissued or modified to identify the new owner or operator and incorporate such other requirements as may be necessary. Upon presentation of the financial assurance proof required by 9VAC20-70 by the new owner, the department will release the old owner from the old owner's closure and financial responsibilities and acknowledge existence of the new or modified permit-by-rule in the name of the new owner.

9VAC20-121-330. Regulated medical waste management plan.

A. All permitted regulated medical waste management facilities, such as regulated medical waste transfer stations or treatment facilities, shall prepare and maintain a written regulated medical waste management plan. The plan shall include a certification page signed by a responsible official. This signature shall certify the plan meets the requirements of this chapter. The plan shall be maintained in the operating record and shall be made available for review by the department upon request. The plan shall include, at a minimum, the items in subsections B through G of this section.

B. A written waste acceptance plan, which includes, at a minimum:

1. Types and quantities of regulated medical waste to be managed, including sources of the waste and proposed service areas (if waste is accepted from offsite). The plan shall identify:

a. Acceptable waste types for treatment onsite (if applicable); and

b. Acceptable wastes types to be transferred to another approved facility for treatment or management offsite. The plan shall include a description of the offsite facility that will receive the waste, including name, address, and telephone number for the receiving facility and how specific waste types will be managed.

2. Protocols for identification and segregation of regulated medical waste from other types of waste, including radioactive wastes, hazardous wastes, and other solid waste. The plan shall include a description of how incoming waste will be monitored to detect the presence of radioactive materials and actions that will be taken to verify the source of any alarm.

3. Procedures for handling Category A waste in accordance with 9VAC20-121-160.

4. Facilities that accept regulated medical waste from offsite shall include the following:

a. A description of onsite traffic control, schedules, and routing for waste delivery vehicle flow and methods of enforcement of traffic flow plans for the waste delivery vehicles;

b. Procedures for arrival confirmatory inspections of each delivery vehicle and their loads to ensure that the waste has been packaged and transported in accordance with the U.S. Department of Transportation Hazardous Materials Regulations and this chapter;

c. A description of how the waste will be off-loaded, weighed, and compared to the shipping paper that accompanies the waste and how any discrepancies will be resolved; and

d. For each generator or customer, the facility shall maintain a signed certificate, contract, or equivalent document for each load or inclusive of all loads received from the generator in which the generator affirms that the loads do not contain unauthorized waste.

5. Procedures for handling regulated medical waste received from onsite or offsite that is not packaged, labeled, or marked correctly; leaking, dented, ripped, torn, bulging, or otherwise damaged; or not accompanied by a shipping paper.

C. A written description of the procedures for the detection and management of unauthorized waste in accordance with 9VAC20-121-230 K. The plan shall contain, at a minimum:

1. A list of unauthorized waste types that are not acceptable for management at the facility.

2. Methods used by the operator to prevent management of unauthorized wastes, such as routine monitoring and observation of incoming waste, generator agreements, and informational materials.

3. Procedures to detect and address any unauthorized waste discovered at the facility, including the protocol for identifying and contacting the generator and to prevent recurrence.

4. Procedures for containing and storing each type of unauthorized waste, such as radioactive or hazardous waste, until it is removed for proper management, including designated storage locations, storage timeframes, packaging, and labeling.

5. Instructions for documenting and notifying the department of receipt and ultimate disposition of unauthorized waste.

D. A written operations plan that includes, at a minimum:

1. A general description of the overall process and equipment used. The plan shall include the following: hours of operation; process rate; procedures for daily startup; methods, containers, and other devices for the collection, off-loading, tipping, and conveyance of regulated medical waste from the point of generation or receipt to areas for processing; normal loading, unloading, and waste handling procedures; and timeframes for transfer or treatment.

2. Protocols for packaging and labeling regulated medical waste for treatment onsite or transport offsite, including protocols for labeling or marking wheeled carts, containers, conveyance systems, or other items used for moving regulated medical waste.

3. Procedures for temporary onsite storage of regulated medical waste until it is collected for treatment onsite or transport offsite. The plan shall identify each storage location and capacity, the maximum length of time the waste will be stored, and procedures used to document compliance with required storage timeframes.

4. Methods and equipment used to empty, clean, and disinfect reusable containers in accordance with 9VAC20-121-130, including types and quantities of reusable containers and disinfectant to be used, disinfection procedures utilized between uses, and final disposal in case of damage or wear and tear. The plan shall also include a description of appropriate personal protective equipment, such as puncture and leak resistant gloves, safety glasses or face shield, protective coveralls or bib, protective footwear, and mask or respiratory protection as needed, used to protect personnel when cleaning and disinfecting reusable containers.

5. Procedures for spill prevention and response and how spilled waste will be collected, packaged, and the spill area decontaminated in accordance with 9VAC20-121-140. This includes locations and contents of all spill containment and cleanup kits.

6. Names, addresses, and telephone number of final treatment or ultimate disposal facilities to be used for

untreated waste and treated residues, facility-generated wastes, unauthorized waste, hazardous waste, radioactive waste, and other waste bypassed or disposed.

7. A description of equipment and procedures used to control access to areas used for the storage, transfer, and treatment of regulated medical waste. The plan shall identify all entry and exit points where access is controlled.

8. Methods and equipment used for routine cleaning and disinfection of facility equipment, floors, vehicles, and other surfaces that come into contact with regulated medical waste.

9. Measures used to control and monitor for fire, dust, noise, litter, odors, vectors, and blowing debris at the facility.

10. Collection and management of effluent, wash water, and other runoff from facility floors, storage and processing areas, waste compactors, and reusable container cleaning and disinfection areas, including location and discharge of drains.

11. Identification of all appropriate personal protective equipment, such as puncture and leak resistant gloves, safety glasses or face shield, protective coveralls or bib, protective footwear, and mask or respiratory protection as needed, and when the items are used to protect personnel managing regulated medical waste at the facility. The plan shall also include a description of donning and offing procedures for personal protective equipment.

12. A self-inspection plan that at a minimum includes copies of the inspection checklists that comply with 9VAC20-121-230 U of this chapter along with a description of the types of potential problems and corrective actions that may result from the inspections.

13. A schedule and description of initial and annual refresher training to be provided to employees in-person, in a language they can understand, including interactive training, and the types and numbers of adequately trained personnel. Initial training shall be provided within seven working days of employment, and annual refresher training shall be provided within one year from the date of the last training. Training shall include:

a. Operational procedures in accordance with 9VAC20-121-230 V;

b. Protocols to recognize, manage, document, and report unauthorized waste in accordance with 9VAC20-121-230 K;

c. Procedures for retraining staff when noncompliance or other incidents occur; and

d. Any other specialized waste training specific to the job function.

14. Procedures for recordkeeping in accordance with 9VAC20-121-340. The procedures shall address how inventory will be managed and methods used to track, link, and document specific incoming waste loads to specific outgoing waste loads.

15. A description of the type and estimated daily quantity of any facility-generated waste residues and procedures for handling and disposal of the residues.

E. A written treatment plan for each unit used to treat regulated medical waste that meets the standards of 9VAC20-121-240 and 9VAC20-121-250 and includes at a minimum:

1. A detailed description of the treatment technology to be used, including:

a. An overview of the treatment process and description of the treatment unit, including manufacturer, model name or number, and treatment capacity;

b. Procedures for equipment startup and shut down including warm-up, loading and unloading wastes, and anticipated load size during routine operation;

c. A description of built-in automatic controls and fail safe mechanisms to ensure the waste cannot bypass the treatment process;

d. If applicable, methods used to grind, shred, or puncture containers or packaging before, during, or after treatment, along with the methods to prevent exposure to the waste; contain any aerosol, bioaerosol, or mists caused by the process; and treat or filter any air evacuated from the chamber during processing;

e. If applicable, methods to transfer from a grinder or shredder to or from a treatment unit under forced draft ventilation that removes fumes from the operations area to a safe discharge;

f. Methods for maintaining negative pressure atmospheric control in the vessel and filtering all vents, discharges, and fugitive emissions of air from the process units through a high efficiency particulate air (HEPA) filter with efficiency of 99.97% for 0.3 microns. Installation and maintenance of filters shall be specified;

g. Methods to manage effluent including location and discharge of drains; and

h. A description of preventative maintenance that is performed on the treatment unit, including on engineering and electronic controls.

2. Identification of acceptable waste types to be treated and a listing of types of wastes that shall not be treated.

3. Treatment unit operating parameters (e.g., cycle duration, temperature, pressure, chemical concentration, irradiation exposure time, or other treatment parameters as applicable) and a description of how the operating parameters will be monitored and recorded, including number, type, and location of parametric monitoring devices, thermochemical indicators, and thermochemical recording devices, as applicable for routine operation.

4. Identification of the biological indicators to be used and documentation that lack of growth in the treated indicator corresponds to a 6 log10 reduction of viable spores. An explanation of why each indicator is suitable for the treatment process and wastes to be treated, including referencing any standards, guidelines, or information from peer reviewed journals, shall be included. The facility shall also specify the:

a. Type of biological indicators (spore strip, suspension, or self-contained), including a copy of the supplier's certificate of performance (or certificate of analysis) that identifies the organism (genus, species, strain, and population), purity, and for thermal treatment systems (including autoclaves) the D-value, and Z-value;

b. Estimated shelf life and storage conditions to be maintained;

c. Culture medium, incubation procedures, and incubation time (for self-contained biological indicators) and the media, growth, and culture conditions (for non-self-contained biological indicators), including how the results are to be interpreted and recorded;

d. Carrier system or material and primary packaging;

e. Relative resistance to temperature, pressure, chemicals, irradiation, infectious agents, or any other conditions used in the treatment process; and

f. Number, location, and placement of untreated (control) and treated indicators relative to the coldest spot in the treatment unit as identified by the manufacturer.

5. Number, type, and placement of thermochemical indicators, including a description of how results will be interpreted and recorded.

6. A validation plan that includes a detailed description of the validation testing protocol used to demonstrate effective treatment by each treatment unit that meets the standards of 9VAC20-121-260 and includes:

a. Surrogate waste load composition, including packaging type, porosity, relative percentages of inorganic and organic components, moisture content, thermal resistance, and a relative breakdown of solid components, such as blood culture bottles, plastics (including suction canisters), microbiological waste, and sharps;

b. Load configuration including packing density, orientation, and load size;

c. Number, type, and location or placement of biological indicators; thermochemical indicators; thermochemical recording devices; and any other methods used to monitor operating parameters and accuracy of parametric monitoring devices during validation runs to ensure that the gauge or electronic read-out is a true reflection of conditions inside the treatment unit;

d. A description of how the results will be interpreted and documented; and

e. Identification of who will conduct the validation testing.

7. A detailed description of the periodic challenge testing procedures used to evaluate the effectiveness of each treatment device under full loading, which meets the standards of 9VAC20-121-270 and includes:

a. Frequency of challenge testing to be performed;

b. Number, type, and location or placement of biological and thermochemical indicators, and other methods used to monitor operating parameters;

c. A description of how the results will be interpreted and documented;

d. Procedures used to address challenge test failures, including evaluating and correcting any issues with the treatment cycle and unit, and management of untreated regulated medical waste to include temporary storage or diversion to another approved facility for treatment or disposal; and

e. Procedures for reporting failing results of challenge testing to the department in accordance with 9VAC20-121-340.

8. Identification of all appropriate personal protective equipment, such as puncture and leak resistant gloves, safety glasses or face shield, protective coveralls or bib, protective footwear, and mask or respiratory protection as needed, and when the items are used to protect personnel.

9. Safety procedures used to minimize occupational exposure and prevent physical injury to operators during loading, unloading, and treatment cycle.

10. Procedures for handling and disposing of treated wastes, including packaging, labeling, and transport.

11. A copy of the written agreement with each permitted solid waste management facility that will transfer, store, or dispose of the treated waste in accordance with 9VAC20-121-280 D.

F. A written emergency contingency plan that describes the organized, planned, coordinated courses of action to be followed in the event of emergencies and nonoperation. In addition to submission to the department, the plan shall be provided to the local police and fire departments, local emergency manager, and local emergency health coordinator. The plan shall include:

1. Procedures to minimize hazards to human health and the environment from utility failure, fires or explosions, spills, leaks and releases, and exposure to regulated medical waste.

2. A description of the actions facility personnel shall take in the event of various emergency situations (fire, explosion, catastrophic loss, temporary shutdown, release of regulated medical waste or regulated medical waste constituents, or other incident that could threaten human health or the environment), including evacuation procedures.

3. A list of available fire protection and emergency equipment, and appropriate uses, such as fire extinguishers, emergency safety showers, eye wash stations, spill control materials, and alarm systems.

4. Procedures to be employed in the event of equipment breakdown or maintenance events, including standby equipment, extension of operating hours, or diversion of waste to another facility.

5. A list of onsite and offsite backup equipment with names and telephone numbers where offsite equipment may be obtained.

6. Provisions for loading, unloading, storage, transfer, treatment, or other disposal capabilities to be used during emergency situations, including when the facility downtime exceeds 24 hours.

7. The designation of alternate treatment areas or plans for transfer of stored waste in the event facility or system downtime exceeds 72 hours.

8. Procedures for spill cleanup and decontamination following a release of regulated medical waste.

9. A description of arrangements made with the local police and fire department that allow for immediate entry into the facility by their authorized representatives should the need arise, such as in the case of response personnel responding to an emergency situation.

10. The telephone numbers for local fire and police departments.

11. An identification of personnel designated as emergency coordinators. A list of names, addresses, and phone numbers (office and home) of all persons qualified to act as an emergency coordinator for the facility. Where more than one person is listed, one shall be named as primary emergency coordinator and the other shall be listed in the order in which they will assume responsibility as alternates. The emergency coordinator must be onsite or on-call and is responsible for responding to emergencies and coordinating emergency response measures.

12. A description of where and how emergency response information will be posted.

G. A written closure plan that identifies the steps necessary to completely close the facility or unit at its full operation under the permit conditions, which includes:

1. Procedures for removal of regulated medical waste, treated residue, and other materials for proper treatment or disposal;

2. Methods for cleaning and disinfecting the unit or facility and all related equipment, structures, and surfaces;

3. A description of any sampling to be conducted to ensure the facility has been decontaminated;

4. A schedule for final closure including, as a minimum, the anticipated date when wastes will no longer be received, the date when completion of final closure is anticipated, and intervening milestone dates that will allow tracking of the progress of closure; and

5. Actions necessary for facility abandonment or uses other than for regulated medical waste management.

9VAC20-121-340. Recordkeeping and reporting required of a permittee.

A. Regulated medical waste management facilities having coverage under a permit-by-rule shall maintain and retain records and reports as required by this chapter.

B. A facility shall retain records whenever monitoring is required.

1. The facility shall retain records of all monitoring information, including all calibration and maintenance records and all original recordings for continuous monitoring instrumentation, for at least three years from the sample or measurement date. The director may request that this period be extended.

2. Records of monitoring information shall include:

a. The date, exact place, and time of sampling or measurements;

b. The name of the individuals who performed the sampling or measurements;

c. The date analysis were performed;

d. The name of the individuals who performed the analysis;

e. The analytical techniques or methods used; and

f. The results of such analyses.

C. The facility must maintain accurate written records as required by this chapter. Records shall include all records required by the facility permit, this chapter, or other applicable regulations. Records must be maintained at the facility or another location approved by the department for at least three years from the date of the record, sample or measurement date, treatment date, shipping date, or receipt date. The department may request that this period be extended. Records shall be available for review by the department as requested.

D. The facility shall maintain a regulated medical waste management plan in the operating record in accordance with 9VAC20-121-330.

E. The owner or operator of a regulated medical waste management facility under a permit-by-rule that transfers or treats regulated medical waste, except for a captive regulated medical waste management facility, shall submit a Solid Waste Information and Assessment report to the department by March 31 of each year in accordance with 9VAC20-81-80.

F. A disclosure statement identifying all key personnel as required by § 10.1-1408.1 of the Code of Virginia shall be on file with the department and updated on a quarterly basis as necessary. At least one operator listed as key personnel on the facility's disclosure statement shall be licensed by the Board for Waste Management Facility Operators as required by § 10.1-1408.2 of the Code of Virginia.

G. If regulated medical waste is received from offsite, records shall be maintained for three years following receipt of the waste and shall include the date of receipt, name of each offsite generator, transporter, type and quantity (weight or volume) of waste received, and dates of subsequent treatment onsite or shipment offsite. The facility shall maintain a signed certificate, contract, or equivalent document for each load or inclusive of all loads received from offsite in which the generator affirms that the load does not contain hazardous waste or radioactive materials, unless the facility is permitted to receive those types of wastes.

H. If regulated medical waste is shipped or transferred offsite, the facility shall maintain records, including copies of all shipping papers, specifying the date of shipment, type, and quantity (weight or volume) of waste removed from the site and the names, addresses, and telephone numbers of both the transporters and the destination facility receiving the shipments for treatment or disposal.

I. A regulated medical waste treatment facility shall maintain an onsite treatment log at each treatment unit that is complete for the preceding three-year period. The log shall record the date, start time, end time, and operator of each treatment cycle; the type and quantity (weight or volume) of regulated medical waste treated onsite; monitoring records for the operating parameters (e.g. time, temperature, pressure, and chemical concentration) achieved throughout each treatment cycle; and the results of all validation and periodic challenge testing. Monitoring records shall include original recordings for continuous monitoring instrumentation and parametric controls as well as the results of all biological and thermochemical indicators. Where multiple treatment units are used, a working log can be maintained at each unit and such logs periodically consolidated at a central location as long as the records distinguish which treatment unit is applicable to each record. The consolidated logs shall be retained for three years and be available for review.

J. The facility shall retain records of all unauthorized waste in accordance with 9VAC20-121-230 K.

K. The facility must maintain a record of self-inspections in an inspection log. The log must include the date and time of the inspection, the name of the inspector, a description of the inspection, including the identity of the specific equipment and structures inspected, observations recorded, and the date and nature of any remedial actions implemented or repairs made.

L. Written documentation of all training received by each employee, including the date and topics of the training, shall be maintained in the facility's operating record.

M. A regulated medical waste management facility shall be subject to the following reporting requirements. The facility shall report to the department any noncompliance, emergency, or unusual condition that may endanger health, the environment, or the facility's operation. Any information shall be provided orally within 24 hours from the time the permittee becomes aware of the circumstances. A written submission shall also be provided within five working days of the time the facility becomes aware of the circumstances. The written report shall contain a description of the circumstances and its cause; the period of occurrence, including exact dates and times; and if the circumstance has not been corrected, the anticipated time it is expected to continue. It shall also contain steps taken or planned to reduce, eliminate, and prevent reoccurrence of the circumstances resulting in an unusual condition or noncompliance, to include retraining of staff as necessary. Reportable conditions include:

1. Any interruption to operations that requires implementation of the facility's emergency contingency plan or diversion of regulated medical waste to another management facility;

2. Releases or discharges of regulated medical waste from a fire, explosion, storm, or other emergency that could endanger human health or the environment outside the facility;

3. Unauthorized discharge of effluent, wash water, waste, or other pollutant to surface water (i.e., offsite, natural water body or tributary, including wetlands);

4. Spills of regulated medical waste in any areas not protected from the elements, such as outside of a building;

5. Storage of regulated medical waste beyond capacity or storage timeframes;

6. Failing results of periodic challenge testing;

7. Receipt or discovery of unauthorized waste;

8. Receipt of Category A waste; and

9. Shipment of regulated medical waste offsite in inappropriate packaging.

N. Copies of all reports required and records of all data used to complete the permit-by-rule application must be retained for at least three years from the date of the report or application. The director may request that this period be extended.

O. When the permittee becomes aware that the permittee failed to submit any relevant facts or submitted incorrect information in a permit-by-rule application or in any report to the department, the permittee shall promptly submit such omitted facts or the correct information with an explanation.

Part VI
Variance Application Procedures

9VAC20-121-400. General.

A. Any person affected by this chapter may apply to the department for a variance from any requirement of this chapter. Variance determinations shall be subject to the provisions of the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

B. The department shall not accept any variance application relating to:

1. Equivalent testing or analytical methods contained in EPA Publication SW-846;

2. A change in the regulatory requirements that the applicant is currently violating until such time as the violation has been resolved through the enforcement process.

9VAC20-121-410. Variance to requirements.

A. The director may grant a variance from any regulation contained in Part III (9VAC20-121-20 et seq.) through Part V (9VAC20-121-300 et seq.) of this chapter to an applicant if the applicant demonstrates to the satisfaction of the director that:

1. a. Strict application of the regulation to the facility will result in undue hardship that is caused by the applicant's particular situation;

b. The alternate is equally protective of human health and the environment as that provided for in the regulations; or

c. Technical conditions exist that make a strict application of the regulation difficult to achieve; and

2. Granting the variance will not result in an unreasonable risk to the public health or the environment.

B. Effects of the decisions.

1. When the director renders a decision under this section in accordance with the procedures contained in 9VAC20-121-420, the director may:

a. Deny the application;

b. Grant the variance as requested; or

c. Grant a modified or partial variance.

2. When a variance is granted, the director may:

a. Specify the termination date of the variance; or

b. Include a schedule for:

(1) Compliance, including increments of progress, by the facility with each requirement of the variance; and

(2) Implementation by the facility of such control measures as the director finds necessary in order that the variance may be granted.

9VAC20-121-420. Administrative procedures.

A. Persons requesting variance from a provision of this chapter shall submit an application for such variance in accordance with this section.

1. All applications submitted to the director shall include:

a. The applicant's name and address;

b. A statement of applicant's interest in the proposed action;

c. A description of the desired action and a citation to the regulation from which a variance is requested;

d. A description of the need and justification for the proposed action;

e. The duration of the variance, if applicable;

f. The potential impact of the variance on public health or the environment;

g. Other information believed by the applicant to be pertinent; and

h. The following statements signed by the applicant or his authorized representative:

"I certify that I have personally examined and am familiar with the information submitted in this application and all attached documents, and that, based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment."

2. In addition to the general information required of all applicants under this part:

a. To be successful the applicant shall address the applicable standards and criteria;

b. An explanation of the applicant's particular situation that prevents the facility from achieving compliance with the cited regulation; and

c. Other information as may be required by the department.

B. The variance application shall be processed in accordance with this subsection.

1. After receiving an application that includes the information required in subsection A of this section, the director will determine whether the information received is sufficient to render the decision. If the information is deemed to be insufficient, the director will request that additional information be furnished.

2. The applicant may submit the additional information requested or may demonstrate that the additional information should not be required. If the director agrees that the additional information should not be required, the

director will act in accordance with subdivision 3 of this subsection.

3. After the application is deemed complete:

a. The director will make a tentative decision to grant or deny the variance request.

b. If the variance request is tentatively denied, the director will offer the applicant the opportunity to withdraw the request, submit additional information, or proceed with the evaluation.

c. The director will issue a notice tentatively granting the variance request. Notification of this tentative decision will be provided by newspaper advertisement in the locality where the applicant is located. The director will accept comment on the tentative decision for 30 days.

d. After evaluating all public comments, the director will, within 15 days after the expiration of the comment period:

(1) Notify the applicant of the final decision; and

(2) Notify all persons who commented on the tentative decision.

C. Decision resolution.

1. In the case of a denial, the applicant has a right to request a formal hearing to challenge the rejection.

2. If the director grants a variance request, the notice to the applicant shall provide that the variance may be terminated upon a finding by the director that the applicant has failed to comply with any variance requirements.

NOTICE: The following forms used in administering the regulation have been filed by the agency. Amended or added forms are reflected in the listing and are published following the listing. Online users of this issue of the Virginia Register of Regulations may also click on the name to access a form. The forms are also available from the agency contact or may be viewed at the Office of Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (9VAC20-121)

Solid Waste Management Facility Permit Applicant's Disclosure Statement (Cover Sheet), DEQ Form DISC 01 (rev. 9/2020)

Solid Waste Management Facility Permit Applicant's Disclosure Statement - Key Personnel Statement, DEQ Form DISC 02 (rev. 9/2020)

Local Government Certification Request, DEQ Form CERT 01 (rev. 8/2018)

Regulated Medical Waste Management Facility Permit-by-Rule Form, DEQ Form RMW PBR (eff. 1/2022)

Application for Evaluation and Approval of Regulated Medical Waste Treatment Technology, DEQ Form RMWTP 01 (rev. 9/2018)

DOCUMENTS INCORPORATED BY REFERENCE (9VAC20-121)

Managing Solid Waste Contaminated with a Category A Infectious Substance (August 2019), approved for publication by the National Security Council (NSC)-led Domestic Resilience Group (DRG) on August 19, 2019.

VA.R. Doc. No. R19-5395; Filed January 5, 2022, 3:35 p.m.

Proposed Regulation

Title of Regulation: **9VAC20-160. Voluntary Remediation Regulations (amending 9VAC20-160-10, 9VAC20-160-30, 9VAC20-160-65, 9VAC20-160-70, 9VAC20-160-90 through 9VAC20-160-120; adding 9VAC20-160-57; repealing 9VAC20-160-55, 9VAC20-160-60).**

Statutory Authority: § 10.1-1232 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: April 18, 2022.

Agency Contact: Meade Anderson, Voluntary Remediation Program and Brownfields Program Manager, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23219, telephone (804) 659-1341, FAX (804) 698-4178, or email j.meade.anderson@deq.virginia.gov.

Basis: Section 10.1-1232 of the Code of Virginia directs the Virginia Waste Management Board to promulgate regulations that facilitate voluntary cleanup of contaminated sites where remediation is not clearly mandated by federal or state law or other applicable authority. Section 10.1-1402 of the Code of Virginia authorizes the board to promulgate and enforce regulations necessary to carry out its powers and duties, the intent of the Virginia Waste Management Act, and the federal acts.

Purpose: The goal of the Voluntary Remediation Program (VRP) is to facilitate the remediation of sites where remediation is not clearly mandated by the Comprehensive Environmental Response, Compensation and Liability Act (42 USC § 9601 et seq.) (CERCLA), the Resource Conservation and Recovery Act (42 USC § 6901 et seq.) (RCRA), the Virginia Waste Management Act (§ 10.1-1400 et seq. of the Code of Virginia), the State Water Control Law (§ 62.1-44.2 et seq. of the Code of Virginia), or other applicable authority. The remediation of sites protects the health, safety, and welfare of citizens as well as resolving environmental liability issues while facilitating redevelopment of sites and economic development. Currently, sites enrolled prior to July 1, 2014, are not assessed annual fees for their continued participation in the VRP. Some of these sites have been enrolled in the VRP for over 23 years, and agency staff are continuing to expend time to oversee the activities of the site. Agency personnel costs for some individual sites are estimated to have cost the agency as much as $150,000. The purpose of this amendment is to require all sites enrolled in the program to pay an annual registration

fee to defray a portion of the department's costs of the program. VRP registration fees are proposed to increase and be annually adjusted for inflation. Additional proposed amendments include revisions to the definitions, clarifications of public notice requirements, and clarification to the language of the eligibility and waiver requirements to encourage additional sites participation in the program.

Substance: Sites are eligible for participation in the program if remediation has not been clearly mandated by the U.S. Environmental Protection Agency, the department, or a court pursuant to the CERCLA, the RCRA, the Virginia Waste Management Act, the Virginia State Water Control Law, or other applicable statutory or common law or jurisdiction of the statutes listed in clause has been waived. The agency proposes requiring all sites continuing to participate in the program to pay annual fees. The agency proposes raising the registration fee amount and adjusting the fees annually for inflation. The annual registration fee will defray a portion of the department's costs of the program. Additional proposed amendments include revisions to the definitions, clarifications of public notice requirements, and clarification to the language of the eligibility and waiver requirements to encourage additional sites participation in the program.

Issues: This regulation is a voluntary program and has no negative economic impact on small businesses and poses no disadvantage to private citizens, the regulated community, or to the Commonwealth. The VRP provides the opportunity for reasonable cleanup goals and protects human health and the environment. These cleanups facilitate the sale and reuse of industrial and commercial properties, provide economic benefits for the buyer and seller, and reduce green space development. Communities in the Commonwealth benefit when these projects are completed. The cleanup of a contaminated site affects surrounding properties by increasing property values, tax revenues, employment opportunities, and community pride. The citizens, businesses, and local governments of the Commonwealth all derive benefits from the VRP.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Waste Management Board (Board) proposes to amend the fee structure in the voluntary remediation program to make it financially self-sufficient.

Background. The voluntary remediation program (VRP) facilitates the cleanup of contaminated sites that might not otherwise occur. These are sites where remediation is not clearly mandated by the Comprehensive Environmental Response, Compensation and Liability Act, the Resource Conservation and Recovery Act, the Virginia Waste Management Act, State Water Control Law or other applicable authority. The program establishes procedures for owners or operators to voluntarily remedy contamination at their sites. When remediation is satisfactorily completed, the Department of Environmental Quality (DEQ) issues a "Certification of Satisfactory Completion of Remediation" or "certificate". This certificate provides immunity from enforcement of Virginia environmental laws. The immunity granted by the certificate is limited to the known releases described in the certificate and is conditional upon satisfactory performance by the participant of all obligations required by DEQ under the program.

Site remediation protects the health, safety, and welfare of citizens and resolves environmental liability issues. As a result, DEQ notes that remediation facilitates the sale, reuse or redevelopment of affected sites, thereby providing economic benefits for the buyer and seller and reducing development of undeveloped ("green") space. Communities in the Commonwealth benefit because the cleanup of a contaminated site increases the value of surrounding properties, which in turn increases tax revenues, employment opportunities, and community pride. The citizens, businesses, and local governments of the Commonwealth all derive benefits from the program.

DEQ reports that the program's administrative costs are approximately $1.4 million annually. Historically, federal funding has provided the bulk of the fiscal support for program operations. However, federal funding of Virginia's program has been steadily declining since 2002 because of the increased participation of other states, territories, and tribes in this program. Approximately $50 million was set aside nationwide in 2002 under the federal Brownfields legislation. This amount has not changed, but the number of recipients, particularly the tribes, has increased over time which decreased the amount available to each jurisdiction. The most Virginia received from the federal Brownfields grant was $1.18 million early in the program however by 2019, this amount had steadily decreased down to $486,000.

This regulation provides for the collection of registration fees. The fee structure was last amended in 2014, in response to Chapter 366 of the 2014 Acts of Assembly,[1] which amended the statute governing the VRP.[2] As directed by statute, the Board removed a cap on registration fees that applied to sites that enrolled on or after July 1, 2014.[3] This cap had limited the one-time registration fee to 1% of the total cost of remediation or a maximum of $5,000, whichever was less. At the end of the project, the program participant would provide DEQ with the total costs of remediation for the project. The registration fee would then be calculated based on 1% of the total cost of remediation and would be compared to the registration fee paid to date. Any overpayment of the registration fee would be refunded or in the case of an underpayment, the participant would pay the additional required registration fee, not to exceed the statutory maximum ($5,000).

In addition to removing the registration fee cap for all sites that enrolled on or after July 1, 2014, the 2014 amendments put in place a three phase registration fee structure. Phase I is an application registration fee, Phase II is an enrollment registration fee, and Phase III is an annual registration fee.

According to DEQ, despite the additional fees authorized in 2014, the fee structure covers only a fraction of the program's entire administrative costs. Moreover, the lack of annual registration fees for sites that registered before July 1, 2014, is problematic because DEQ continues to perform work on the pre-July 2014 sites without receiving additional funds from those sites. As a result, the program has been incurring costs for the continued oversight of sites that enrolled prior to July 1, 2014, without receiving any annual revenue for these sites. DEQ has been heavily relying on federal funding to cover the funding shortage. DEQ also notes that even as federal funding has steadily declined, more sites have enrolled in the program. This has exacerbated the funding shortage, which DEQ states has reached an unsustainable level. Evaluations have determined an average cost per site to be relatively equal to the proposed Phase III fee.

This action primarily proposes to make the voluntary remediation program financially self-sufficient. The proposal would require all sites continuing to participate in the program, regardless of their enrollment date, to pay annual registration fees. The Board would also adjust the fees so the program has enough resources to continue its operations.

Estimated Benefits and Costs. The voluntary remediation program allows property owners to voluntarily clean up and obtain the "Certification of Satisfactory Completion of Remediation" which in turn provides immunity from enforcement unless new issues are discovered. Historically, program participants have been private property owners, real estate investors and developers, governmental organizations and corporations wishing to divest property and resolve liability. For example, the owner of a strip mall may wish to redevelop a store front that was previously used to operate a dry cleaner and now desires to run a day care center. In order to cleanup any residual chemicals such as the dry cleaning solvent, tetrachloroethylene released to the environment, and thereby obtain immunity from enforcement actions under Virginia's environmental laws, the owner may choose to participate in the program.

While the project owners pay for the costs of the remediation itself, the program incurs administrative costs in terms of personnel, travel, and oversight of remediation of the sites. DEQ can withhold the certificate of completion for a project until all fees are paid, but has no recourse for recouping fees if a pre-2014 participant drops out of the program before his project is completed or has no interest in obtaining the certificate. In addition, the current fees cover only a fraction of the actual administrative costs. The costs to DEQ for individual pre-2014 sites are estimated to be between $20,000 and $150,000. DEQ has had some projects where participants have only paid several hundred dollars when the actual program administration costs were much more than that. As an example, a site enrolled in the year 2000 and paid a registration fee of $27.05 and this site is still enrolled in the program with minimal progress being made towards completion. Numerous sites paid a registration fee of $1,000 or less and have remained in the program for years.

Currently, three types of registration fees are assessed to cover administrative costs: Phase I (application registration fee), Phase II (enrollment registration fee), and Phase III (annual registration fee). Phase I requires the submission of an application and the fee and, DEQ staff would review submitted materials, agency records and may visit the site. Once DEQ determines the site is eligible for participation, the owner is charged a Phase II or enrollment fee and then submits a voluntary remediation report, which consists of a site characterization report, a risk assessment, a remedial action plan, documentation of public notice and a demonstration of completion. The owner is responsible, at his own cost, to remediate environmental hazards on the property. For every subsequent year the property participates in the program beyond the first calendar year, the owner is charged a Phase III annual registration fee. Once remediation is completed and the certificate is issued then no further fees are incurred.

According to DEQ, there are 143 enrolled sites. All of these sites have paid a registration fee to participate in the program. Seventy-two of the sites were enrolled prior to July 1, 2014, and were assessed only a single registration fee of one percent of the remediation costs, not to exceed $5,000; these sites are not currently assessed annual registration fees for their continued participation in the program. Some of these 72 sites have been enrolled in the program for over 23 years. Of the 71 sites enrolled on or after July 1, 2014, 63 have not completed the remediation and remain enrolled and are assessed an annual registration fee of $4,500 for their continued participation after the first calendar year. Administrative costs that exceed the fees collected are paid from federal funds.

Under the current fee structure, program participants do not share the full administrative costs of the program operation, but stand to directly gain from it. This may create a free-rider problem and some adverse incentives. This is particularly the case for the pre-2014 site owners who are no longer interested in remediating the site in a timely manner, but have no incentives to leave the program because they are not assessed any annual registration fees. The funding shortage is worsened by these incentives. Since federal funding continues to be reduced, this presents an unsustainable path for the program as funding is divided among more recipients.

According to DEQ, most entities that participate in this program are in the process of trying to sell or develop their land and take part in the program in hopes of increasing the value of their holding by limiting the environmental liabilities their property may carry through the certificate. Simply, the participants stand to directly gain from participation in the program.

An economically efficient allocation of limited resources (i.e. limited administrative funding for the program) calls for each participant to pay for the full administrative costs of their clean up. The Board proposes to adjust the fees to make the program

financially self-sustainable by the fees assessed. Once the new fees go into effect, DEQ plans to distribute a portion of the federal funding it receives under this program to the localities to assist with the environmental assessment of properties. The following table shows the estimated current and the proposed changes in the fee structure by site type. The proposed fees also include an annual adjustment for inflation according to the U.S. Department of Labor Consumer Price Index for all-urban consumers.[4]

Sites	Current annual registration fees	Proposed annual registration fees to be adjusted by inflation
Pre July 1, 2014 sites	None ($0 X 72 sites)	Phase III: $525,000 ($10,500 X 50 sites)
Post July 1, 2014 sites	Phase I: $44,000 ($2,000 X 22 sites) Phase II: $165,000 ($7,500 X 22 sites) Phase III: $283,500 ($4,500 X 63 sites)	Phase I: $66,000 ($3,000 X 22 sites) Phase II: $165,000 ($7,500 X 22 sites) Phase III: $661,500 ($10,500 X 63 sites)
Estimated Annual Revenue	$492,500	$1,417,500
Source: Voluntary Remediation Program Regulatory Advisory Panel Presentation, DEQ, February 21, 2020.		

As a result of the proposed fee changes for the pre-2014 projects, some project participants, particularly participants who remain dormant before project completion, would either chose to pay the additional fees or terminate from the program. Such an impact would improve the economic allocation of the program's administrative resources by either requiring dormant participants to pay for the costs they may be unnecessarily imposing on the program or eliminate such unnecessary costs if they terminate from the program. DEQ estimates that of the 72 sites that entered the program prior to July 1, 2014, up to 22 may terminate from the program rather than pay the proposed annual registration fee of $10,500.

The proposed fee increase for post-2014 projects would raise participation costs, encourage speedy project completion, and free up federal funds to be used within the grant requirements to enhance the state programs with a portion to be utilized for environmental assessments in localities. In general, higher participation costs would be expected to discourage voluntary remediation activities; however, DEQ notes that the increase in fees would be relatively small compared to overall project costs and economic gains an owner may expect from his remediated property. Thus, this potential negative impact would likely be small. In addition, participation in the program is voluntary. We can reliably infer that by enrolling in the program, and maintaining enrollment, a project owner reveals that the expected economic gains exceed the likely costs. DEQ also expects about 22 new sites to register for the program annually. The amount that would likely be available to be used within the grant requirements to enhance the state programs with a portion available to be utilized for environmental assessments in localities which would be approximately $486,000 based on 2019 data, but that amount would likely be smaller in the future as more and more jurisdictions participate nationally in the federal Brownfields program and the amount of the federal grant decreases.

Additional proposed amendments include revisions to the definitions, clarification of public notice requirements, and clarification to the language of the eligibility and waiver requirements. These amendments will not change the current practices and are unlikely to create monetary costs or benefits. However, to the extent these clarifying changes streamline processes and/or make these regulations easier to understand, affected entities would likely benefit.

Businesses and Other Entities Affected. The proposed amendments apply to site owners voluntarily participating in the program. Currently, 143 sites are enrolled.[5] Approximately, 72 site owners who enrolled in the program prior to July 1, 2014, would be subject to the same annual registration fees as the 73 sites that are enrolled after this date.

As noted above, the proposals to amend the fee structure would increase costs for site owners, but also make the program financially self-sufficient. An adverse economic impact[6] on site owners is indicated.

Small Businesses[7] Affected.

Types and Estimated Number of Small Businesses Affected. DEQ estimates that of the 143 of sites currently participating in the program 100 are small businesses.

Costs and Other Effects. The proposed changes introduce the same fees to the sites owned by small businesses.

Alternative Method that Minimizes Adverse Impact. There does not appear to be a clear alternative method that both reduce the adverse impact and meet the intended policy goals.

Localities[8] Affected.[9] Once this program becomes financially self-sufficient with the proposed fee revenues, DEQ plans to use federal funds within the grant requirements to enhance the state programs with a portion to be utilized for environmental assessments within the localities. In 2019, this amount was $486,000, but the amount has been steadily decreasing and will likely continue to decrease. However, this regulation contains no language about such a distribution. Thus, the proposed amendments do not introduce costs or benefits for local governments, nor do they particularly affect any locality more

than others. Accordingly, no additional funds would be required. Any potential benefit to localities depends on how DEQ would implement the planned brownfield assistance to these organizations.

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 fee structure is expected to improve economic allocation of program's administrative costs and align site owner's incentives with the administrative costs the sites generate for DEQ. To the extent such effects speed up existing remediation programs and redirect DEQs existing administrative resources from dormant sites to active sites, we may see an increase in the remediated land areas or properties which in turn would add to the use and value of such properties and potentially reduce real estate development costs.

[1]See https://lis.virginia.gov/cgi-bin/legp604.exe?141+sum+SB431

[2]See https://law.lis.virginia.gov/vacode/title10.1/chapter12.1/section10.1-1232/

[3]See https://townhall.virginia.gov/l/ViewStage.cfm?stageid=7004

[4]This CPI value changed from 254.943 to 255.548 from April 2019 to April 2020 representing a 0.24% increase. The CPI can also decrease and cause a reduction in the fees.

[5]Data source: DEQ

[6]Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined.

[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."

[8]"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.

[9]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

Agency's Response to Economic Impact Analysis: The department has reviewed the economic impact analysis prepared by the Department of Planning and Budget and has no comment.

Summary:

The proposed amendments require all sites continuing to participate in the Voluntary Remediation Program to pay annual fees. The agency proposes raising the registration fee amount and adjusting the fees annually for inflation to defray a portion of the department's costs of the program. Additional proposed amendments include revisions to the definitions, clarifications of public notice requirements, and clarification to the language of the eligibility and waiver requirements.

9VAC20-160-10. Definitions.

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

"Adjacent property" means either properties meeting at a shared property boundary or parcels of land that are not widely separated, including at a point or corner, or separated only by one or more relatively narrow linear features. Such linear features may include roadways, railways, and narrow bodies of water.

"Applicant" means a person who has applied to the program but is not a participant.

"Authorized agent" means any person who is authorized ~~in writing~~ by the applicant, site owner, or participant to fulfill the requirements of this program.

"Board" means the Virginia Waste Management Board.

"Carcinogen" means a chemical classification for the purpose of risk assessment as an agent that is known or suspected to cause cancer in humans, including a known or likely human carcinogen or a probable or possible human carcinogen under an U.S. Environmental Protection Agency (EPA) weight-of-evidence classification system.

"Certificate" means a written certification of satisfactory completion of remediation issued by the department pursuant to § 10.1-1232 of the Code of Virginia.

"Completion" means fulfillment of the commitment agreed to by the participant as part of this program.

"Contaminant" means any man-made or man-induced alteration of the chemical, physical, or biological integrity of soils, sediments, air and surface water, or groundwater including such alterations caused by any hazardous substance (as defined in the Comprehensive Environmental Response, Compensation, and Liability Act, 42 USC § 9601(14)), hazardous waste (as defined in 9VAC20-60), solid waste (as defined in 9VAC20-81), petroleum (as defined in Articles 9 (§ 62.1-44.34:8 et seq.) and 11 (§ 62.1-44.34:14 et seq.) of the Virginia State Water Control Law), or natural gas.

"Cost of remediation" means all costs incurred by the participant pursuant to activities necessary for completion of voluntary remediation at the site, based on an estimate of the net present value (NPV) of the combined costs of the site investigation, report development, remedial system installation, operation and maintenance, and all other costs associated with participating in the program and addressing the contaminants of concern at the site.

"Covenant" means a servitude that imposes land use controls.

"Department" means the Department of Environmental Quality of the Commonwealth of Virginia or its successor agency.

"Director" means the Director of the Department of Environmental Quality.

~~"Engineering controls" means physical modification to a site or facility to reduce or eliminate potential for exposure to~~

~~contaminants. These include stormwater conveyance systems, pump and treat systems, slurry walls, vapor mitigation systems, liner systems, caps, monitoring systems, and leachate collection systems.~~

~~"Environmental covenant" means a servitude arising under an environmental response project that imposes activity and use limitations pursuant to the Uniform Environmental Covenants Act (§ 10.1-1238 et seq. of the Code of Virginia).~~

"Hazard index" or "HI" means the sum of more than one hazard quotient for multiple contaminants or multiple exposure pathways or both. The HI is calculated separately for chronic, subchronic, and shorter duration exposures.

"Hazard quotient" means the ratio of a single contaminant exposure level over a specified time period to a reference dose for that contaminant derived from a similar period.

"Hydraulic gradient" means the change in total hydraulic head, measured at two or more points within an underground layer of water-bearing permeable materials, divided by the distance over which the change occurs.

"Incremental upper-bound lifetime cancer risk" means a conservative estimate of the incremental probability of an individual developing cancer over a lifetime as a result of exposure to the potential carcinogen. Upper-bound lifetime cancer risk is likely to overestimate "true risk."

~~"Institutional controls" means legal or contractual restrictions on property use that remain effective after remediation is completed and are used to reduce or eliminate the potential for exposure to contaminants. The term may include deed, land use, and water use restrictions and environmental covenants.~~

"Land use controls" means legal, contractual, or physical restrictions on the use of, or access to, ~~a site~~ property to reduce or eliminate potential for exposure to contaminants or prevent activities that could interfere with the effectiveness of remediation. ~~Land use controls include engineering and institutional controls.~~

"Monitored natural attenuation" means a remediation process that monitors the natural or enhanced attenuation process.

"Natural attenuation" means the processes by which contaminants break down naturally in the environment. Natural attenuation processes include a variety of physical, chemical, or biological processes that, under favorable conditions, act without human intervention to reduce the mass, toxicity, mobility, volume, or concentrations of contaminants in soil or groundwater.

"Noncarcinogen" means a chemical classification for the purposes of risk assessment as an agent for which there is either inadequate toxicological data or is not likely to be a carcinogen based on an EPA weight-of-evidence classification system.

"Owner" means any person currently owning or holding legal or equitable title or possessory interest in a property, including the Commonwealth of Virginia, or a political subdivision thereof, including title or control of a property conveyed due to bankruptcy, foreclosure, tax delinquency, abandonment, or similar means.

"Participant" means a person who has received confirmation of eligibility and has remitted payment of the phase 2 registration fee.

"Person" means an individual, corporation, partnership, association, a governmental body, a municipal corporation, or any other legal entity.

"Post-certificate monitoring" means monitoring of environmental or site conditions stipulated as a condition of issuance of the certificate.

"Program" means the Virginia Voluntary Remediation Program.

"Property" means a parcel of land defined by the boundaries in the deed.

"Reference dose" means an estimate of a daily exposure level for the human population, including sensitive subpopulations, that is likely to be without an appreciable risk of deleterious effects during a lifetime.

"Registration fee" means the fees paid to apply for, obtain eligibility for, enroll in, and participate in the Voluntary Remediation Program.

"Release" means any spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, or disposing of any contaminant into the environment.

"Remediation" means actions taken to clean up, mitigate, correct, abate, minimize, eliminate, control, contain, or prevent a release of a contaminant into the environment in order to protect human health and the environment. Remediation may include, when appropriate and approved by the department, land use controls, natural attenuation, and monitored natural attenuation.

"Remediation level" means the concentration of a contaminant with applicable land use controls that is protective of human health and the environment.

"Restricted use" means any use other than residential.

"Risk" means the probability that a contaminant will cause an adverse effect in exposed humans or to the environment.

"Risk assessment" means the process used to determine the risk posed by contaminants released into the environment. Elements include identification of the contaminants present in the environmental media, assessment of exposure and exposure pathways, assessment of the toxicity of the contaminants present at the site, characterization of human health risks, and characterization of the impacts or risks to the environment.

"Risk management" means the process of identifying, evaluating, and selecting actions to reduce risk to human health and the environment.

"Site" means any property or portion thereof, as agreed to and defined by the participant and the department, ~~which~~ that contains or may contain contaminants being addressed under this program.

"Termination" means the formal discontinuation of participation in the Voluntary Remediation Program without obtaining a certificate.

"Unrestricted use" means the designation of acceptable future use for a site at which the remediation levels, based on either background or standard residential exposure factors, have been attained throughout the site in all media.

9VAC20-160-30. Eligibility criteria.

A. Applicants and proposed sites shall meet eligibility criteria as defined in this section.

B. Eligible applicants are any persons who own, operate, have a security interest in, or enter into a contract for the purchase or use of an eligible site. Those who wish to voluntarily remediate a site may apply to participate in the program. Any person who is an authorized agent of any of the parties identified in this subsection may apply to participate in the program.

Applicants who are not site owners must demonstrate that they have access to the property at the time of payment of the phase 2 registration fee in accordance with 9VAC20-160-60 and must maintain such right of access until a certificate is issued or participation in the program is terminated pursuant to 9VAC20-160-100.

C. Sites are eligible for participation in the program if (i) remediation has not been clearly mandated by the U.S. Environmental Protection Agency, the department, or a court pursuant to the Comprehensive Environmental Response, Compensation and Liability Act (42 USC § 9601 et seq.), the Resource Conservation and Recovery Act (42 USC § 6901 et seq.), the Virginia Waste Management Act (§ 10.1-1400 et seq. of the Code of Virginia), the Virginia State Water Control Law (§ 62.1-44.2 et seq. of the Code of Virginia), or other applicable statutory or common law; or (ii) jurisdiction of the statutes listed in clause (i) has been waived.

1. A site on which an ~~eligible party~~ applicant or another person has performed remediation of a release ~~is potentially~~ may be eligible for the program (i) if the actions can be documented in a way so that the actions are shown to be equivalent to the requirements for this chapter, and (ii) provided the site meets applicable remediation levels.

2. ~~Petroleum~~ A site containing petroleum or oil releases not mandated for remediation under Articles 9 (§ 62.1-44.34:8 et seq.) and 11 (§ 62.1-44.34:14 et seq.) of the Virginia State Water Control Law may be eligible for participation in the program.

3. ~~Where~~ A site where an applicant ~~raises~~ establishes a genuine issue based on documented evidence as to the legal or factual applicability of regulatory programs in subsection D of this section, ~~the site~~ may be eligible for the program. Such evidence may include a demonstration that:

a. It is not clear whether the release involved a waste material ~~or a virgin material~~ for which remediation has been clearly mandated;

b. It is not clear ~~that~~ whether the release ~~occurred after~~ is subject to the relevant regulations ~~became effective~~ listed in subsection D of this section; or

c. It is not clear ~~that~~ whether the release ~~occurred at a regulated unit~~ is a new release or an existing release.

D. For the purposes of this chapter, remediation has been clearly mandated if any of the following conditions exist, unless jurisdiction for such mandate has been waived. Any such waiver is conditioned on and subject to the applicant enrolling in and completing the program and obtaining a certificate:

1. Remediation of the release is the subject of a permit issued by the U.S. Environmental Protection Agency or the department, a closure plan, an administrative order, a court order, or a consent order, or the site is on the National Priorities List;

2. The site is one at which ~~the release occurred (i)~~ one or more of the following exists:

a. The release is subject to the Virginia Hazardous Waste Management Regulations (9VAC20-60) (VHWMR)~~, is~~;

b. Is a permitted facility~~, is~~;

c. Is applying for or should have applied for a permit~~, is under~~; or

d. Is under interim status or should have applied for interim status, or was previously under interim status, and ~~(ii)~~ is thereby subject to requirements of the VHWMR;

3. The site at which the release occurred has been determined by the department prior to the application submittal date to be an open dump or unpermitted solid waste management facility under 9VAC20-81-45 of the Solid Waste Management Regulations and such conditions still exist that made the site an open dump or unpermitted solid waste management facility;

4. The department determines that the release poses an imminent and substantial threat to human health or the environment; or

5. Remediation of the release is otherwise the subject of a response action or investigation required by local, state, or federal law or regulation.

E. The department may determine that a site ~~under subdivision D 3 of this section may~~ is eligible to participate in the program ~~provided that~~ if such participation ~~complies with the substantive requirements of the applicable regulations~~ is deemed acceptable under a memorandum of agreement between the department and the U.S. Environmental Protection Agency and such participation otherwise complies with the substantive requirements of the program.

9VAC20-160-55. ~~Registration fees for applications received prior to January 29, 2014.~~ (Repealed.)

~~A. For applicants that submitted an application that was received by the department prior to January 29, 2014, the registration fee submitted and any registration fee refund sought shall be in accordance with the requirements of this section. On and after July 1, 2014, any addition of acreage to a site participating in the program based upon an application subject to registration fees under this section shall require a new application for the additional acreage, which shall be subject to registration fees pursuant to the requirements of 9VAC20-160-65. If the participant elects to subdivide the site or conduct a phased remediation project requiring multiple certificates for the site, the additional site shall be subject to phase 2 registration fees as required by 9VAC20-160-65 C 1 b and phase 3 registration fees as required by 9VAC20-160-65 D 6.~~

~~B. The registration fee shall be at least 1.0% of the actual cost of the remediation at the site, not to exceed $5,000. To determine the appropriate registration fee, the applicant shall provide an estimate of the anticipated total cost of remediation and remit that amount. As an alternative to providing an estimate, the applicant may elect to pay the maximum registration fee.~~

~~C. If the participant did not elect to remit the maximum registration fee, the participant shall provide the department with the actual total cost of the remediation prior to issuance of a certificate. The department shall calculate any balance adjustment to be made to the initial registration fee. Any negative balance owed to the department shall be paid by the participant prior to the issuance of a certificate. Any overpayment to be refunded to the participant shall be remitted by the department with issuance of the certificate.~~

~~D. If the participant elected to remit the maximum registration fee and an overpayment has been made, the department shall refund any balance owed to the participant after receiving the actual total cost of remediation. If no remedial cost summary is provided to the department within 60 days of the participant's receipt of the certificate, the participant will have waived the right to a refund.~~

9VAC20-160-57. Transition to new fee structure for participants that paid registration fees for applications received prior to July 1, 2014.

A. In accordance with § 10.1-1232 A 5 of the Code of Virginia, applications submitted prior to July 1, 2014, were required to submit a registration fee of at least 1.0% of the actual cost of remediation at the site, not to exceed $5,000. Registration fees submitted by participants prior to July 1, 2014, are held in an account until a certificate is issued. Participants that submitted a registration fee prior to July 1, 2014, shall notify the department by (insert date 60 days after effective date of the regulation) which of the following options they select:

1. Continue participation in the program.

a. If the participant remitted the maximum $5,000 registration fee and an overpayment has been made, the participant shall provide the department with the actual costs of remediation by (insert date 60 days after the effective date of the regulation). The department shall refund any balance owed to the participant after receiving that actual cost of remediation. If no remedial cost summary is provided to the department by (insert date 60 days after the effective date of this regulation), the participant will have waived the right to a refund; or

b. If the participant did not remit the maximum $5,000 registration fee, the participant shall provide the department with the actual total cost of remediation by (insert date 60 days after the effective date of this regulation). The department shall calculate any balance adjustment to be made to the registration fee. The department shall refund any balance owed to the participant after receiving that actual cost of remediation. Any negative balance owed to the department shall be paid by the participant within 60 days of notification by the department to continue to participate in the program. Continued participation in the program means the participant waives the right to a refund.

2. Terminate participation in the program. The participant shall notify the department they are terminating participation in the program. No portion of the registration fee will be refunded if participation is terminated pursuant to 9VAC20-160-100.

B. Participants that submitted applications prior to July 1, 2014, that have not been issued a certificate are required to submit phase 3 registration fees in accordance with 9VAC20-160-65 D to continue participation in the program.

9VAC20-160-60. ~~Registration fees for applications received on or after January 29, 2014, and prior to July 1, 2014.~~ (Repealed.)

~~A. In accordance with § 10.1-1232 A 5 of the Code of Virginia, the applicant shall submit a registration fee to defray the cost of the program. For applicants submitting an~~

~~application that is received by the department on or after January 29, 2014, and prior to July 1, 2014, the registration fee submitted and any registration fee refund sought shall be in accordance with the requirements of this section. On and after July 1, 2014, any addition of acreage to a site participating in the program based upon an application subject to registration fees under this section shall require a new application for the additional acreage, which shall be subject to registration fees pursuant to the requirements of 9VAC20-160-65. If the participant elects to subdivide the site or conduct a phased remediation project requiring multiple certificates for the site, the additional site shall be subject to phase 2 registration fees as required by 9VAC20-160-65 C 1 b and phase 3 registration fees as required by 9VAC20-160-65 D 6.~~

~~B. The preliminary registration fee shall be $5,000. Payment shall be required after eligibility has been verified by the department and prior to technical review of submittals pursuant to 9VAC20-160-80. Payment shall be made payable to the Commonwealth of Virginia and remitted to Virginia Department of Environmental Quality, P.O. Box 1104, Receipts Control, Richmond, VA 23218.~~

~~C. Failure to remit the required registration fee within 90 days of the date of eligibility determination shall result in the loss of eligibility status of the applicant. The applicant must reestablish applicant eligibility for participation in the program and the eligibility of the site, unless the department agrees to extend the period for remitting the registration fee. Once eligibility is lost for failure to remit the registration fee pursuant to this subsection, the applicant shall submit a new application in order to reestablish applicant eligibility for participation in the program and the eligibility of the site and shall be subject to the registration fees under the provisions of 9VAC20-160-65.~~

~~D. Upon completion of remediation and issuance of the certificate pursuant to 9VAC20-160-110, the participant whose final cost of remediation is less than $500,000 may seek a refund of a portion of the preliminary registration fee. The refund amount shall be reconciled as the difference between the preliminary registration fee and the final registration fee amounts.~~

~~1. In order to receive a refund, the participant shall provide the department with a summary of the final cost of remediation within 60 days of issuance of a certificate. The final registration fee amount for such projects shall be calculated as 1.0% of the final cost of remediation. The department shall review the summary, calculate the refund amount due, and issue a refund to the participant.~~

~~2. If no summary of the final cost of remediation is provided to the department within 60 days of issuance of the certificate, the final registration fee amount shall be equal to the preliminary registration fee amount, and no portion of the preliminary registration fee shall be refunded.~~

~~3. Concurrence with the summary of the final cost of remediation does not constitute department verification of the actual cost incurred.~~

~~E. No portion of the preliminary registration fee will be refunded if participation is terminated pursuant to the provisions of 9VAC20-160-100.~~

9VAC20-160-65. Registration fees ~~for applications received on or after July 1, 2014~~.

A. In accordance with § 10.1-1232 A 5 of the Code of Virginia, the applicant shall submit a registration fee to defray the cost of the program. ~~For applications received by the department on and after July 1, 2014, the~~ The registration fee shall be remitted in three phases as required by this section.

1. Registration fees shall be adjusted annually on November 1 by the change in the Consumer Price Index. The annual adjustment of the registration fees shall be based upon the annual registration fee amount for the preceding calendar year and the change in the CPI value published by the U.S. Department of Labor for all-urban consumers over the 12-month period ending on April 30 of the calendar year preceding the calendar year in which the registration fee is assessed.

2. The Consumer Price Index for all-urban consumers is published by the U.S. Department of Labor, Bureau of Labor Statistics, U.S. All items, CUUR0000SA0.

3. Registration fees shall be rounded to the nearest dollar.

4. All fees included in this regulation shall be adjusted annually using the process described in subdivisions 1, 2, and 3 of this subsection.

5. Registration fees shall be rounded to the nearest dollar.

6. All fees included in this chapter shall be adjusted annually using the process described in subdivisions 1, 2, and 3 of this subsection.

B. Phase 1 of the registration fee shall be an application fee ~~in the amount of $2,000~~. The initial phase 1 registration fee is $3,000.

1. Payment of the phase 1 registration fee is required for each application received by the department on or after July 1, 2014.

2. The phase 1 registration fee is due when the application is submitted and shall be made payable to the Treasurer of Virginia.

3. The phase 1 registration fee shall be submitted separately from the application package and remitted to Virginia Department of Environmental Quality, P.O. Box 1104, Receipts Control, Richmond, VA 23218.

4. An application is not administratively complete until the phase 1 registration fee is received by the department.

Review of an application for eligibility in accordance with 9VAC20-160-30 and 9VAC20-160-40 shall not commence until the application is administratively complete.

C. Phase 2 of the registration fee shall be an eligibility fee ~~in the amount of $7,500~~. The initial phase 2 registration fee is $7,500.

1. Payment of the phase 2 registration fee shall be required after eligibility has been verified by the department and prior to technical review of submittals pursuant to 9VAC20-160-80. Upon receipt of the phase 2 registration fee, the site and applicant shall be considered by the department to be participating in the program.

a. A phase 2 registration fee shall be required from the applicant for each site that has been determined to be eligible for participation in the program based upon an application received by the department on or after July 1, 2014.

b. A separate phase 2 registration fee is required for each section of a phased remediation project that requires a separate eligibility determination or for any site that requires a separate certificate issued for that section pursuant to 9VAC20-160-110. In the event that the phased remediation work continues beyond November 1, then phase 3 registration fees shall also be billed and remitted annually until project completion in accordance with subsection D of this section.

c. No phase 2 registration fee shall be required for a site that has been determined to be eligible for participation in the program based upon an application received by the department prior to July 1, 2014, unless the site requires more than a single certificate to be issued.

d. If multiple certificates are issued at the same time for different portions of a project pursuant to 9VAC20-160-110, a phase 1 fee shall be due for each certificate after the first.

2. Payments of phase 2 registration fees shall (i) be made payable to the Treasurer of Virginia, (ii) include the Voluntary Remediation Program (VRP) ID number assigned by the department, and (iii) be remitted to Virginia Department of Environmental Quality, P.O. Box 1104, Receipts Control, Richmond, VA 23218. The phase 2 registration fees shall be remitted to the department within 90 days after date of the eligibility determination unless the department agrees to extend the period for remitting the phase 2 registration fee.

3. Failure to remit the required phase 2 registration fee in accordance with subdivision 2 of this subsection within 90 days after the date of eligibility determination shall result in the loss of eligibility status of the applicant and the site. After such loss of eligibility, the applicant must reestablish eligibility in order to participate in the program.

a. The department shall mail notification of nonpayment of the phase 2 registration fee and pending loss of eligibility at least 30 days prior to loss of the applicant's and the site's eligibility.

b. If eligibility is lost as a result of failure to remit a phase 2 registration fee, the applicant shall pay new phase 1 and phase 2 registration fees as part of reestablishing eligibility.

D. Phase 3 of the registration fee shall be an annual program cost defrayment fee ~~in the amount of $4,500. If a~~ The initial phase 3 registration fee is $10,500. Any site ~~(i)~~ that has been determined to be eligible for participation in the Voluntary Remediation Program ~~based upon an application received by the department on or after July 1, 2014,~~ and ~~(ii)~~ is participating in the Voluntary Remediation Program~~,~~ shall be assessed a phase 3 registration fee ~~shall be assessed~~ for that site as follows:

1. On November 1 of each calendar year, any site participating in the program on that day shall be assessed a phase 3 registration fee if the application on which the eligibility determination was based was received by the department in a calendar year prior to that year.

a. For example, any eligible site participating in the program on November 1, 2017, based upon an application that had been received by the department in calendar year 2016 will be assessed a phase 3 registration fee to be billed on March 1, 2018.

~~b. For any site where the application was received prior to July 1, 2014, the site is not subject to a phase 3 registration fee unless the site requires multiple certificates (e.g., the original site was divided and certificates are issued at separate times).~~

~~c.~~ b. Sites that are not participating in the program, including sites that have not yet been determined to be eligible to participate in the program, sites that have had a certificate issued pursuant to 9VAC20-160-110 prior to November 1, and sites that have been terminated from participation in the program pursuant to 9VAC20-160-100 prior to November 1 are not subject to a phase 3 registration fee assessment for that calendar year and will not be billed on March 1 of the following year.

2. The phase 3 registration fee is not prorated for participation in the program for portions of calendar years.

3. The phase 3 registration fee assessed for an eligible site shall be billed to the applicant on March 1 of the calendar year following the November 1 assessment.

4. The assessed phase 3 registration fee is due on April 1 of the billing year and shall (i) be made payable to the Treasurer of Virginia, (ii) include the VRP ID number assigned by the department, and (iii) be remitted to Virginia Department of Environmental Quality, P.O. Box 1104, Receipts Control, Richmond, VA 23218.

5. The phase 3 registration fees shall be remitted to the department by the due date specified in subdivision 4 of this subsection unless extended by the department.

a. Failure to remit a required phase 3 registration fee within 30 days of the due date shall be cause for termination from the program in accordance with 9VAC20-160-100 A 4.

b. The department shall mail notification of nonpayment of the phase 3 registration fee and intent to terminate participation in accordance with 9VAC20-160-100 to the participant at least 30 days prior to termination.

6. ~~No phase 3 registration fee shall be assessed for a site participating in the program based upon an application received by the department prior to July 1, 2014, unless the participant elected to subdivide the site or conduct a phased remediation project requiring multiple certificates for the site.~~ Sites participating in the program that submitted an application to the department prior to July 1, 2014, are required to submit phase 3 annual registration fees assessed as of November 1 to participate in the program.

7. Any assessed phase 3 fees shall be remitted to the department before a certificate is issued.

E. The total amount of fees collected by the board shall defray the actual reasonable costs of the program. The director shall take whatever action is necessary to ensure that this limit is not exceeded.

F. No portion of Voluntary Remediation Program registration fees collected pursuant to this section shall be refunded.

G. If a site has been terminated from the program in accordance with 9VAC20-160-100, a new application shall be submitted before the site will be considered for a new eligibility determination and reenrollment into the program. The applicant shall also remit new phase 1 and phase 2 registration fees in accordance with this section and no monetary credit will be given for any fees submitted prior to termination.

H. Amendments to a site's certificate or the associated ~~declaration of restrictive~~ covenants issued by the department pursuant to 9VAC20-160-110 shall be subject to registration fees based on the amendments requested. The land owner shall submit a certificate amendment request to the department describing the changes being requested. The department will review the request and notify the land owner of any additional information required and the amount of the registration fee to be remitted as follows:

1. For amendments to the certificate or the associated ~~declaration of restrictive~~ covenants not requiring a technical review by the department, only a phase 1 registration fee shall be required.

2. For amendment requests that require technical review by the department, ~~no phase 1 registration fee~~ payment in the amount of one half of the phase 3 registration fee shall be required~~, but a reduced phase 2 registration fee in the amount of $4,500 shall be required~~. In the event that the amendment request also meets the phase 3 registration fee criteria in subsection D of this section based upon the date that the department received the amendment request being the date of the application for such purpose, phase 3 registration fees shall also be billed and remitted.

I. For a site that has been determined to be eligible for participation in the program based upon an application received by the department, a request to change the participant for such site received by the department will not in and of itself subject the site to the fees under this section.

9VAC20-160-70. Work to be performed.

A. The Voluntary Remediation Report shall consist of the following components: a site characterization, a risk assessment, a remedial plan, a demonstration of completion, and documentation of public notice. Each separate component of the Voluntary Remediation Report shall be submitted as listed in this subsection:

1. The site characterization component shall provide an understanding of the site conditions, including the identification and description of ~~each area~~ known or suspected areas of concern ~~(~~or ~~source)~~ potential sources of contaminants); a determination of the sources; the nature and extent of releases to all media, including ~~a map~~ maps of hydraulic gradient and groundwater flow direction; the onsite and offsite vertical and horizontal ~~extent~~ extents of contaminants present at concentrations above levels consistent with 9VAC20-160-90; and a discussion of the potential risks posed by the release. If remedial activities have occurred prior to enrollment, this information shall be included.

2. The risk assessment component shall contain an evaluation of the risks to human health and the environment posed by the release, including an assessment of risk to offsite properties; a proposed set of remediation level objectives consistent with 9VAC20-160-90 that are protective of human health and the environment; ~~and either~~ recommended remediation actions to achieve the proposed objectives; and recommended risk management activities or a demonstration that no action is necessary. The risk assessment shall include an uncertainty analysis that discusses any remaining risk.

3. The remedial action plan component shall propose the specific remedial activities, a schedule for those activities, any permits required to initiate and complete the remediation, and specific design plans for implementing remediation that will achieve the remediation level objectives specified in the risk assessment component of the report. Control or elimination of continuing onsite sources of releases to the environment shall be discussed. Land use

controls and any permits required for the remediation process should be discussed as appropriate. If no remedial action is necessary, the remedial action plan shall discuss the reasoning for no action.

4. The demonstration of completion component shall include the following, as applicable:

a. A detailed summary of the remediation implemented at the site, including a discussion of the remediation systems installed and a description of the remediation activities that occurred at the site.

b. A detailed summary of how the established site-specific objectives have been achieved, including (i) a description of how onsite releases (or sources) of contamination have been eliminated or controlled~~,~~ and exposure pathways controlled; and (ii) confirmational sampling results demonstrating that the remediation level objectives have been achieved and that the migration of contamination has been stabilized.

c. A description of any site restrictions including land use controls that are proposed for the certificate.

d. A demonstration that all other criteria for completion of remediation have been satisfied.

e. A statement signed by the participant or authorized agent that to the best of the participant's knowledge, the activities performed at the site pursuant to this chapter have been in compliance with applicable regulations.

5. The documentation of public notice component is required to demonstrate that public notice has been provided in accordance with 9VAC20-160-120. Such documentation shall, at a minimum, consist of copies of all of the documents required pursuant to the provisions of subsection E of 9VAC20-160-120.

B. It is the participant's responsibility to ensure that the investigation and remediation activities (e.g., waste management and disposal, erosion and sedimentation controls, air emission controls, and activities that impact wetlands and other sensitive ecological habitats) comply with all applicable federal, state, and local laws and regulations.

C. All work, to include sampling and analysis, shall be performed in accordance with Test Methods for Evaluating Solid Waste, USEPA SW-846, revised March 2009, or other media-specific methods approved by the department and completed using appropriate quality assurance and quality control protocols. All analyses shall be performed by laboratories certified by the Virginia Environmental Laboratory Accreditation Program (VELAP). Laboratory certificates of analysis shall be included with applicable reports.

D. While participating in the program, the participant shall notify the department in writing within 30 days of any change in property ownership and if the participant changes, then the new participant shall notify the department within 30 days of the change.

E. While participating in the program, the participant shall notify the department in writing within 30 days of any change in ~~agent for the property owner or the participant~~ the name or address of the participant, the authorized agent, or the site owner.

9VAC20-160-90. Remediation levels.

A. The participant, with the concurrence of the department, shall consider impacts to human health and the environment in establishing remediation levels.

B. Remediation levels based on human health shall be developed after appropriate site characterization data have been gathered as provided in 9VAC20-160-70. Remediation levels may be derived from the three-tiered approach provided in this subsection. Any tier or combination of tiers may be applied to establish remediation levels for contaminants present at a given site.

1. Tier I remediation levels are based on media backgrounds levels. These background levels shall be determined from a portion of the property or a nearby property or other areas as approved by the department that have not been impacted by the contaminants of concern.

2. Tier II remediation levels are derived assuming that there will be no restrictions on the use of groundwater, surface water, and soil on the site.

a. Tier II groundwater remediation levels shall be based on the most beneficial use of groundwater. The most beneficial use of groundwater is for a potable water source, unless demonstrated otherwise by the participant and accepted by the department. Therefore, they shall be based on (i) federal maximum contaminant levels (MCLs) or action levels for lead and copper as established by the Safe Drinking Water Act (42 USC § 300 (f)) and the National Primary Drinking Water Regulations (40 CFR Part 141) or, in the absence of a MCL, (ii) tap water values derived using the methodology provided in the Regional Screening Level Table, Region III, VI, and IX, United States Environmental Protection Agency, December 2009, using an acceptable individual carcinogenic risk of $1 \text{ X } 10^{-5}$ and an individual noncarcinogen hazard quotient of 0.1.

b. Tier II soil remediation levels shall be determined as the lower of the ingestion or cross-media transfer values, according to the following:

(1) For ingestion, values derived using the methodology provided in the Regional Screening Level Table, Region III, VI, and IX, United States Environmental Protection Agency, December 2009.

(a) For carcinogens, the soil ingestion concentration for each contaminant, reflecting an individual upper-bound lifetime cancer risk of $1 \text{ X } 10^{-5}$.

(b) For noncarcinogens, 0.1 of the soil ingestion concentration, to account for multiple systemic toxicants at the site. For sites where there are fewer than 10 contaminants exceeding 0.1 of the soil ingestion concentration, the soil ingestion concentration may be divided by the number of contaminants such that the resulting hazard index does not exceed 1.0.

(2) For cross-media transfer, values derived from the USEPA Soil Screening Guidance (OSWER, July 1996, Document 9355.4-23, EPA/540/R-96/018) and USEPA Supplemental Guidance for Developing Soil Screening Levels for Superfund Sites (OSWER, December 2002, Document 9355.4-24) shall be used as follows:

(a) The soil screening level for transfer to groundwater, with adjustment to a hazard quotient of 0.1 for noncarcinogens, if the value is not based on a MCL; or

(b) The soil screening level for transfer to air, with adjustment to a hazard quotient of 0.1 for noncarcinogens and a risk level of 1×10^{-5} for carcinogens, using default residential exposure assumptions.

(c) For noncarcinogens, for sites where there are fewer than 10 contaminants exceeding 0.1 of the soil screening level, the soil screening level may be divided by the number of contaminants such that the resulting hazard index does not exceed 1.0.

(3) Values derived under subdivisions 2 b (1) and (2) of this subsection may be adjusted to allow for updates in approved toxicity factors as necessary.

c. Tier II remediation levels for surface water shall be based on the Virginia Water Quality Standards (WQS) as established by the State Water Control Board (9VAC25-260), according to the following:

(1) The chronic aquatic life criteria shall be compared to the appropriate human health criteria and the lower of the two values selected as the Tier II remediation level.

(2) For contaminants that do not have a Virginia WQS, the federal Water Quality Criteria (WQC) may be used if available. The chronic federal criterion continuous concentration (CCC) for aquatic life shall be compared to the appropriate human health based criteria and the lower of the two values selected as the Tier II remediation level.

(3) If neither a Virginia WQS nor a federal WQC is available for a particular contaminant detected in surface water, the participant should perform a literature search to determine if alternative values are available. If alternative values are not available, the detected contaminants shall be evaluated through a site-specific risk assessment.

3. Tier III remediation levels are based upon site-specific assumptions about current and potential exposure scenarios for the population or populations of concern and characteristics of the affected media and can be based upon a site-specific risk assessment and risk management. Land-use controls can be considered.

a. In developing Tier III remediation levels, and unless the participant proposes ~~other guidance~~ an alternative methodology that is acceptable to the department, the participant shall use, for all media and exposure routes, the methodology specified in Risk Assessment Guidance for Superfund, Volume 1, Human Health Evaluation Manual (Part A), Interim Final, USEPA, December 1989 (EPA/540/1-89/002) and (Part B, Development of Preliminary Remediation Goals) Interim, USEPA, December 1991 (Publication 9285.7-01B) with modifications as appropriate to allow for site-specific conditions. ~~The participant may use other methodologies approved by the department.~~

b. For a site with carcinogenic contaminants, the remediation goal for individual carcinogenic contaminants shall be an incremental upper-bound lifetime cancer risk of 1×10^{-5}. The remediation levels for the site shall not result in an incremental upper-bound lifetime cancer risk exceeding 1×10^{-4} considering multiple contaminants and multiple exposure pathways, unless the use of a MCL for groundwater that has been promulgated under 42 USC § 300g-1 of the Safe Drinking Water Act and the National Primary Drinking Water Regulations (40 CFR Part 141) results in a cumulative risk greater than 1×10^{-4}.

c. For noncarcinogens, the hazard index shall not exceed a combined value of 1.0.

d. In setting remediation levels, the department may consider risk assessment methodologies approved by another regulatory agency and current at the time of the Voluntary Remediation Program site characterization.

C. The participant shall determine if ecological receptors are present at the site or in the vicinity of the site and if they are impacted by releases from the site.

1. At sites where ecological receptors are of concern and there are complete exposure pathways, the participant shall perform a screening level ecological evaluation demonstrating that remediation levels developed under the three-tiered approach described in this section are also protective of such ecological receptors.

2. For sites where a screening level ecological evaluation has shown that there is a potential for ecological risks, the participant shall perform an ecological risk assessment demonstrating that remediation levels developed under the three-tiered approach described in this section are also protective of ecological receptors. If the remediation levels developed for human health are not protective of ecological receptors, the remediation levels shall be adjusted accordingly.

9VAC20-160-100. Termination.

A. Participation in the program shall be terminated:

1. When evaluation of new information obtained during participation in the program results in a determination by the

department that the site is ineligible or that a participant has taken an action to render the site ineligible for participation in the program. If such a determination is made, the department shall notify the participant that participation has been terminated and provide an explanation of the reasons for the determination. Within 30 days, the participant may submit additional information, or accept the department's determination.

2. Upon 30 days written notice of withdrawal by the participant.

3. Upon the participant's failure to make reasonable progress towards completion of the program, as determined by the department, and the participant's subsequent failure to respond appropriately within 30 days to the department's written request for an update of program-related activities and a projected timeline to fulfill the program requirements.

4. Upon failure to submit required registration fees in accordance with ~~9VAC20-160-55 (for applications received prior to January 29, 2014), 9VAC20-160-60 (for applications received on or after January 29, 2014, and prior to July 1, 2014),~~ 9VAC20-160-57 or 9VAC20-160-65 ~~(for applications received on or after July 1, 2014)~~. The department shall mail notification of the department's intent to terminate participation in the program to the participant at least 30 days prior to terminating the site's participation in the program. If the participant fails to remit the required fee within 30 days of the date of such notification, the site's participation in the program shall be terminated. The department reserves the right to collect unpaid fees due to the department pursuant to 9VAC20-160-57 and 9VAC20-160-65.

B. The department shall be entitled to receive and use, upon request, copies of any and all information developed by or on behalf of the participant as a result of work performed pursuant to participation in the program, after application has been made to the program whether the program is satisfactorily completed or terminated.

9VAC20-160-110. Certification of satisfactory completion of remediation.

A. The department shall issue a certificate when:

1. The participant has demonstrated that migration of contamination has been stabilized;

2. The participant has demonstrated that the site has met the applicable remediation levels and will continue to meet the applicable remediation levels in the future for both onsite and offsite receptors;

3. All provisions of the final remedial action plan as applicable have been ~~completed~~ implemented;

4. All applicable requirements of this chapter have been completed;

5. The department accepts all work submitted, as set forth in 9VAC20-160-70; and

6. All registration fees due to the department pursuant to ~~9VAC20-160-55, 9VAC20-160-60,~~ 9VAC20-160-57 and 9VAC20-160-65 have been received by the department.

B. The issuance of the certificate shall constitute immunity to an enforcement action under the Virginia Waste Management Act (§ 10.1-1400 et seq. of the Code of Virginia), the Virginia State Water Control Law (§ 62.1-44.2 et seq. of the Code of Virginia), the Virginia Air Pollution Control Law (§ 10.1-1300 et seq. of the Code of Virginia), or other applicable Virginia law for the releases described in the certificate.

C. A site shall be deemed to have met the requirements for unrestricted use if the remediation levels, based on either background or standard residential exposure factors, have been attained throughout the site and in all media. Attainment of these levels will allow the site to be given an unrestricted use classification. No remediation techniques or land use controls that require ongoing management may be employed to achieve this classification.

D. For sites that do not achieve the unrestricted use classification, land use controls may be proffered in order to develop remediation levels based on restricted use. The restrictions imposed upon a site may be media-specific, may vary according to site-specific conditions, and may be applied to limit present and future use. All controls necessary to attain the restricted use classification shall be described in the certificate as provided in this section and defined in a ~~declaration of restrictive covenants~~ covenant. Land use controls accepted by the department for use at the site are considered remediation for the purposes of this chapter.

E. If a use restriction is specified in the certificate, the participant shall cause the certificate and a ~~declaration of restrictive covenants~~ covenant to be recorded among the land records in the office of the clerk of the circuit court for the jurisdiction in which the site is located within 90 days of execution of the certificate by the department, unless a longer period is specified in the certificate. If the certificate does not include any use restriction, recordation of the certificate is at the option of the participant. The immunity accorded by the certificate shall apply to the participant and current or future property owner and shall run with the land identified as the site.

F. The immunity granted by issuance of the certificate shall be limited to the known releases as described in the certificate. The immunity is further conditioned upon satisfactory performance by the participant of all obligations required by the department under the program and upon the veracity, accuracy, and completeness of the information submitted to the department by the participant relating to the site. Specific limitations of the certificate shall be enumerated in the certificate. The immunity granted by the certificate shall be dependent upon the identification of the nature and extent of

contamination as presented in the Voluntary Remediation Report.

G. The certificate shall specify the conditions for which immunity is being accorded, including:

1. A summary of the information that was considered;

2. Any restrictions on future use;

3. Any local land use controls on surrounding properties that were taken into account;

4. Any proffered land use controls; and

5. Any post-certificate monitoring.

H. The certificate may be revoked by the department in any of the following situations, provided that (i) the department has given the owner written notice of the deficiency and (ii) the owner has failed to cure the deficiency within 60 days of the date of the written notice or some longer period granted by the department.

1. In the event that conditions at the site, unknown at the time of issuance of the certificate, pose a risk to human health or the environment;

2. In the event that the certificate was based on information that was false, inaccurate, or misleading; or

3. In the event that the conditions of the certificate have not been met or maintained.

I. The certificate is not and shall not be interpreted to be a permit or a modification of an existing permit or administrative order issued pursuant to state law, nor shall it in any way relieve the participant of its obligation to comply with any other federal or state law, regulation, or administrative order. Any new permit or administrative order, or modification of an existing permit or administrative order, must be accomplished in accordance with applicable federal and state laws and regulations.

J. The issuance of the certificate shall not preclude the department from taking any action authorized by law for failure to meet a requirement of the program or for liability arising from future activities at the site that result in the release of contaminants.

K. The issuance of the certificate by the department shall not constitute a waiver of the Commonwealth's sovereign immunity unless otherwise provided by law.

9VAC20-160-120. Public notice.

A. The participant shall give public notice of the voluntary remediation. The notice shall be made after the department accepts the site characterization component of the Voluntary Remediation Report and the proposed or completed remediation and shall occur prior to the department's issuing a certificate or prior to issuing an amendment to the certificate that has additional remedial work or changes in land use controls. Such notice shall be paid for by the participant.

B. The participant shall:

1. Provide written notice to the local government in which the facility is located;

2. Provide written notice to all adjacent property owners and other owners whose property has been affected by contaminants as determined pursuant to the provisions of subdivision A 1 of 9VAC20-160-70; and

3. Publish a notice once in a newspaper of general circulation in the area affected by the voluntary action.

C. A comment period of at least 30 days must follow issuance of the notices pursuant to this section. The department, at its discretion, may increase the duration of the comment period to 60 days. The contents of each public notice required pursuant to subsection B of this section shall include:

1. The name and address of the participant and the location of the proposed voluntary remediation;

2. A brief description of the general nature of the release, any remediation, and any proposed land use controls;

3. The address and telephone number of a specific person familiar with the remediation from whom information regarding the voluntary remediation may be obtained; and

4. A brief description of how to submit comments.

D. The participant shall send all commenters a letter acknowledging receipt of written comments and providing responses to the same.

E. The participant shall provide the following as documentation of public notice required in subdivision A 5 of 9VAC20-160-70:

1. A signed statement that the participant has provided public notice as required by subsection B of this section;

2. A copy of the public notice and a list of names and addresses of all persons to whom the notice was sent; and

3. Copies of all written comments received during the public comment period, copies of acknowledgment letters, and copies of any response to comments, as well as an evaluation of the comment's impact on the planned or completed remedial action or actions.

VA.R. Doc. No. R20-6078; Filed January 5, 2022, 3:42 p.m.

STATE WATER CONTROL BOARD

Final Regulation

REGISTRAR'S NOTICE: The State Water Control Board is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 14 of the Code of Virginia, which exempts adoption, amendment, or repeal of wasteload allocations by the State Water Control Board pursuant to State Water Control Law (§ 62.1-44.2 et seq. of the Code of Virginia) if the board (i) provides public notice in the Virginia Register; (ii) if requested by the public during the initial public notice 30-day comment period, forms an advisory group composed of relevant stakeholders; (iii) receives and provides summary response to written comments; and (iv) conducts at least one public meeting.

Title of Regulation: **9VAC25-720. Water Quality Management Planning Regulation (amending 9VAC25-720-50, 9VAC25-720-80, 9VAC25-720-120).**

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

Effective Date: March 2, 2022.

Agency Contact: Justin L. Williams, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 659-1125, FAX (804) 698-4178, or email justin.williams@deq.virginia.gov.

Summary:

The amendments to the Water Quality Management Planning Regulation include adding (i) one new total maximum daily load (TMDL) wasteload allocation in the Potomac-Shenandoah River Basin; (ii) two new TMDL wasteload allocations in the Roanoke River Basin; and (iii) 13 new TMDL wasteload allocations in the York River Basin.

9VAC25-720-50. Potomac-Shenandoah River Basin.

A. Total maximum daily loads (TMDLs).

TMDL #	Stream Name	TMDL Title	City/County	WBID	Pollutant	WLA[1]	Units
EDITOR'S NOTE: Subdivisions 1 through 219 are not amended; therefore, that text is not set out.							
220.	Lewis Creek	PCB Total Maximum Daily Load Development for Lewis Creek, Staunton, Virginia	Staunton	B12R	PCBs	3,040	mg/yr

Notes:
[1]The total WLA can be increased prior to modification provided that DEQ tracks these changes for bacteria TMDLs where the permit is consistent with water quality standards for bacteria.

[2]There were no point source dischargers in the modeled TMDL area.

EDITOR'S NOTE: Subsections B and C of 9VAC25-720-50 are not amended; therefore, that text is not set out.

9VAC25-720-80. Roanoke River Basin.

A. Total maximum daily loads (TMDLs).

TMDL #	Stream Name	TMDL Title	City/County	WBID	Pollutant	WLA[1]	Units
EDITOR'S NOTE: Subdivisions 1 through 118 are not amended; therefore, that text is not set out.							
119.	Lynch Creek	Benthic TMDL Development for the	Campbell	L19R	Sediment	8,069	lbs/year

		Lynch Creek and Reed Creek Watersheds Located in Campbell and Pittsylvania Counties					
120.	Reed Creek	Benthic TMDL Development for the Lynch Creek and Reed Creek Watersheds Located in Campbell and Pittsylvania Counties	Pittsylvania	L19R	Sediment	22,250	lbs/year

Notes:
[1]The total WLA can be increased prior to modification provided that DEQ tracks these changes for bacteria TMDLs where the permit is consistent with water quality standards for bacteria.

[2]WLAs from the Dan River TMDL report represent the WLA for the watershed, which may include North Carolina waters in addition to Virginia waters. Virginia permits will be issued in accordance with the Virginia water quality standard.

EDITOR'S NOTE: Subsections B and C of 9VAC25-720-80 are not amended; therefore, that text is not set out.

9VAC25-720-120. York River Basin.

A. Total maximum daily loads (TMDLs).

TMDL #	Stream Name	TMDL Title	City/County	WBID	Pollutant	WLA[1]	Units
EDITOR'S NOTE: Subdivisions 1 through 51 are not amended; therefore, that text is not set out.							
52.	Aylett Creek	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King William	F23R	E. coli	2.42E+11	counts/year
53.	Courthouse Creek	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen	F24R	E. coli	1.41E+11	counts/year
54.	Dickeys Swamp	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen	F23R	E. coli	2.22E+11	counts/year

55.	Dogwood Fork	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen	F23R	E. coli	1.79E+10	counts/year
56.	Dorrell Creek	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King William	F21R	E. coli	5.75E+10	counts/year
57.	Garnetts Creek	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen	F23R	E. coli	8.72E+10	counts/year
58.	Gravel Run	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen	F21R	E. coli	1.10E+11	counts/year
59.	Herring Creek	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King William	F21R	E. coli	6.30E+11	counts/year
60.	Market Swamp	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen	F23R	E. coli	1.10E+11	counts/year

61.	Mattaponi River (nontidal)	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen, King William	F21R	E. coli	1.00E+12	counts/year
62.	Mattaponi River (tidal)	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen, King William	F23E	E. coli	1.87E+11	counts/year
63.	XDN-Garnetts Creek, unnamed tributary	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen	F23R	E. coli	2.65E+10	counts/year
64.	XJG-Dickeys Swamp, unnamed tributary	Bacteria Total Maximum Daily Load (TMDL) Development for the Mattaponi River and Tributaries Located in Caroline, Essex, King William, and King and Queen Counties, Virginia	King and Queen	F23R	E. coli	2.01E+10	counts/year

Notes:
[1]The total WLA can be increased prior to modification provided that DEQ tracks these changes for bacteria TMDLs where the permit is consistent with water quality standards for bacteria.

[2]There were no point source dischargers in the modeled TMDL area.

EDITOR'S NOTE: Subsections B and C of 9VAC25-720-120 are not amended; therefore, that text is not set out.

VA.R. Doc. No. R22-7023; Filed January 3, 2022, 2:47 p.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Proposed Regulation

Title of Regulation: **12VAC5-90. Regulations for Disease Reporting and Control (amending 12VAC5-90-80, 12VAC5-90-90).**

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

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: April 1, 2022.

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.

Basis: Sections 32.1-12 and 32.1-35 of the Code of Virginia authorize the State Board of Health to promulgate the proposed regulation. Specifically, § 32.1-35 of the Code of Virginia directs the board to promulgate regulations specifying which diseases occurring in the Commonwealth are to be reportable and the method by which they are to be reported.

Purpose: The proposed changes are essential to protect the health and safety of citizens because they will improve the ability of the Virginia Department of Health (VDH) to conduct surveillance and investigations, collect necessary public health information, and continue to implement disease control measures for COVID-19. The changes will position the agency to better detect and respond to these illnesses to protect the health of the public.

Substance: Amendments to current regulations will for COVID-19: (i) require all suspect or confirmed COVID-19 case report forms be submitted electronically to VDH; (ii) clarify that the category laboratory directors includes all entities that hold Clinical Laboratory Improvement Amendments Certificates of Waiver so that entities testing for COVID-19 are required to report to VDH; (iii) require all COVID-19 laboratory reports be submitted electronically to VDH; (iv) add the requirement that patient telephone number, email address, and ethnicity be included in the list of fields that are reported by physicians, laboratory directors, and directors of medical care facilities; and (v) add "coronavirus, severe" to the list of infectious diseases that shall be reported to persons practicing funeral services.

Issues: The primary advantages to the public are the improved ability of the agency to control the risk of disease in the community based on timelier reporting through VDH's online morbidity reporting portal and the improved ability to accurately report COVID-19 data. No disadvantages have been identified.

The primary advantage to the agency is that the proposed changes improve the focus of surveillance and ability of VDH to conduct surveillance and implement disease control for conditions of public health concern in a timely manner. The changes will position the agency to better detect and respond to these illnesses to protect the health of the public. No disadvantages have been identified.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented below represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. The State Board of Health (Board) proposes to make permanent a discretionary emergency regulation that would add COVID-19 to the list of reportable diseases.[2] Specifically, the proposed amendments would (i) specify the patient information to be collected and reported to the Virginia Department of Health (VDH), (ii) require COVID-19 case and laboratory reports to be submitted electronically, (iii) identify all entities (physicians, lab directors, and other non-traditional providers who conduct COVID testing) that are required to report COVID-19, and (iv) add "coronavirus, severe" to the list of infectious diseases that shall be reported to persons practicing funeral services at the time of transferring custody of a dead body.

Background. The Regulations for Disease Reporting and Control provide information about the process and procedures for reporting diseases to VDH, including what diseases must be reported, who must report them, and other details.

The 2020 federal Coronavirus Aid, Relief, and Economic Security (CARES) Act requires that every laboratory that performs a test that is "intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19 shall report the results of each such test to the Secretary of Health and Human Services until the end of the Public Health Emergency declaration with respect to COVID-19 or any extension of such declaration.[3] Details regarding who had to report testing data to whom, and what information had to be reported, were left to the Secretary's discretion. A federal public health emergency for COVID-19 was first declared on January 31, 2020, and has been renewed every three months since then, most recently on October 18, 2021.[4]

In order to implement these requirements, the Centers for Disease Prevention and Control (CDC) has communicated specific requirements for laboratories, including details regarding who must make reports (what entities are considered "laboratories") and what data elements must be reported.[5] The CDC requires all COVID-19 testing sites to have a Clinical Laboratory Improvement Amendments (CLIA) certificate and requires every CLIA-certified testing site to report data for all

diagnostic and screening testing completed, including molecular, antigen, and antibody testing for each individual tested, within 24 hours of test completion.[6] These reporting requirements apply to all entities conducting COVID-19 testing; VDH's reporting requirements described below separate reporters into two groups for the purposes of this regulation: (a) physicians and directors of medical care facilities, and (b) directors of laboratories, including other entities that hold CLIA Certificates of Waiver. The CDC has also directed all entities conducting COVID-19 testing to report testing data to state or local public health departments according to state law or policy.

Subsequently, the Board promulgated emergency regulations to clarify and enforce the CARES Act reporting requirements and to collect necessary information to guide state-level policy making in response to COVID-19.[7] Specifically, the Board added "Coronavirus, severe" to 12VAC5-90-80 List of diseases that shall be reported and a subsection specifying who would report COVID-19 tests and how. The proposed amendments at this stage largely preserve the changes made at the emergency stage, with the exception of one significant change that is discussed here.

The proposed amendments require physicians and directors of medical care facilities to report COVID-19 testing data when a person who is infected with or is suspected of having COVID-19 is treated or examined, hospitalized, or admitted to an intensive care unit. Physicians and directors of medical care facilities would be required to report "the person's name, telephone number, email address, address, age, date of birth, race, ethnicity, sex, and pregnancy status; name of disease diagnosed or suspected; the medical record number (if applicable); the date of onset of illness; available laboratory tests and results; and the name, address, and telephone number of the physician and medical facility where the examination was made.[8] The proposed language also specifies that case reports shall be submitted immediately or within 24 hours by entering the information into VDH's online Confidential Morbidity Report portal or via electronic case reporting.[9]

The proposed amendments include analogous reporting requirements for directors of laboratories, including other entities that hold CLIA Certificates of Waiver; while the patient data to be reported is the same as above, labs would also have to report the source of the specimen, the laboratory method and the result. Under the emergency regulation, lab directors were required to report both positive and negative test results; as per the proposed amendments at this stage, lab directors would only have to report positive test results. In practice, this change would only affect lab directors once the federal public health emergency declaration is lifted, since the CARES Act requires that every test be reported to the Secretary of Health and Human Services and VDH will continue to act as a conduit for that information. As for physicians, lab directors would also be required to report tests within 24 hours, either by entering information into VDH's online portals for lab reporting or via electronic lab reporting.[10]

Lastly, 12VAC5-90-90 states that, "In accordance with § 32.1-37.1 of the Code of Virginia, any person in charge of a hospital, nursing facility or nursing home, assisted living facility, or correctional facility shall, at the time of transferring custody of any dead body to any person practicing funeral services, notify the person practicing funeral services or his agent if the dead person was known to have had, immediately prior to death, an infectious disease which may be transmitted through exposure to any bodily fluids." COVID-19 was added to the list of infectious diseases subject to this requirement at the emergency stage; this change would be made permanent.

Estimated Benefits and Costs.[11] The primary benefits of timely data collection about COVID-19 suspected cases and test results were, and continue to be, the protection of public health. In the initial stages of the COVID-19 pandemic, this included critical decision making regarding the procurement of personal protective equipment for hospital staff and other frontline workers, the procurement and allocation of ventilators and oxygen and other critical supplies, and hiring and staffing decisions for hospitals, nursing homes, emergency rooms, and other providers. Funeral services workers would benefit from the addition of COVID-19 to the list of infectious diseases they are informed of so that they can take adequate precautions.

In addition, collecting information on both positive and negative tests allowed public health experts to calculate and report the percent-positivity rate, which served as a leading indicator of community transmission at the local, regional, and state levels. This information was and continues to be used to guide public health policies such as social distancing, recommendations (and mandates) regarding masking, travel, capacity limits for various businesses, and lockdowns. Thus, in addition to meeting federal requirements, the proposed amendments have benefited and would likely continue to benefit the public, at least as long as the pandemic continues.

The direct costs of the proposed amendments fall on physicians and lab directors who face a significant reporting burden and a binding time constraint. To the extent that this reporting is required by the CARES Act and the Secretary of Health and Human Services, these costs are unavoidable. VDH has attempted to mitigate this burden by providing multiple online portals and secure electronic transmission methods in order to reduce the time and paperwork costs of these requirements. As the pandemic has evolved, the criteria for testing have changed and tests have become more widely available; people may be more likely to get tested in order to travel or attend an event, or to get tested more frequently if they have to be present in-person for work or education. Thus, as the number of negative tests increase in general, percent positivity may not be as informative or useful as it once was. In recognition of these trends, the Board proposes to remove the requirement to report negative COVID-19 tests, which would significantly reduce the reporting burden for labs, including entities with CLIA waivers. At the same time, requiring that positive cases and tests be reported would ensure that new "spikes" or "hotspots" can be identified quickly.

Many of the patient-specific data elements (such as biographical and contact information) that would be required by these proposed changes are already required for other reportable diseases. However, this proposed change is the first time that this regulation has required that the telephone number, email address, and ethnicity be reported. An indirect cost of the proposed amendments, therefore, relates to individuals' data privacy and the risk that one's personal biographical details, contact details, and health information may be accessed by unauthorized persons or entities and/or used for nefarious purposes. Such concerns may discourage individuals from getting tested even when they do exhibit symptoms, which would defeat the purpose of collecting this information. All the patient-related data fields included in the proposed amendments (except e-mail address) are currently required by the CARES Act, so VDH does not have much leeway in amending the scope of data collected.[12] Further, the reported data are transmitted to the CDC and possibly other entities, which amplifies privacy concerns since data sharing increases the risk of a security breach, even if the data are de-identified.

In order to ameliorate these costs in the long run, the Board and VDH could revisit the scope of data collection and the list of data fields once the federal public health emergency is lifted and re-evaluate the proposed requirements. If COVID-19 ends up becoming more common and less dangerous, VDH could consider only requiring physicians to report cases that require hospitalization or admission to intensive care, or only requiring lab reports to include select demographic data but no personally identifiable information.

Businesses and Other Entities Affected. The proposed amendments affect roughly 20,000 physicians, 125 laboratories, 100 hospitals, and 250 nursing homes in Virginia.[13] There are currently 7,791 entities with CLIA certificates in Virginia (including the 125 laboratories mentioned previously) who are potentially impacted by the proposed amendments.[14] Some of these entities may operate multiple testing locations, such as a school district with one certificate that covers 13 schools.

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[15] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. As noted above, the proposal to add new reporting requirements would increase costs for physicians, hospitals, nursing homes, labs and other testing centers. Thus, an adverse impact is indicated.

Small Businesses[16] Affected.[17] To the extent that some of the affected laboratories or nursing homes may be small businesses, the proposed amendments would appear to adversely affect small businesses.

Types and Estimated Number of Small Businesses Affected. The number of small businesses impacted by the proposed amendments is unknown. Some of the affected laboratories or nursing homes may be small businesses and some small businesses (not necessarily connected to health care) may have acquired CLIA Waivers to offer on-site testing for employees or clients. To the extent that offering testing improves employee or client satisfaction for the latter category of small businesses, their costs may be offset by other gains.

Costs and Other Effects. The proposed amendments increase reporting requirements, which requires staff time. An adverse economic impact[18] on laboratories, including entities with CLIA Waivers is indicated because there do not appear to be any offsetting direct benefits to these small businesses.

Alternative Method that Minimizes Adverse Impact. There are no clear alternative methods that both reduce adverse impact and meet federal requirements and the intended policy goals.

Localities[19] Affected.[20] The proposed amendments potentially affect all 132 localities, but localities with greater COVID-19 prevalence may have higher rates of testing; thus, physicians, hospitals, nursing homes, and labs in those localities would be disproportionately affected. The proposed amendments do not introduce costs for local governments. Accordingly, no additional funds would be required. Consequently, no adverse economic impact[21] is indicated for any particular locality.

Projected Impact on Employment. The proposed amendments do not appear to affect total employment directly. Some hospitals, nursing homes, or labs may have hired additional temporary staff in order to meet the reporting requirements.

Effects on the Use and Value of Private Property. The proposed new reporting requirements for private hospitals, nursing homes, and laboratories, including entities with CLIA waivers moderately increase their costs. However, given the role played by such organizations in responding to the COVID-19 pandemic and the public health benefits of the data collected, it would be unlikely to reduce the value of these firms. Some laboratories may have expanded the scale of their operations and become more valuable if they were able to hire personnel and use technology to more efficiently meet the reporting requirements while also performing more tests. The proposed amendments do not affect real estate development costs.

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[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]See https://townhall.virginia.gov/l/ViewStage.cfm?stageid=9040 for the Emergency/NOIRA stage, which became effective on January 20, 2021 and expires on July 19, 2022.

[3]See https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf, Sec. 18115(a). The Act became effective March 27, 2020.

[4]See https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx. As of this writing, there is no indication as to when the emergency declaration will stop being renewed.

[5]See https://www.cdc.gov/coronavirus/2019-ncov/lab/reporting-lab-data.html.

[6]See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/cliabrochure.pdf. Anyone who performs testing of human specimens for the diagnosis, prevention or treatment of disease or health problems must apply for a CLIA certificate. This includes physicians who operate their own in-office laboratories and medical care facilities. There are 4 types of CLIA certificates: Certificate of Waiver, Provider Performed Microscopy, Compliance, and Accreditation. CLIA Certificate of Waiver holders may now include various entities that have started conducting some types of COVID tests, such as school districts, employers, sports teams, etc. Thus, "labs" and "directors of laboratories" are broad classifications in the context of CARES Act reporting requirements and this regulation.

[7]See https://townhall.virginia.gov/l/ViewStage.cfm?stageid=9040. Although the emergency regulation became effective January 20, 2021, VDH reported that they had begun collecting COVID-19 data in March 2020, as required by the CARES Act. The emergency regulation expires on July 19, 2022.

[8]Details regarding data elements appear in a new section 80-90 I., titled COVID-19 (SARS-CoV-2), to specify that they are only required for COVID-19. VDH has clarified that physicians would not be required to report patients' other diagnosed or suspected health conditions, nor be required to submit information on any lab tests that are not COVID-19 tests.

[9]The proposed amendments include hyperlinks to these online portals. The emergency language requires physicians and directors of medical care facilities to report hospitalizations and intensive care unit admissions through the Emergency Department Care Coordination program. That requirement would be removed at this stage. Separately, VDH also created a point-of-care reporting portal in September 2020 due to the high volume of point-of-care tests that were being conducted for COVID-19 to make reporting easier. (https://apps.vdh.virginia.gov/pocreporting/login/login.aspx)

[10]This deviates from the emergency stage, which allowed the use of paper Epi-1 forms or the laboratory's own forms if it contained the required information, and computer generated reports containing the required information.

[11]The Economic Impact Analysis compares the proposed regulation to the regulation in the Virginia Administrative Code. The emergency regulation is: 1) not in the Virginia Administrative Code (see http://law.lis.virginia.gov/admincode) and 2) temporary. Thus, the Economic Impact Analysis assesses the impact of changing the permanent regulations. Consequently, to the extent that the proposed text matches the emergency text, some of the benefits and costs described here have likely already accrued.

[12]See https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf from https://www.hhs.gov/coronavirus/testing/covid-19-diagnostic-data-reporting/index.html. The list of data fields on pages 2-4 contains all the data fields required by VDH in the proposed text, except the patient's email address. Individuals may choose not to disclose biographical or contact information when getting tested. Although testing sites are required to make every effort to collect this information, if individuals choose not to disclose certain information the testing site would still be able to submit incomplete records to VDH.

[13]Agency Background Document, page 5: https://townhall.virginia.gov/l/GetFile.cfm?File=58\5581\9399\AgencyStatement_VDH_9399_v1.pdf.

[14]VDH reported that in federal fiscal years 2020 and 2021, 1,429 new CLIA Certificates of Waiver were created for testing entities in Virginia. Not all of these were testing for COVID-19, but a large majority were. Further, there is no federal requirement for facilities with CLIA certificates to notify VDH or CLIA if they have added a test as long as the test of the same complexity and specialty of their certificate; thus all 7,791 entities with current certificates may be affected.

[15]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[16]Pursuant to § 2.2-4007.04, 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."

[17]If the proposed regulatory action may have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to Code § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[18]Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined.

[19]"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.

[20]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

[21]Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined.

Agency's Response to Economic Impact Analysis: The Virginia Department of Health (VDH) agrees with the findings of the economic impact analysis (EIA), with two caveats.

The EIA prepared by the Department of Planning and Budget for the proposed stage amendment to the Disease Reporting and Control Regulations, (12VAC5-90) states that "the Board proposes to remove the requirement to report negative COVID-19 tests." This statement is true; however, VDH would like to clarify that this continues to be a federal reporting requirement in the CARES Act and all laboratories, including those with Clinical Laboratory Improvement Amendments waivers, will be required to continue reporting negative COVID-19 test results until the federal requirement is removed

Further, the EIA indicates that an "indirect cost of the proposed amendments, therefore, relates to individuals" data privacy and the risk that one's personal biographical details, contact details, and health information may be accessed by unauthorized persons or entities and/or used for nefarious purpose." Data reported to VDH related to this action are required to be kept confidential per §§ 32.1-36, 32.-38, and 32.1-41of the Code of Virginia. Further, all of VDH's data systems are compliant with Commonwealth of Virginia security standards. With these controls in place, risk addressed here is extremely minimal.

Summary:

The proposed amendments add to the reporting requirements for physicians and directors of medical care facilities for COVID-19 to (i) require physicians and directors of medical care facilities to report suspected or

confirmed COVID-19 cases and COVID-19 hospitalizations and intensive care unit admissions to the Virginia Department of Health (VDH) through participation in the Emergency Department Care Coordination Program; (ii) require all suspected or confirmed COVID-19 case report forms be submitted electronically to VDH; (iii) clarify that the category "laboratory directors" includes pharmacies that hold Clinical Laboratory Improvement Amendments Certificates of Waiver so that pharmacies testing for COVID-19 are required to report to VDH; (iv) require laboratory directors report both positive and negative COVID-19 test results; (v) require patient telephone number, email address, and ethnicity be included in the list of fields that are reported by physicians, laboratory directors, and directors of medical care facilities; and (vi) add "coronavirus, severe" to the list of infectious diseases that shall be reported to persons practicing funeral services.

12VAC5-90-80. Lists of diseases that shall be reported.

A. Reportable disease list. The board declares suspected or confirmed cases of the following named diseases, toxic effects, and conditions to be reportable by the persons enumerated in 12VAC5-90-90. Conditions identified by an asterisk (*) require immediate communication to the local health department by the most rapid means available upon suspicion or confirmation, as defined in subsection C of this section. Other conditions should be reported within three days of suspected or confirmed diagnosis, unless otherwise specified in this section. Neonatal Abstinence Syndrome shall be reported as specified in subsection E of this section. COVID-19 (SARS-CoV-2) shall be reported as specified in subsection I of the section.

Amebiasis (Entamoeba histolytica)

*Anthrax (Bacillus anthracis)

Arboviral infections (e.g., CHIK, dengue, EEE, LAC, SLE, WNV, Zika)

Babesiosis (Babesia spp.)

*Botulism (Clostridium botulinum)

*Brucellosis (Brucella spp.)

Campylobacteriosis (Campylobacter spp.)

Candida auris, infection or colonization

Carbapenemase-producing organism, infection or colonization

Chancroid (Haemophilus ducreyi)

Chickenpox (Varicella virus)

Chlamydia trachomatis infection

*Cholera (Vibrio cholerae O1 or O139)

*Coronavirus infection, severe

Cryptosporidiosis (Cryptosporidium spp.)

Cyclosporiasis (Cyclospora spp.)

*Diphtheria (Corynebacterium diphtheriae)

*Disease caused by an agent that may have been used as a weapon

Ehrlichiosis/Anaplasmosis (Ehrlichia spp., Anaplasma phagocytophilum)

Giardiasis (Giardia spp.)

Gonorrhea (Neisseria gonorrhoeae)

Granuloma inguinale (Calymmatobacterium granulomatis)

*Haemophilus influenzae infection, invasive

Hantavirus pulmonary syndrome

Hemolytic uremic syndrome (HUS)

*Hepatitis A

Hepatitis B (acute and chronic)

Hepatitis C (acute and chronic)

Hepatitis, other acute viral

Human immunodeficiency virus (HIV) infection

Influenza, confirmed

*Influenza-associated deaths if younger than 18 years of age

Lead, blood levels

Legionellosis (Legionella spp.)

Leprosy (Hansen's disease) (Mycobacterium leprae)

Leptospirosis (Leptospira interrogans)

Listeriosis (Listeria monocytogenes)

Lyme disease (Borrelia spp.)

Lymphogranuloma venereum (Chlamydia trachomatis)

Malaria (Plasmodium spp.)

*Measles (Rubeola)

*Meningococcal disease (Neisseria meningitidis)

Mumps

Neonatal abstinence syndrome (NAS)

Ophthalmia neonatorum

*Outbreaks, all (including foodborne, health care-associated, occupational, toxic substance-related, waterborne, and any other outbreak)

*Pertussis (Bordetella pertussis)

*Plague (Yersinia pestis)

*Poliovirus infection, including poliomyelitis

*Psittacosis (Chlamydophila psittaci)

*Q fever (Coxiella burnetii)

*Rabies, human and animal

Rabies treatment, post-exposure

*Rubella, including congenital rubella syndrome

Salmonellosis (Salmonella spp.)

Shiga toxin-producing Escherichia coli infection

Shigellosis (Shigella spp.)

*Smallpox (Variola virus)

Spotted fever rickettsiosis (Rickettsia spp.)

Streptococcal disease, Group A, invasive or toxic shock

Streptococcus pneumoniae infection, invasive if younger than five years of age

Syphilis (Treponema pallidum) report *congenital, *primary, *secondary, and other

Tetanus (Clostridium tetani)

Toxic substance-related illness

Trichinosis (Trichinellosis) (Trichinella spiralis)

*Tuberculosis, active disease (Mycobacterium tuberculosis complex)

Tuberculosis infection

*Tularemia (Francisella tularensis)

*Typhoid/Paratyphoid infection (Salmonella Typhi, Salmonella Paratyphi)

*Unusual occurrence of disease of public health concern

*Vaccinia, disease or adverse event

Vancomycin-intermediate or vancomycin-resistant Staphylococcus aureus infection

*Vibriosis (Vibrio spp.)

*Viral hemorrhagic fever

*Yellow fever

Yersiniosis (Yersinia spp.)

B. Conditions reportable by directors of laboratories. Laboratories shall report all test results indicative of and specific for the diseases, infections, microorganisms, conditions, and toxic effects specified in this subsection for humans. Such tests include microbiological culture, isolation, or identification; assays for specific antibodies; and identification of specific antigens, toxins, or nucleic acid sequences. Additional condition-specific requirements are noted in this subsection and subsection D of this section. Conditions identified by an asterisk (*) require immediate communication to the local health department by the most rapid means available upon suspicion or confirmation, as defined in subsection C of this section. Other conditions should be reported within three days of suspected or confirmed diagnosis.

Amebiasis (Entamoeba histolytica)

*Anthrax (Bacillus anthracis)

Arboviral infection, for example, CHIK, dengue, EEE, LAC, SLE, WNV, or Zika

Babesiosis (Babesia spp.)

*Botulism (Clostridium botulinum)

*Brucellosis (Brucella spp.)

Campylobacteriosis (Campylobacter spp.)

Candida auris - Include available antimicrobial susceptibility findings in report.

Carbapenemase-producing organism - Include available antimicrobial susceptibility findings in report.

Chancroid (Haemophilus ducreyi)

Chickenpox (Varicella virus)

Chlamydia trachomatis infection

*Cholera (Vibrio cholerae O1 or O139)

*Coronavirus infection, severe (e.g., SARS-CoV, MERS-CoV)

Cryptosporidiosis (Cryptosporidium spp.)

Cyclosporiasis (Cyclospora spp.)

*Diphtheria (Corynebacterium diphtheriae)

Ehrlichiosis/Anaplasmosis (Ehrlichia spp., Anaplasma phagocytophilum)

Giardiasis (Giardia spp.)

Gonorrhea (Neisseria gonorrhoeae) - Include available antimicrobial susceptibility findings in report.

*Haemophilus influenzae infection, invasive

Hantavirus pulmonary syndrome

*Hepatitis A

Hepatitis B (acute and chronic) - For All hepatitis B patients, also report available results of serum alanine aminotransferase (ALT) and all available results from the hepatitis panel.

Hepatitis C (acute and chronic) - For all patients with any positive HCV test, also report all results of HCV viral load tests, including undetectable viral loads and report available results of serum alanine aminotransferase (ALT) and all available results from the hepatitis panel.

Hepatitis, other acute viral - Any finding indicative of acute infection with hepatitis D, E, or other cause of viral hepatitis. For any reportable hepatitis finding, submit all available results from the hepatitis panel.

Human immunodeficiency virus (HIV) infection - For HIV-infected patients, report all results of CD4 and HIV viral load tests, including undetectable viral loads. For HIV-infected patients, report all HIV genetic nucleotide sequence data associated with HIV drug resistance tests by electronic submission. For children younger than three years of age, report all tests regardless of the test findings (e.g., negative or positive).

Influenza, confirmed - By culture, antigen detection by direct fluorescent antibody (DFA), or nucleic acid detection.

Lead, blood levels - All lead results from tests of venous or capillary blood performed by a laboratory certified by the Centers for Medicare and Medicaid Services in accordance with 42 USC § 263a, the Clinical Laboratory Improvement Amendment of 1988 (CLIA-certified).

Legionellosis (Legionella spp.)

Leptospirosis (Leptospira interrogans)

Listeriosis (Listeria monocytogenes), invasive or if associated with miscarriage or stillbirth from placental or fetal tissue

Lyme disease (Borrelia spp.)

Malaria (Plasmodium spp.)

*Measles (Rubeola)

*Meningococcal disease (Neisseria meningitidis), invasive - Include identification of gram-negative diplococci.

Mumps

*Mycobacterial diseases - (See 12VAC5-90-225 B) Report any of the following:

1. Acid fast bacilli;
2. M. tuberculosis complex or any other mycobacteria;
3. Antimicrobial susceptibility results for M. tuberculosis complex.

*Pertussis (Bordetella pertussis)

*Plague (Yersinia pestis)

*Poliovirus infection

*Psittacosis (Chlamydophila psittaci)

*Q fever (Coxiella burnetii)

*Rabies, human and animal

*Rubella

Salmonellosis (Salmonella spp.)

Shiga toxin-producing Escherichia coli infection

Shigellosis (Shigella spp.)

*Smallpox (Variola virus)

Spotted fever rickettsiosis (Rickettsia spp.)

Streptococcal disease, Group A, invasive or toxic shock

Streptococcus pneumoniae infection, invasive if younger than five years of age

*Syphilis (Treponema pallidum)

Toxic substance-related illness - By blood or urine laboratory findings above the normal range, including heavy metals, pesticides, and industrial-type solvents and gases. When applicable and available, report speciation of metals when blood or urine levels are elevated in order to differentiate the chemical species (elemental, organic, or inorganic).

Trichinosis (Trichinellosis) (Trichinella spiralis)

Tuberculosis infection

*Tularemia (Francisella tularensis)

*Typhoid/Paratyphoid infection (Salmonella Typhi, Salmonella Paratyphi A, Salmonella Paratyphi B, Salmonella Paratyphi C)

*Vaccinia, disease or adverse event

Vancomycin-intermediate or vancomycin-resistant Staphylococcus aureus infection - Include available antimicrobial susceptibility findings in report.

*Vibriosis (Vibrio spp., Photobacterium damselae, Grimontia hollisae), other than toxigenic Vibrio cholera O1 or O139, which are reportable as cholera

*Viral hemorrhagic fever

*Yellow fever

Yersiniosis (Yersinia spp.)

C. Reportable diseases requiring rapid communication. Certain of the diseases in the list of reportable diseases because of their extremely contagious nature, potential for greater harm, or availability of a specific intervention that must be administered in a timely manner require immediate identification and control. Reporting of persons confirmed or suspected of having these diseases, listed in this subsection, shall be made immediately by the most rapid means available, preferably by telephone to the local health department. (These

same diseases are also identified by an asterisk (*) in subsections A and B, where applicable, of this section.)

Anthrax (Bacillus anthracis)

Botulism (Clostridium botulinum)

Brucellosis (Brucella spp.)

Cholera (Vibrio cholerae O1 or O139)

Coronavirus infection, severe

Diphtheria (Corynebacterium diphtheriae)

Disease caused by an agent that may have been used as a weapon

Haemophilus influenzae infection, invasive

Hepatitis A

Influenza-associated deaths if younger than 18 years of age

Influenza A, novel virus

Measles (Rubeola virus)

Meningococcal disease (Neisseria meningitidis)

Outbreaks, all

Pertussis (Bordetella pertussis)

Plague (Yersinia pestis)

Poliovirus infection, including poliomyelitis

Psittacosis (Chlamydophila psittaci)

Q fever (Coxiella burnetii)

Rabies, human and animal

Rubella, including congenital rubella syndrome

Smallpox (Variola virus)

Syphilis, congenital, primary, and secondary (Treponema pallidum)

Tuberculosis, active disease (Mycobacterium tuberculosis complex)

Tularemia (Francisella tularensis)

Typhoid/Paratyphoid infection (Salmonella Typhi, Salmonella Paratyphi (all types))

Unusual occurrence of disease of public health concern

Vaccinia, disease or adverse event

Vibriosis (Vibrio spp., Photobacterium damselae, Grimontia hollisae), other than toxigenic Vibrio cholerae O1 or O139, which are reportable as cholera

Viral hemorrhagic fever

Yellow fever

D. Submission of initial isolate or other specimen for further public health testing. A laboratory identifying evidence of any of the conditions in this subsection shall notify the local health department of the positive culture or other positive test result within the timeframes specified in subsection B of this section and submit the initial isolate (preferred) or other initial specimen to the Division of Consolidated Laboratory Services or other public health laboratory where specified in this subsection within seven days of identification. All specimens must be identified with the patient and physician information required in 12VAC5-90-90 B.

Anthrax (Bacillus anthracis)

Botulism (Clostridium botulinum)

Brucellosis (Brucella sp.)

Candida auris

Candida haemulonii

Carbapenem-resistant Enterobacteriaceae

Carbapenem-resistant Pseudomonas aeruginosa

Cholera (Vibrio cholerae O1 or O139)

Coronavirus infection, severe (e.g., SARS-CoV, MERS-CoV)

Diphtheria (Corynebacterium diphtheriae)

Haemophilus influenzae infection, invasive

Influenza, unsubtypeable

Listeriosis (Listeria monocytogenes)

Meningococcal disease (Neisseria meningitidis)

Plague (Yersinia pestis)

Poliovirus infection

Q fever (Coxiella burnetii)

Salmonellosis (Salmonella spp.)

Shiga toxin-producing E. coli infection (Laboratories that identify a Shiga toxin but do not perform simultaneous culture for Shiga toxin-producing E. coli should forward all positive stool specimens or positive enrichment broths to the Division of Consolidated Laboratory Services for confirmation and further characterization.)

Shigellosis (Shigella spp.)

Streptococcal disease, Group A, invasive

Tuberculosis (A laboratory identifying Mycobacterium tuberculosis complex (see 12VAC5-90-225) shall submit a representative and viable sample of the initial culture to the Division of Consolidated Laboratory Services or other laboratory designated by the board to receive such specimen.)

Tularemia (Francisella tularensis)

Typhoid/Paratyphoid infection (Salmonella Typhi, Salmonella Paratyphi (all types))

Vancomycin-intermediate or vancomycin-resistant Staphylococcus aureus infection

Vibriosis (Vibrio spp., Photobacterium damselae, Grimontia hollisae)

Yersiniosis (Yersinia spp.)

Other diseases as may be requested by the health department.

E. Neonatal abstinence syndrome. Neonatal abstinence syndrome shall be reported by physicians and directors of medical care facilities when a newborn has been diagnosed with neonatal abstinence syndrome, a condition characterized by clinical signs of withdrawal from exposure to prescribed or illicit drugs. Reports shall be submitted within one month of diagnosis by entering the information into the Department of Health's online Confidential Morbidity Report portal (http://www.vdh.virginia.gov/clinicians).

F. Outbreaks. The occurrence of outbreaks or clusters of any illness that may represent a group expression of an illness that may be of public health concern shall be reported to the local health department immediately by the most rapid means available, preferably by telephone.

G. Toxic substance-related illnesses. All toxic substance-related illnesses, including pesticide and heavy metal poisoning or illness resulting from exposure to an occupational dust or fiber or radioactive substance, shall be reported.

If such illness is verified or suspected and presents an emergency or a serious threat to public health or safety, the report of such illness shall be made immediately by the most rapid means available, preferably by telephone.

H. Unusual occurrence of disease of public health concern. Unusual or emerging conditions of public health concern shall be reported to the local health department immediately by the most rapid means available, preferably by telephone. In addition, the commissioner or the commissioner's designee may establish surveillance systems for diseases or conditions that are not on the list of reportable diseases. Such surveillance may be established to identify cases (delineate the magnitude of the situation), to identify the mode of transmission and risk factors for the disease, and to identify and implement appropriate action to protect public health. Any person reporting information at the request of the department for special surveillance or other epidemiological studies shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

I. COVID-19 (SARS-CoV-2). COVID-19 shall be reported by physicians and directors of medical care facilities when a person who is infected with or who is suspected of having COVID-19 is treated or examined, hospitalized, or admitted into the intensive care unit. Physicians and directors of medical care facilities shall report that person's name, telephone number, email address, address, age, date of birth, race, ethnicity, sex, and pregnancy status; name of disease diagnosed or suspected; the medical record number (if applicable); the date of onset of illness; available laboratory tests and results; and the name, address, and telephone number of the physician and medical facility where the examination was made. Case reports shall be submitted immediately or within 24 hours by entering the information into the Department of Health online Confidential Morbidity Report portal at http://www.vdh.virginia.gov/clinicians or via electronic case reporting (https://www.vdh.virginia.gov/meaningful-use/meaningful-use-submissions-of-electronic-case-reports/).

Positive SARS-CoV-2 tests shall be reported by directors of laboratories, including other entities that hold Clinical Laboratory Improvement Amendments Certificates of Waiver. Each report shall give the source of the specimen and the laboratory method and result; the name, telephone number, email address, address, age, date of birth, race, ethnicity, sex, and pregnancy status (if known) of the person from whom the specimen was obtained; and the name, address, and telephone number of the physician at whose request and medical facility at which the examination was made. Reports shall be submitted immediately or within 24 hours to the department. Reports shall be made by entering information into the department's available portal for laboratory reporting at http://www.vdh.virginia.gov/clinicians or via electronic laboratory reporting at http://www.vdh.virginia.gov/meaningful-use/submissionofreportablelabresults.

12VAC5-90-90. Those required to report.

A. Physicians. Each physician who treats or examines any person who is suffering from or who is suspected of having a reportable disease or condition shall report that person's name, address, age, date of birth, race, sex, and pregnancy status for females; name of disease diagnosed or suspected; the date of onset of illness; available laboratory tests and results; and the name, address, and telephone number of the physician and medical facility where the examination was made, except that influenza should be reported by number of cases only (and type of influenza, if available). Reports are to be made to the local health department serving the jurisdiction where the physician practices. A physician may designate someone to report on his behalf, but the physician remains responsible for ensuring that the appropriate report is made. Any physician, designee, or organization making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

Such reports shall be made on a Form Epi-1, a computer generated printout containing the data items requested on Form Epi-1, or a CDC or VDH surveillance form that provides the

same information and shall be made within three days of the suspicion or confirmation of disease except that those identified in 12VAC5-90-80 C shall be reported immediately by the most rapid means available, preferably by telephone, to the local health department serving the jurisdiction in which the facility is located. Reporting may be done by means of secure electronic transmission upon agreement of the physician and the department.

Additional elements are required to be reported for individuals with confirmed or suspected active tuberculosis disease. Refer to Part X (12VAC5-90-225 et seq.) for details on these requirements.

B. Directors of laboratories. Laboratory directors shall report any laboratory examination of any clinical specimen, whether performed in-house or referred to an out-of-state laboratory, which yields evidence, by the laboratory ~~method(s)~~ method indicated or any other confirmatory test, of a disease listed in 12VAC5-90-80 B.

Each report shall give the source of the specimen and the laboratory method and result; the name, address, age, date of birth, race, sex, and pregnancy status for females (if known) of the person from whom the specimen was obtained; and the name, address, and telephone number of the physician at whose request and medical facility at which the examination was made. When the influenza virus is isolated, the type should be reported, if available. Reports shall be made within three days of identification of evidence of disease, except that those identified in 12VAC5-90-80 C shall be reported immediately by the most rapid means available, preferably by telephone, to the local health department serving the jurisdiction in which the laboratory is located. Reports shall be made on Form Epi-1 or on the laboratory's own form if it includes the required information. Computer generated reports containing the required information may be submitted. Reporting may be done by means of secure electronic transmission upon agreement of the laboratory director and the department. Reports of HIV genetic nucleotide sequence data associated with HIV drug resistance tests must be submitted electronically. Any person making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

A laboratory identifying evidence of any of the following conditions shall notify the local health department of the positive culture or other positive test result within the timeframes specified in 12VAC5-90-80 and submit the initial isolate or other initial specimen to the Division of Consolidated Laboratory Services within seven days of identification. All specimens must be identified with the patient and physician information required in this subsection.

Anthrax

Botulism

Brucellosis

Cholera

Diphtheria

E. coli infection, Shiga toxin-producing. (Laboratories that use a Shiga toxin EIA methodology but do not perform simultaneous culture for Shiga toxin-producing E. coli should forward all positive stool specimens or positive enrichment broths to the Division of Consolidated Laboratory Services for confirmation and further characterization.)

Haemophilus influenzae infection, invasive

Influenza A, novel virus

Listeriosis

Meningococcal disease

Pertussis

Plague

Poliovirus infection

Q fever

Salmonellosis

Shigellosis

Streptococcal disease, Group A, invasive

Tuberculosis (A laboratory identifying Mycobacterium tuberculosis complex (see 12VAC5-90-225) shall submit a representative and viable sample of the initial culture to the Division of Consolidated Laboratory Services or other laboratory designated by the board to receive such specimen.)

Tularemia

Typhoid/Paratyphoid fever

Vancomycin-intermediate or vancomycin-resistant Staphylococcus aureus infection

Vibrio infection, including infections due to Photobacterium damselae and Grimontia hollisae

Yersiniosis

Other diseases as may be requested by the health department

When a clinical specimen yields evidence indicating the presence of a select agent or toxin as defined by federal regulations in 42 CFR Part 73, the person in charge of the laboratory shall contact the Division of Consolidated Laboratory Services and arrange to forward an isolate for confirmation. If a select agent or toxin has been confirmed in a clinical specimen, the laboratory director shall consult with Division of Consolidated Laboratory Services or CDC regarding isolate transport or destruction.

Laboratories operating within a medical care facility shall be considered to be in compliance with the requirement to notify the local health department when the director of that medical care facility assumes the reporting responsibility; however, laboratories are still required to submit isolates to the Division of Consolidated Laboratory Services or other designated laboratory as noted in this subsection.

C. Persons in charge of a medical care facility. Any person in charge of a medical care facility shall make a report to the local health department serving the jurisdiction where the facility is located of the occurrence in or admission to the facility of a patient with a reportable disease listed in 12VAC5-90-80 A unless he has evidence that the occurrence has been reported by a physician. Any person making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia. The requirement to report shall include all inpatient, outpatient, and emergency care departments within the medical care facility. Such report shall contain the patient's name, address, age, date of birth, race, sex, and pregnancy status for females; name of disease being reported; available laboratory tests and results; the date of admission; ~~hospital chart~~ medical record number; date expired (when applicable); and attending physician. Influenza should be reported by number of cases only (and type of influenza, if available). Reports shall be made within three days of the suspicion or confirmation of disease except that those identified in 12VAC5-90-80 C shall be reported immediately by the most rapid means available, preferably by telephone, to the local health department serving the jurisdiction in which the facility is located. Reports shall be made on Form Epi-1, a computer generated printout containing the data items requested on Form Epi-1, or a CDC or VDH surveillance form that provides the same information. Reporting may be done by means of secure electronic transmission upon agreement of the medical care facility and the department.

A person in charge of a medical care facility may assume the reporting responsibility on behalf of the director of the laboratory operating within the facility.

D. Persons in charge of a residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, or a school, child care center, or summer camp. Any person in charge of a residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, or a school, child care center, or summer camp as defined in § 35.1-1 of the Code of Virginia shall report immediately to the local health department the presence or suspected presence in his program, service, facility, school, child care center, or summer camp of persons who have common symptoms suggesting an outbreak situation. Such persons may report additional information, including identifying and contact information for individuals with communicable diseases of public health concern or individuals who are involved in outbreaks that occur in their facilities, as necessary to facilitate public health investigation and disease control. Any person so reporting shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

E. Local health directors. The local health director shall forward any report of a disease or report of evidence of a disease which has been made on a resident of his jurisdiction to the Office of Epidemiology within three days of receipt. This report shall be submitted immediately by the most rapid means available if the disease is one requiring rapid communication, as required in 12VAC5-90-80 C. All such rapid reporting shall be confirmed in writing and submitted to the Office of Epidemiology, by either a paper report or entry into a shared secure electronic disease surveillance system, within three days. Furthermore, the local health director shall immediately forward to the appropriate local health director any disease reports on individuals residing in the latter's jurisdiction or to the Office of Epidemiology on individuals residing outside Virginia. The Office of Epidemiology shall be responsible for notifying other state health departments of reported illnesses in their residents and for notifying CDC as necessary and appropriate.

F. Persons in charge of hospitals, nursing facilities or nursing homes, assisted living facilities, and correctional facilities. In accordance with § 32.1-37.1 of the Code of Virginia, any person in charge of a hospital, nursing facility or nursing home, assisted living facility, or correctional facility shall, at the time of transferring custody of any dead body to any person practicing funeral services, notify the person practicing funeral services or his agent if the dead person was known to have had, immediately prior to death, an infectious disease which may be transmitted through exposure to any bodily fluids. These include any of the following infectious diseases:

Coronavirus, severe

Creutzfeldt-Jakob disease

Human immunodeficiency virus infection

Hepatitis B

Hepatitis C

Rabies

Smallpox

Syphilis, infectious

Tuberculosis, active disease

Vaccinia, disease or adverse event

Viral hemorrhagic fever

G. Employees, conditional employees, and persons in charge of food establishments. 12VAC5-421-80 of the Food Regulations requires a food employee or conditional employee to notify the person in charge of the food establishment when diagnosed with certain diseases that are transmissible through food and requires the person in charge of the food

establishment to notify the regulatory authority. Refer to 12VAC5-421-80 for further guidance and clarification regarding these reporting requirements.

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DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Fast-Track Regulation

Titles of Regulations: **12VAC30-10. State Plan under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (amending 12VAC30-10-10, 12VAC30-10-410; repealing 12VAC30-10-20).**

12VAC30-20. Administration of Medical Assistance Services (amending 12VAC30-20-205, 12VAC30-20-210).

12VAC30-30. Groups Covered and Agencies Responsible for Eligibility Determination (amending 12VAC30-30-10).

12VAC30-40. Eligibility Conditions and Requirements (adding 12VAC30-40-348).

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

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: March 2, 2022.

Effective Date: March 17, 2022.

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: This regulation is essential to protect the health, safety, and welfare of citizens in that it implements the General Assembly mandate to expand Medicaid coverage to new populations.

Rationale for Using Fast-Track Rulemaking Process: This regulatory package is expected to be noncontroversial because it describes changes that were approved by the Centers for Medicare and Medicaid Services (CMS) that went into effect on January 1, 2019. As of August 23, 2019, over 312,000 individuals had enrolled in Medicaid expansion, and no formal or informal complaints or comments had been received about these changes from any Medicaid member, Medicaid provider, or member of the public.

Substance: This regulatory action seeks to combine several of the expansion-related state plan amendments that were required by CMS into one regulatory package. The changes related to the expansion of Medicaid to the adult group are contained in 12VAC30-30-10. These changes amend mandatory eligibility categories to include adults with incomes below 138% of the federal poverty level.

The changes related to the Health Insurance Premium Payment (HIPP) and HIPP for Kids programs are in 12VAC30-20-205 and 12VAC30-20-210. The changes related to the HIPP program in 12VAC30-20-210 include (i) adding text related to the cost-effectiveness methodology; (ii) clarifying recipient eligibility criteria, application criteria, effective dates, termination dates, and rules for non-Medicaid eligible family members; and (iii) adding text relating to the cost-sharing wrap and provider participation and enrollment. The changes to the HIPP for Kids program in 12VAC30-20-2015 include adding text related to (i) the cost-effectiveness methodology, (ii) the cost-sharing wrap, and (iii) provider participation or enrollment. These changes update both the HIPP and the HIPP for Kids programs to meet CMS requirements.

The changes related to the federal medical assistance percentage are in a new section, 12VAC30-40-348. This section describes the methodology used by DMAS to determine the increased federal medical assistance percentage (FMAP) rates associated with new enrollees in the expansion population.

The changes related to the change from an assessment state to a determination state are in 12VAC30-10-10, 12VAC30-10-20, and 12VAC30-10-410. These changes delegate DMAS authority to make eligibility determinations to the federally facilitated marketplace. (Under an assessment state, these eligibility determinations came to DMAS for verification; that will no longer be the case.) In addition, the changes delegate eligibility hearings that arise out of marketplace determinations to the U.S. Department of Health and Human Services appeals entity.

The emergency regulation included changes related to the expedited enrollment of Supplemental Nutrition Assistance Program (SNAP) recipients on a one-time basis for purposes of increasing enrollment in Medicaid expansion. This one-time enrollment has already occurred and will not occur again in the future without additional approval from CMS. Therefore, the text relating to the use of SNAP income was not included in this action replacing the emergency regulation with permanent regulations.

Issues: The primary advantage of this regulatory action to the public and the Commonwealth is that additional individuals will have access to comprehensive health insurance, which should help improve health measures and outcomes across the Commonwealth. There are no disadvantages to the agency or the public.

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), on behalf of the Board of Medical Assistance Services, proposes to promulgate a permanent regulation to replace an emergency regulation that went into effect on September 19, 2019. As with the emergency regulation, the permanent regulation would incorporate the changes that were made to the Virginia State Plan in order to implement the Medicaid expansion that became effective on January 1, 2019.

Background. The proposed regulation is part of the overall implementation process for Medicaid expansion in accordance with several legislative mandates: the 2018 Acts of Assembly, Chapter 2, Item 303.SS.4(a)(1); the 2019 Acts of Assembly, Chapter 854, Item 303.SS.4(a)(1); the 2020 Acts of Assembly, Chapter 1289, Item 313.QQ.3(a)(1); and the 2021 Special Session 1 Acts of Assembly, Chapter 552, Item 313.QQ.3(a)(1). These mandates direct DMAS to "amend the State Plan for Medical Assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act."

The State Plan Amendments have already been made and approved by the federal Centers for Medicare and Medicaid Services, and emergency regulations were subsequently adopted. This action permanently replaces several key elements of the regulation that effectuated the expansion. More specifically, the regulatory provisions being permanently adopted by this action include: incorporation of the new adult eligibility group as a group eligible for Medicaid coverage; incorporation of expansion-related changes to the federal medical assistance percentage; incorporation of the federal medical assistance percentage for expenditures associated with new enrollees; and clarification of the language for the Health Insurance Premium Payment (HIPP) program and the HIPP for Kids program.

Estimated Benefits and Costs. According to DMAS, the primary effect of the proposed changes would be consistency between the Medicaid State Plan and the Virginia Administrative Code (VAC). It has long been a practice to amend the regulation to mirror the changes that were previously made to the Medicaid State Plan. In that sense, this regulatory action is a housekeeping measure. Under the General Assembly's multiple directives stated above, the expansion of Medicaid coverage to indigent adults addressed in this regulation has already been in effect for more than two years.

As explained in the economic impact analysis for a separate regulatory action,[1] the Medicaid expansion is completely funded by the provider coverage assessment and the payment rate assessment (both of which are non-state funding sources), plus the corresponding federal match. These funding sources made the coverage of indigent adults possible. According to DMAS, there are 400,000 Virginians estimated to be eligible under Medicaid expansion. More than 327,000 members are enrolled in expansion as of November 1, 2019, and more than 375,000 members have been enrolled at some point since the beginning of the Medicaid expansion.

Although permanently amending the Virginia Administrative Code to reflect what has already been implemented will not create any immediate economic impact, the practice still has value. The legislation has addressed important aspects of expansion in a piecemeal fashion. And though the State Plan stitched these directives together, its purpose is to provide a basis for federal authority. In contrast, the VAC is the basis for the state authority. To the extent that the proposed amendments help serve as a comprehensive repository for the General Assembly's multiple directives regarding expansion, the proposal should benefit Medicaid providers, recipients, and the public in general.

Businesses and Other Entities Affected. The proposed amendments should benefit Medicaid providers, recipients, and the public in general in terms of providing a comprehensive and permanent source for the rules governing expansion population as envisioned by the General Assembly. No adverse economic impact[2] on any entity is indicated.

Small Businesses[3] Affected. The proposed amendments do not adversely affect small businesses.

Localities[4] Affected.[5] The proposed amendments do not introduce costs for local governments.

Projected Impact on Employment. The proposed amendments do not affect total employment.

Effects on the Use and Value of Private Property. No effects on the use and value of private property or real estate development costs is expected.

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[1]https://townhall.virginia.gov/L/GetFile.cfm?File=64\5100\8442\EIA_DMAS_8442_v1.pdf

[2]Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined.

[3]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."

[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.

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:

Chapter 2, Item 303 SS 4 a of the 2018 Acts of Assembly directs the Department of Medical Assistance Services (DMAS) to "...amend the State Plan for Medical Assistance ... to implement coverage for newly eligible individuals..."

The amendments incorporate changes made to the State Plan for Medical Assistance to implement Medicaid expansion, including (i) establishing the adult eligibility group as a group eligible for Medicaid coverage, (ii) updating the Health Insurance Premium Payment (HIPP) program and HIPP for Kids program, (iii) making expansion-related changes to the federal medical assistance percentage, and (iv) updating the federal medical assistance percentage for expenditures associated with new enrollees.

12VAC30-10-10. Designation and authority.

A. The Department of Medical Assistance Services (DMAS) is the single state agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this subsection.)

12VAC30-20-10 is a certification signed by the State Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program.

B. The entire plan under Title XIX is administered or supervised by the state agency named in subsection A of this section.

C. No waivers of the single state agency requirements have ever been granted.

D. ~~Determinations of eligibility for Medicaid under this plan are made by the agency or agencies specified in 12VAC30-30-10. There is a written agreement between the agency named in subsection A of this section and other agencies making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.~~ Eligibility determinations (including any delegations).

1. The entities that conduct determinations of eligibility for families, adults, and individuals younger than 21 years of age are DMAS, the single state agency under Title IV-A (TANF), and the Exchange, which is a government agency established under § 1311(b)(1) or 1321(c)(1) of the Patient Protection and Affordable Care Act (42 USC § 18001).

2. The entities that conduct determinations of eligibility based on age, blindness, and disability are DMAS and the single state agency under Title IV-A (TANF).

3. DMAS makes the following assurances with regard to eligibility determinations:

a. DMAS is responsible for all Medicaid eligibility determinations.

b. There is a written agreement between DMAS, the Exchange, and the single state agency under Title IV-A. The Exchange and the single state agency under Title IV-A have been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

c. DMAS does not delegate authority to make eligibility determinations to entities other than government entities that maintain personnel standards on a merit basis.

d. The delegated entity is capable of performing the delegated functions.

E. All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under Title XI of the Act.

F. All other requirements of 42 CFR 431.10 are met.

12VAC30-10-20. ~~Organization for administration.~~ (Repealed.)

~~A. 12VAC30-20-20 contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.~~

~~B. Within the state agency, the Department of Medical Assistance Services has been designated as the medical assistance unit. 12VAC30-20-30 contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.~~

~~C. 12VAC30-20-40 contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.~~

~~D. Eligibility determinations are made by state or local staff of an agency other than the agency named in 12VAC30-10-10 A.~~

12VAC30-10-410. Hearings for applicants and recipients.

A. The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR 431, Subpart E.

~~No termination of coverage under § 1925 shall be effective earlier than 10 days after the date of mailing of the notice required by § 1925(b)(3)(B).~~ The Medicaid agency is responsible for all Medicaid fair hearings.

B. The entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are the Department of Medical Assistance Services (DMAS) and the Health and Human Services appeals entity within the Exchange.

C. The Commonwealth assures the following with respect to delegations of authority to conduct fair hearings regarding eligibility based on MAGI:

1. There is a written agreement between DMAS and the Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

2. When authority is delegated to the Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their hearing conducted instead by DMAS.

3. DMAS does not delegate authority to conduct fair hearings to entities other than government agencies that maintain personnel standards on a merit basis.

4. The delegated entity is capable of performing the delegated function.

D. All fair hearings not related to an eligibility determination based on MAGI are conducted at DMAS.

12VAC30-20-205. Health Insurance Premium Payment ~~(HIPP)~~ for Kids.

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

"Case" means all family members who are eligible for coverage under the ~~group health plan~~ qualified employer-sponsored insurance plan and who are eligible for Medicaid.

"Code" means the Code of Virginia.

"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.

"DSS" means the Department of Social Services consistent with Chapter 1 (§ 63.2-100 et seq.) of Title 63.2 of the Code of Virginia.

"Family member" means ~~individuals~~ an individual in the household, who is not a parent and who ~~are~~ is related by blood, marriage, ~~or~~ adoption, or legal custody.

"Group health plan" means a plan which meets § 5000(b)(1) of the Internal Revenue Code of 1986 and includes continuation coverage pursuant to Title XXII of the Public Health Service Act (42 USC § 201 et seq.), § 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974 (42 USC § 200I et seq.). Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is a plan, including a self-insured plan, of, or contributed to by, an employer (including a self-insured person) or employee association to provide health care (directly or otherwise) to the employees, former employees, or the families of such employees or former employees, or the employer.

"High deductible health plan" means a plan as defined in § 223(c)(2) of the Internal Revenue Code of 1986, without regard to whether the plan is purchased in conjunction with a health savings account (as defined under § 223(d) of the Internal Revenue Code of 1986).

"HIPP" means the Health Insurance Premium Payment Program administered by DMAS consistent with § 1906 of the ~~Act~~ Social Security Act (42 USC § 301 et seq.) (the Act).

"HIPP for Kids" means the Health Insurance Premium Payment Program administered by DMAS consistent with § 1906A of the Act.

"Member" means a person who is eligible for Medicaid as determined by DMAS~~,~~ or a DMAS designated agent, ~~or~~ including the Department of Social Services.

"Network provider" means a provider who is enrolled with a DMAS contracted managed care organization (MCO) as a provider and meets the requirement for an expedited enrollment as a fee-for-service (FFS) Medicaid provider for payment and billing purposes.

"Parent" means the biological or adoptive parent ~~or parents~~, or the biological or adoptive parent and the stepparent, living in the home with the Medicaid-eligible child. The health insurance policyholder shall be a parent as defined ~~herein~~ in this section.

"Payee" means the insured employee who is the policy holder of the qualified employer-sponsored insurance plan who is paid the HIPP or HIPP for Kids premium and cost-sharing reimbursement.

"Premium" means the fixed cost of participation in the ~~group health plan~~ qualified employer-sponsored insurance plan, which cost may be shared by the employer and employee or paid in full by either party.

"Premium assistance subsidy" means the amount that DMAS will pay of the employee's cost of participating in the qualified employer-sponsored ~~coverage~~ insurance plan to cover the Medicaid eligible member ~~or members under age~~ younger than 19 years of age if DMAS determines it is cost effective to do so.

"Qualified employer-sponsored ~~coverage"~~ insurance" as defined in § 2105(c)(10)(B) of the Social Security Act means a group health plan or health insurance coverage offered through an employer:

1. That qualifies as creditable coverage as a group health plan under § 2701(c)(1) of the Public Health Service Act;

2. For which the employer contribution toward any premium for such coverage is at least 40%; and

3. That is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of ~~paragraph (3)(A)(ii) of § 105(h)~~ § 105(h)(3)(A)(ii) of the Internal Revenue Code of 1986 ~~(but determined~~ without regard to ~~clause (i) of subparagraph (B) of such paragraph)~~ § 105(h)(3)(B)(i).

"State Plan" means the State Plan for Medical Assistance for the Commonwealth of Virginia.

B. Program purpose. The purpose of the HIPP for Kids program shall be to:

1. Enroll members who are eligible for coverage under a qualified employer-sponsored ~~coverage~~ insurance plan.

2. Provide premium assistance subsidy for payment of the employee share of the premiums and other cost-sharing obligations for the ~~Medicaid eligible~~ Medicaid-eligible child ~~under age~~ younger than 19 years of age. In addition, to provide cost sharing for the child's ~~noneligible~~ parent who is not Medicaid eligible for items and services covered under the qualified employer-sponsored ~~coverage~~ insurance that are also covered services under the State Plan. There is no cost sharing for parents for services not covered by the qualified employer-sponsored ~~coverage~~ insurance.

3. Treat coverage under such ~~employer group health plan~~ qualified employer-sponsored insurance plan as a ~~third party~~ third-party liability consistent with § ~~1902(a)(25)~~ 1906 of the Social Security Act.

C. Cost effectiveness methodology.

1. DMAS shall evaluate the member to determine the appropriate managed care organization (MCO) capitation rate to be used. The capitation rate will be determined based on aid category, nursing facility or waiver eligibility, age, gender, and region.

2. DMAS shall adjust the capitation rate to exclude Medicaid services that are not available through commercial group health insurance policies. This requires that the capitation rate be adjusted to exclude services, including nursing facility and long-term services and supports provided in the Commonwealth Coordinated Care (CCC) Plus program as well as community mental health services and nonemergency transportation services available in CCC Plus and Medallion.

3. DMAS shall adjust the reduced capitation rate from subdivision 2 of this subsection to reflect the higher prices employer plans pay. The Virginia price factor shall be based on the national factor of 1.3 that is published by the Centers for Medicare and Medicaid Services.

4. The qualified employer-sponsored insurance plan cost for the member shall be increased to reflect the amount of coinsurance and other member cost sharing typically imposed on HIPP members and paid by DMAS. Such amount shall be determined by averaging the aggregate amount of such expenditures by DMAS in the most recently completed fiscal year by the number of HIPP members covered during the fiscal year.

5. The qualified employer-sponsored insurance plan cost determined in subdivision 4 of this subsection shall be increased to reflect the DMAS administrative expenses directly related to the HIPP program. This additional cost is determined based on the average total monthly compensation paid to each HIPP analyst employed by DMAS and divided by the anticipated caseload.

6. The cost effectiveness shall be affirmed if the adjusted capitation rate from subdivision 3 of this subsection equals or exceeds the adjusted qualified employer-sponsored insurance plan cost from subdivision 5 of this subsection.

D. Member eligibility.

1. DMAS shall obtain specific information on qualified employer-sponsored ~~coverage~~ insurance available to the members in the case including~~, but not limited to,~~ the effective date of coverage, the services covered by the plan, the deductibles and copayments required by the plan, and the amount of the premium paid by the employer and employee. Coverage that is not comprehensive shall be denied premium assistance. A qualified employer-sponsored insurance plan must provide the following services in order to be considered comprehensive:

a. Physician services;

b. Inpatient and outpatient hospitalization;

c. Outpatient labs, shots, and x-rays; and

d. Prescription drugs.

2. All ~~Medicaid eligible~~ Medicaid-eligible family members ~~under the age of~~ younger than 19 years of age who are eligible for coverage under the qualified employer-sponsored ~~coverage~~ insurance shall be eligible for consideration for HIPP for Kids except the following:

~~1.~~ a. The member who is Medicaid eligible due to "spenddown"; or

~~2.~~ b. The member who is currently enrolled in the qualified employer-sponsored ~~coverage~~ insurance and is only retroactively eligible for Medicaid.

~~D.~~ E. Application required. A completed HIPP for Kids application must be submitted to DMAS to be evaluated for program eligibility. The HIPP for Kids application consists of the forms prescribed by DMAS and any necessary information as required by the program to evaluate eligibility and determine if the plan meets the criteria for qualified employer-sponsored ~~coverage~~ insurance.

~~E.~~ F. Exceptions. The term "qualified employer-sponsored ~~coverage"~~ insurance" does not include coverage consisting of:

1. Benefits provided under a health flexible spending arrangement (as defined in § 106(c)(2) of the Internal Revenue Code of 1986) ~~or~~;

2. A high deductible health plan (as defined in § 223(c)(2) of the Internal Revenue Code of 1986), without regard to whether the plan is purchased in conjunction with a health

savings account (as defined under § 223(d) of the Internal Revenue Code of 1986).; or

3. For self-employed individuals, qualified employer-sponsored coverage insurance obtained through self-employment activities shall not meet the program requirements unless the self-employment activities are the family's primary source of income and the insurance meets the requirements of the definition of qualified employer-sponsored coverage insurance in subsection A of this section. Family for this purpose includes family by blood, marriage, or adoption.

F. G. Payments. When DMAS determines that a qualified employer-sponsored coverage insurance plan is eligible and other eligibility requirements have been met, DMAS shall provide for the payment of premium assistance subsidy and other cost-sharing obligations for items and services otherwise covered under the State Plan, except for the nominal cost-sharing amounts permitted under § 1916 of the Social Security Act.

1. Effective date of premium assistance subsidy. Payment of premium assistance subsidies and other cost-sharing obligations shall become effective on the first day of the month in which DMAS receives a complete HIPP application or the first day of the month in following an approved application for which qualified employer-sponsored coverage insurance becomes effective, whichever is later. Payments shall be made to either the employer, the insurance company, or the individual who is carrying the group health plan qualified employer-sponsored insurance plan coverage.

2. Payments for deductibles, coinsurances, and other cost-sharing obligations.

a. Medicaid eligible children under age younger than 19 years of age pursuant to § 1906A of the Act. The Medicaid agency pays all premiums, deductibles, coinsurance, and other cost-sharing obligations for items and services covered under the State Plan, as specified in the qualified employer-sponsored coverage insurance, without regard to limitations specified in § 1916 or § 1916A of the Act, for eligible individuals under age younger than 19 years of age who have access to and elect to enroll in such coverage. The eligible individual is entitled to services covered by the State Plan that are not included in the qualified employer-sponsored coverage insurance.

b. In order to receive reimbursement, the individual shall submit to DMAS an explanation of benefits or similar documentation from the insurance company or doctor's office showing the date of service (DOS), that the expense is the responsibility of the member or parent, that the expense was paid prior to the submission of the request, and sufficient identification codes for the DOS to enable DMAS to determine if the service is reimbursable before applying the remaining cost sharing criteria.

c. Reimbursement for cost sharing shall be processed on a quarterly basis.

d. Ineligible family members. When coverage for Medicaid-eligible family members under age younger than 19 years of age is not possible unless an ineligible a parent who is not Medicaid eligible enrolls in qualified employer-sponsored health insurance, the Medicaid agency pays premiums only for enrollment of the ineligible parent who is not Medicaid eligible and, at the parent's option, other family members who are eligible for coverage under the qualified employer-sponsored coverage insurance. In addition, the agency provides cost sharing for the child's ineligible parent who is not Medicaid eligible for items and services covered under the qualified employer-sponsored coverage insurance that are also covered services under the State Plan. There is no cost-sharing cost sharing for ineligible parents who are not Medicaid eligible for items and services not covered by the qualified employer-sponsored coverage insurance.

3. Documentation required for premium assistance subsidy reimbursement. A person payee to whom DMAS is paying a qualified employer-sponsored coverage insurance premium assistance subsidy shall, as a condition of receiving such payment, provide documentation as prescribed by DMAS of the payment of the employer group health plan qualified employer-sponsored insurance plan premium, as well as payment of coinsurances, copayments, and deductibles for services received.

H. Cost-sharing wrap.

1. Premium assistance enrollment will be voluntary. Individuals enrolled in the Commonwealth's Health Insurance Premium Payment (HIPP) program are afforded the same member protections provided to all other Medicaid enrollees. Cost sharing shall only be charged to Medicaid members as permitted under §§ 1916 and 1916A of the Social Security Act. Cost sharing shall not exceed 5.0% of household income.

2. The Commonwealth will provide a cost-sharing wrap to any cost-sharing amounts of a Medicaid covered service that exceeds the cost-sharing limits described in the State Plan, regardless of whether individuals enrolled in a HIPP program receive care from a Medicaid participating provider or a nonparticipating provider.

3. To effectuate the cost-sharing wrap, the Commonwealth will encourage nonparticipating providers to enroll by conducting targeted outreach to inform nonparticipating Medicaid providers on how to enroll in Medicaid for the purposes of receiving payment from the Commonwealth for cost-sharing amounts that exceed the Medicaid permissible limits.

4. The Commonwealth will inform members regarding options available when the member obtains care from a

nonparticipating provider, including, as applicable, reimbursement for out-of-pocket, cost-sharing costs from this provider.

5. In order to receive reimbursement, the individual shall submit to DMAS an explanation of benefits or similar documentation from the insurance company or doctor's office showing DOS, that the expense is the responsibility of the member or parent, that the expense was paid prior to the submission of the request, and sufficient identification codes for the DOS to enable DMAS to determine if the service is reimbursable before applying the remaining cost-sharing criteria.

6. Reimbursement for cost-sharing shall be processed on a quarterly basis.

~~G.~~ I. Program participation requirements. Participants must comply with program requirements as prescribed by DMAS for continued enrollment in HIPP for Kids. Failure to comply with the following may result in termination from the program:

1. Submission of documentation of any changes to the qualified employer-sponsored insurance plan, to include any changes to the employee share of the premium expense, within ~~specified time frame in accordance with DMAS established policy~~ 10 days of receipt of notice of the change.

2. ~~Report~~ Any household changes ~~in the qualified employer-sponsored coverage~~, including income and individuals in the household, must be reported within 10 days ~~of the family's receipt of notice~~ of the change.

3. Completion of annual redetermination.

4. Completion of consent forms. Participants may be required to complete a consent form to release information necessary for HIPP for Kids participation and program requirements as required by DMAS.

~~H.~~ J. HIPP for Kids redetermination. DMAS shall redetermine the eligibility of the qualified employer-sponsored ~~coverage~~ insurance periodically, at least every 12 months. DMAS shall also redetermine eligibility when changes occur with the ~~group health plan~~ qualified employer-sponsored insurance plan information that was used in determining HIPP for Kids eligibility.

~~I.~~ K. Program termination. Participation in the HIPP for Kids program may be terminated for failure to comply or meet program requirements. Termination will be effective the last day of the month in which advance notice has been given (consistent with federal ~~regulations)~~ requirements at 42 CFR 431.211).

1. Participation may be terminated for failure to meet program requirements including~~, but not limited to,~~ the following:

a. Failure to submit documentation of payment of premiums;

b. Failure to provide information required for reevaluation of the qualified employer-sponsored ~~coverage (noncompliance)~~ insurance;

c. Loss of Medicaid eligibility for all household members;

d. Medicaid household member no longer covered by the qualified employer-sponsored ~~coverage~~ insurance;

e. Medicaid-eligible child turns ~~age~~ 19 years of age; or

f. Employer-sponsored health plan no longer meets qualified employer-sponsored ~~coverage~~ insurance requirements.

2. Termination date of premiums. Payment of premium assistance subsidy shall end on whichever of the following occurs the earliest:

a. On the last day of the month in which eligibility for Medicaid ends;

b. The last day of the month in which the member loses eligibility for coverage in the ~~group health plan~~ qualified employer-sponsored insurance plan;

c. The last day of the month in which the child turns ~~age~~ 19 years of age;

d. The last day of the month in which adequate notice has been given (consistent with federal requirements~~)~~ at 42 CFR 431.211) that DMAS has determined that the ~~group health plan~~ qualified employer-sponsored insurance plan no longer meets program eligibility criteria; or

~~d.~~ e. The last day of the month in which adequate notice has been given (consistent with federal requirements~~)~~ at 42 CFR 431.211) that HIPP for Kids participation requirements have not been met.

~~J.~~ L. Third-party liability. When members are enrolled in qualified employer-sponsored ~~coverage health~~ insurance plans, these plans shall become the first sources of health care benefits, up to the limits of such plans, prior to the availability of payment under Title XIX.

~~K.~~ M. Appeal rights. ~~Members~~ Applicants and members shall be given the opportunity to appeal adverse agency decisions consistent with agency regulations for client appeals ~~(12VAC30-110)~~ (12VAC30-110-10 through 12VAC30-110-370).

~~L.~~ N. Provider requirements. Providers shall be required to accept the greater of the ~~group health~~ qualified employer-sponsored insurance plan's reimbursement rate or the Medicaid rate as payment in full and shall be prohibited from charging the member or the Medicaid program amounts that would result in aggregate payments greater than the Medicaid rate as required by 42 CFR 447.20.

O. Provider participation or enrollment. The Commonwealth will enroll network providers as full Medicaid providers or enroll as fee-for-service Medicaid providers solely for the purpose of receiving cost sharing, similar to processes related to enrolling Medicare-participating providers that serve dually

eligible members. If the Commonwealth enrolls providers for the sole purpose of being reimbursed for cost sharing, the provider would make the decision to enroll knowing that the provider network would be the same as for other enrollees of the qualified employer-sponsored insurance plan. In either scenario, the member would never pay more than the permissible Medicaid copayment.

12VAC30-20-210. State method on cost effectiveness of ~~employer-based group health~~ qualified employer-sponsored insurance plans.

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

~~"Average monthly Medicaid cost" means average monthly medical expenditures based upon age, gender, Medicaid enrollment covered group, and geographic region of the state.~~

~~"Average monthly wraparound cost" means the average monthly aggregate costs for services not covered by private health insurance but covered under the State Plan for Medical Assistance, also includes copayments, coinsurance, and deductibles.~~

"Case" means all family members who are eligible for coverage under the ~~group health plan~~ qualified employer-sponsored insurance plan and who are eligible for Medicaid.

"Code" means the Code of Virginia.

"Cost effective" and "cost effectiveness" mean the reduction in Title XIX expenditures, which are likely to be greater than the additional expenditures for premiums and cost-sharing items required under § 1906 of the Social Security Act (the Act), with respect to such enrollment.

"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.

"DSS" means the Department of Social Services consistent with Chapter 1 (§ 63.2-100 et seq.) of Title 63.2 of the Code of Virginia.

"Family member" means ~~individuals~~ an individual in the household, who is not a parent and who ~~are~~ is related by blood, marriage, adoption, or legal custody.

~~"Family health plan" and "family care coverage" means a group health plan that covers three or more individuals. Family health plans that cover three or more non-Medicaid eligible individuals are not eligible for the HIPP premium assistance subsidy.~~

"Group health plan" means a plan ~~which~~ that meets § 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Service Act, § 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974. Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is a plan, including a self-insured plan, of, or contributed to by, an employer (including a self-insured person) or employee association to provide health care (directly or otherwise) to the employees, former employees, or the families of such employees or former employees, or the employer.

"High deductible health plan" means a plan as defined in § 223(c)(2) of Internal Revenue Code of 1986, without regard to whether the plan is purchased in conjunction with a health savings account (as defined under § 223(d) of ~~such Code)~~ the Internal Revenue Code of 1986).

"HIPP" means the Health Insurance Premium Payment Program administered by DMAS consistent with § 1906 of the Act.

"Member" means a person who is eligible for Medicaid as determined by DMAS or a DMAS-designated agent, including the Department of Social Services.

"Network provider" means a provider that is enrolled with a DMAS contracted managed care organization (MCO) as a provider and meets the requirement for an expedited enrollment as a fee-for-service (FFS) Medicaid provider for payment and billing purposes.

"Parent" means the biological or adoptive parent, or the biological or adoptive parent and the stepparent, living in the home with the Medicaid-eligible child. The health insurance policyholder shall be a parent as defined in this section.

"Payee" means the insured employee who is the policy holder of the qualified employer-sponsored insurance plan who is paid the HIPP or HIPP for Kids premium and cost-sharing reimbursement.

"Premium" means the fixed cost of participation in the group health plan; such cost may be shared by the employer and employee or paid in full by either party.

"Premium assistance subsidy" means the portion that DMAS will pay of the employee's cost of participating in ~~an employer's health~~ a qualified employer-sponsored insurance plan to cover the Medicaid eligible members under the employer-sponsored plan if DMAS determines it is cost effective to do so.

~~"Recipient" means a person who is eligible for Medicaid as determined by the Department of Social Services.~~

"Qualified employer-sponsored insurance" as defined under § 2105(c)(10)(B) of the Social Security Act means a group health plan or health insurance coverage offered through an employer:

1. That qualifies as creditable coverage as a group health plan under § 2701(c)(1) of the Public Health Service Act;

2. For which the employer contribution toward any premium for such coverage is at least 40%; and

3. That is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of § 105(h)(3)(A)(ii) of the Internal Revenue Code of 1986 without regard to § 105(h)(3)(B)(i).

"State Plan" means the State Plan for Medical Assistance for the Commonwealth of Virginia.

B. Program purpose. The purpose of the HIPP Program shall be to:

1. Enroll ~~recipients~~ members who have ~~an available group health plan~~ qualified employer-sponsored insurance plans that ~~is~~ are likely to be cost effective;

2. Provide premium assistance subsidy for payment of the employee share of the premiums and other cost-sharing obligations for items and services otherwise covered under the State Plan for Medical Assistance ~~(the Plan)~~; and

3. Treat coverage under such ~~employer group health~~ qualified employer-sponsored insurance plan as a ~~third party~~ third-party liability consistent with § 1906 of the Social Security Act.

C. ~~Application required. A completed HIPP application must be submitted to DMAS to be evaluated for HIPP program eligibility; if HIPP program eligibility is established, DMAS shall then evaluate the group health plan for cost effectiveness. The HIPP application consists of the forms prescribed by DMAS and any necessary information as required by the program to evaluate eligibility and perform a cost effectiveness evaluation.~~ Cost effectiveness methodology.

1. DMAS shall evaluate the individual to determine the appropriate managed care organization (MCO) capitation rate to be used. The capitation rate will be determined based on aid category, nursing facility or waiver eligibility, age, gender, and region.

2. DMAS shall adjust the capitation rate to exclude Medicaid services that are not available through commercial group health insurance policies. This requires that the capitation rate be adjusted to exclude services, including nursing facility and long-term services and supports provided in the Commonwealth Coordinated Care (CCC) Plus program as well as community mental health services and nonemergency transportation services available in CCC Plus and Medallion.

3. DMAS shall adjust the reduced capitation rate from subdivision 2 of this subsection to reflect the higher prices employer plans pay. The Virginia price factor shall be based on the national factor of 1.3 that is published by the Centers for Medicare and Medicaid Services.

4. The qualified employer-sponsored insurance cost for the individual shall be increased to reflect the amount of coinsurance and other member cost sharing typically imposed on HIPP members and paid by DMAS. Such amount shall be determined by averaging the aggregate amount of such expenditures by DMAS in the most recently completed fiscal year by the number of HIPP members covered during the fiscal year.

5. The qualified employer-sponsored insurance plan cost determined in subdivision 4 of this subsection shall be increased to reflect the DMAS administrative expenses directly related to the HIPP program. This additional cost is determined based on the average total monthly compensation paid to each HIPP analyst employed by DMAS divided by the anticipated caseload.

6. The cost effectiveness shall be affirmed if the adjusted capitation rate from subdivision 3 of this subsection equals or exceeds the adjusted qualified employer-sponsored insurance plan cost from subdivision 5 of this subsection.

D. ~~Recipient~~ Member eligibility.

1. DMAS shall obtain specific information on all group health plans available to the recipients in the case including~~, but not limited to,~~ the effective date of coverage, the services covered by the plan, the deductibles and copayments required by the plan, the exclusions to the plan, and the amount of the premium. Coverage that is not comprehensive shall be denied premium assistance. A qualified employer-sponsored insurance plan must provide the following services in order to be considered comprehensive:

a. Physician services;

b. Inpatient and outpatient hospitalization;

c. Outpatient labs, shots, and x-rays; and

d. Prescription drugs.

~~Cases that result in a determination that the applicant is not eligible for the HIPP program shall be denied premium assistance and shall not undergo further review as described in subsection E of this section.~~ 2. All ~~family members~~ persons who are eligible for coverage under the ~~group health~~ qualified employer-sponsored insurance plan and who are eligible for Medicaid shall be eligible for consideration for HIPP, except those ~~who meet any one or more of the factors~~ identified in subdivisions ~~1~~ 2 a through ~~7~~ 2 e of this subsection.

~~1.~~ a. The recipient is Medicaid eligible due to ~~"spend-down".~~ "spenddown."

~~2.~~ b. The recipient is currently enrolled in the ~~employer sponsored health~~ qualified employee-sponsored insurance plan and is only retroactively eligible for Medicaid.

~~3.~~ c. The recipient is in a nursing home or has a deduction from patient pay responsibility to cover the insurance premium.

~~4.~~ d. Currently, Medicare beneficiaries who are enrolled in a MCO do not qualify for participation in the HIPP

Program. If a Medicaid beneficiary is enrolled in an MCO, the beneficiary must wait until he is disenrolled from the MCO to become eligible for HIPP. HIPP applications are not approved until the managed care eligibility has ended at the end of the month.

e. The recipient is eligible for Medicare Part B but is not enrolled in Part B.

~~5. The recipient's family has, or would have, family healthcare coverage for three or more members who are not Medicaid eligible. Exceptions to the family health care coverage exclusion are as follows:~~

~~a. The family meets Family Access to Medical Insurance Security (FAMIS) eligibility criteria but due to existing group health insurance cannot enroll in FAMIS for the non-Medicaid family members enrolled in the health care plan; or~~

~~b. Medicaid eligibility is based upon family income (Medicaid family unit) and the family members enrolled in the health care plan are not Medicaid eligible due to Medicaid age restrictions (aged 19 or older).~~

~~6. Medicare eligibility. Medicaid recipients eligible for, or enrolled in, Medicare Part A and/or Part B who are also covered by an employer group health plan are not eligible for HIPP.~~

~~7. High Deductible Health Plans (HDHPs) are defined in § 223(c)(2) of the Internal Revenue Code of 1986. HDHPs are not cost effective for the HIPP program and shall be denied premium assistance and shall not undergo further review as described in subsection E of this section. The annual deductible amount for a HDHP is defined by the Department of Treasury and is updated annually.~~

~~E. Cost effectiveness evaluation. If the Medicaid eligible(s) is enrolled in the health plan and is not excluded from HIPP program participation under the criteria described in subsection D of this section, DMAS shall conduct the premium cost effectiveness evaluation based upon the following methodology:~~

~~1. Recipient information. DMAS shall obtain demographic information on each recipient in each case including, but not limited to, Medicaid enrollment covered group, age, gender, and geographic region of residence in the state.~~

~~2. DMAS shall compute the average monthly Medicaid cost for each Medicaid enrollee on the group health insurance plan and compare the total cost to the employee's responsibility for the health insurance cost.~~

~~3. Wraparound cost. DMAS shall total the average monthly wraparound cost for each Medicaid enrollee on the HIPP case and subtract the amount from the average monthly Medicaid cost for the cost effectiveness evaluation.~~

~~4. Administrative cost. DMAS shall total the administrative costs of the HIPP program and estimate an average administrative cost. DMAS shall subtract the administrative cost from the average monthly Medicaid cost for the cost effectiveness evaluation.~~

~~5. Determination of premium cost effectiveness. DMAS shall determine that a group health plan is likely to be cost effective if subdivision a is less than subdivision b below:~~

~~a. The employee's responsibility for the group health plan premium.~~

~~b. The total of the average monthly Medicaid costs less the wraparound costs for each Medicaid enrollee covered by the group health plan and the administrative cost.~~

~~6. For individuals who otherwise meet all HIPP eligibility criteria in subdivision 5 of this subsection, such individuals may elect to have DMAS reimburse them up to the amount determined in subdivision 5 b of this subsection, if subdivision 5 a of this subsection is not less than subdivision 5 b of this subsection.~~

~~F. Payments. When DMAS determines that a group health plan is likely to be cost effective based on the DMAS established methodology, DMAS shall provide for the payment of premium assistance subsidy and other cost sharing obligations for items and services otherwise covered under the Plan, except for the nominal cost sharing amounts permitted under § 1916.~~

~~1. Effective date of premium assistance subsidy. Payment of premium assistance subsidy shall become effective on the first day of the month following the month in which DMAS receives a complete HIPP application or the first day of the month in which the group health plan coverage becomes effective, whichever is later. Payments shall be made to either the employer, the insurance company or to the individual who is carrying the group health plan coverage.~~

~~2. No payments for deductibles, coinsurances, and other cost sharing obligations for non-Medicaid eligible family members shall be made by DMAS.~~

~~3. Documentation required for premium assistance subsidy reimbursement. A person to whom DMAS is paying an employer group health plan premium assistance subsidy shall, as a condition of receiving such payment, provide documentation as prescribed by DMAS of the payment of the employer group health plan premium for the group health plan that DMAS determined to be cost effective.~~

E. Application required. A completed HIPP application must be submitted to DMAS to be evaluated for HIPP program eligibility; if HIPP program eligibility is established, DMAS shall then evaluate the group health plan for cost effectiveness. The HIPP application consists of the forms prescribed by DMAS and any necessary information as required by the program to evaluate eligibility and perform a cost-effectiveness evaluation.

1. Effective date of premium assistance subsidy. Payment of premium assistance subsidy shall become effective on the first day of the month following the month in which DMAS approves the application and makes the cost effectiveness determination. Payment shall be made to either the employer, the insurance company, or to the individual who is carrying the group health plan coverage.

2. Termination date of premium assistance subsidy. Payment of premium assistance subsidy shall end on whichever of the following occurs the earliest:

a. On the last day of the month in which eligibility for Medicaid ends;

b. The last day of the month in which the recipient loses eligibility for coverage in the qualified employer-sponsored insurance plan; or

c. The last day of the month in which adequate notice has been given (consistent with federal requirements at 42 CFR 431.211) that DMAS has redetermined that the group health plan is no longer cost effective.

3. Non-Medicaid-eligible family members. Payment of premium assistance subsidy for non-Medicaid-eligible family members may be made when their enrollment in the qualified employer-sponsored insurance plan is required in order for the recipient to obtain the qualified employer-sponsored insurance plan coverage. Such payments shall be treated as payments for Medicaid benefits for the recipient. No payments for deductibles, coinsurances, and other cost-sharing obligations for non-Medicaid-eligible family members shall be made by DMAS.

4. Evidence of enrollment required. The payee to whom DMAS is paying the qualified employer-sponsored insurance plan premium assistance subsidy shall, as a condition of receiving such payment, provide to DSS or DMAS, upon request, written evidence of the payment of the employee's share of the plan premium for the qualified employer-sponsored insurance plan that DMAS determined to be cost effective.

F. Cost-sharing wrap.

1. Premium assistance enrollment is voluntary. Individuals enrolled in the HIPP program are afforded the same member protections provided to all other Medicaid enrollees. Cost sharing shall only be charged to Medicaid members as permitted under §§ 1916 and 1916A of the Social Security Act. Cost sharing shall not exceed 5.0% of household income.

2. The Commonwealth will provide a cost-sharing wrap to any cost-sharing amounts of a Medicaid covered service that exceeds the cost-sharing limits described in the State Plan, regardless of whether individuals enrolled in a HIPP program receive care from a Medicaid participating provider or a nonparticipating provider.

3. To effectuate the cost-sharing wrap, the Commonwealth will encourage nonparticipating providers to enroll by conducting targeted outreach to inform nonparticipating Medicaid providers on how to enroll in Medicaid for the purposes of receiving payment from the state for cost-sharing amounts that exceed the Medicaid permissible limits.

4. The Commonwealth will inform members regarding options available when the member obtains care from a nonparticipating provider, including, as applicable, reimbursement for out-of-pocket, cost-sharing costs from this provider.

5. In order to receive reimbursement, the individual shall submit to DMAS an explanation of benefits or similar documentation from the insurance company or doctor's office showing DOS, that the expense is the responsibility of the member or parent, that the expense was paid prior to the submission of the request, and sufficient identification codes for the DOS to enable DMAS to determine if the service is reimbursable before applying the remaining cost-sharing criteria.

6. Reimbursement for cost sharing shall be processed on a quarterly basis.

G. ~~Program~~ HIPP program participation requirements. Participants must comply with the following program requirements as prescribed by DMAS for continued enrollment in HIPP. Failure to comply shall result in termination from the program.

1. Submission of documentation of any change to the qualified employer-sponsored insurance plan, to include any changes to the employee share of the premium expense, within ~~specified time frame in accordance with DMAS established policy~~ 10 days of receipt of notice of the change.

2. ~~Changes that impact the cost-effectiveness evaluation~~ Any household change, including income and individuals in household, must be reported within 10 days of the change.

3. Completion of annual redetermination.

4. Completion of consent forms. Participants may be required to complete a consent form to release information necessary for HIPP participation and program requirements as required by DMAS.

~~5. Participants terminated for noncompliance under subdivision 1 or 2 of this subsection shall be barred from reapplying to the HIPP program for three months from the date of cancellation.~~

H. HIPP redetermination. DMAS shall redetermine the cost effectiveness of the ~~group health~~ qualified employer-sponsored insurance plan periodically, and at least every 12 months. DMAS shall also redetermine cost effectiveness when changes occur with the recipient's average Medicaid cost ~~and/or~~ or with

the ~~group health~~ qualified employer-sponsored insurance plan information that was used in determining the cost effectiveness. When only part of the household loses Medicaid eligibility, DMAS shall redetermine the cost effectiveness to ascertain whether payment of the premium assistance subsidy of the ~~group health~~ qualified employer-sponsored insurance plan continues to be cost effective.

~~I. Program termination. Participation in the HIPP program shall be terminated for failure to comply with or meet program requirements. Termination will be effective the last day of the month in which advance notice has been given (consistent with 42 CFR 431.211)].~~

~~1. In addition to the reasons listed in subsection G of this section, participation shall be terminated for:~~

~~a. Loss of Medicaid eligibility for all household members;~~

~~b. Medicaid household member no longer covered by employer health plan; or~~

~~c. Employer group health plan is determined to be not cost effective.~~

~~2. Termination date of premiums. Payment of premium assistance subsidy shall end on whichever of the following occurs the earliest:~~

~~a. On the last day of the month in which eligibility for Medicaid ends;~~

~~b. The last day of the month in which the recipient loses eligibility for coverage in the group health plan;~~

~~c. The last day of the month in which adequate notice has been given (consistent with federal requirements) that DMAS has determined that the group health plan is no longer cost effective; or~~

~~d. The last day of the month in which adequate notice has been given (consistent with federal requirements) that HIPP participation requirements have not been met.~~

I. Multiple group health plans. When a member is eligible for more than one group health plan, DMAS shall perform the cost effectiveness determination on the group health plan in which the member is enrolled. If the member is not enrolled in a group health plan, DMAS shall perform the cost effectiveness determination on each group health plan available to the member.

J. ~~Third party~~ Third-party liability. When recipients are enrolled in group health plans, these plans shall become the first sources of health care benefits, up to the limits of such plans, prior to the availability of Title XIX benefits.

K. Appeal rights. ~~Recipients~~ Applicants and members shall be given the opportunity to appeal adverse agency decisions consistent with agency regulations for client appeals ~~(12VAC30-110)~~ (12VAC30-110-10 through 12VAC30-110-370).

L. Provider requirements. Providers shall be required to accept the greater of the group health plan's reimbursement rate or the Medicaid rate as payment in full and shall be prohibited from charging the recipient or Medicaid amounts that would result in aggregate payments greater than the Medicaid rate as required by 42 CFR 447.20.

M. Provider participation or enrollment. The Commonwealth will enroll network providers as full Medicaid providers or as fee-for-service Medicaid providers solely for the purpose of receiving cost sharing, similar to processes related to enrolling Medicare-participating providers that serve dually eligible members. If the state enrolls providers for the sole purpose of being reimbursed for cost sharing, the payee would make the decision to enroll knowing that the provider network would be the same as for other enrollees of the qualified employer-sponsored insurance. In either scenario, the member would never pay more than the permissible Medicaid copayment.

12VAC30-30-10. Mandatory coverage: categorically needy and other required special groups.

The Title IV-A agency or the Department of Medical Assistance Services Central Processing Unit determines eligibility for Title XIX services. The following groups shall be eligible for medical assistance as specified:

1. Parents and other caretaker relatives of dependent children with household income at or below a standard established by the ~~state~~ Commonwealth in 12VAC30-40-100 consistent with 42 CFR 435.110 and §§ 1902(a)(10)(A)(i)(l) and 1931(b) of the Social Security Act. Individuals qualifying under this eligibility group shall meet the following criteria:

a. Parents, other caretaker relatives (defined at 42 CFR 435.4) including pregnant women, or dependent children (defined at 42 CFR 435.4) younger than ~~the age of~~ 18 years of age. This group includes individuals who are parents or other caretaker relatives of children who are 18 years of age provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training and are expected to complete such school or training before their 19th birthday.

b. Spouses of parents and other caretaker relatives shall include other relatives of the child based on blood (including those of half-blood), adoption, or marriage. Other relatives of a specified degree of the dependent child shall include any blood relative (including those of half-blood) and including (i) first cousins; (ii) nephews or nieces; (iii) persons of preceding generations as denoted by prefixes of grand, great, or great-great; (iv) stepbrother; (v) stepsister; (vi) a relative by adoption following entry of the interlocutory or final order, whichever is first; (vii) the same relatives by adoption as listed in this subdivision 1 b; and (viii) spouses of any persons named in this subdivision 1 b even after the marriage is terminated by death or divorce.

MAGI-based income methodologies in 12VAC30-40-100 shall be used in calculating household income.

2. Women who are pregnant or postpartum with household income at or below a standard established by the Commonwealth in 12VAC30-40-100, consistent with ~~42CFR~~ 42 CFR 435.116 and §§ 1902(a)(10)(A)(i)(III) and (IV), 1902(a)(10)(A)(ii)(I) and (IX), and 1931(b) of the Act. Individuals qualifying under this eligibility group shall be pregnant or postpartum as defined in 42 CFR 435.4.

a. A woman who, while pregnant, was eligible for, applied for, and received Medicaid under the approved state plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period, beginning on the last day of her pregnancy, and for any remaining days in the month in which the 60th day falls.

b. A pregnant woman who would otherwise lose eligibility because of an increase in income of the family in which she is a member during the pregnancy or the postpartum period that extends through the end of the month in which the 60-day period, beginning on the last day of pregnancy, ends.

MAGI-based income methodologies in 12VAC30-40-100 shall be used in calculating household income.

3. Infants and children younger than ~~the age of~~ 19 years of age with household income at or below standards based on this age group, consistent with 42 CFR 435.118 and §§ 1902(a)(10)(A)(i)(III), (IV) and (VIII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) of the Act. Children qualifying under this eligibility group shall meet the following criteria:

a. They are younger than ~~the age of~~ 19 years of age; and

b. They have a household income at or below the standard established by the Commonwealth.

MAGI-based income methodologies in 12VAC30-40-100 shall be used in calculating household income.

4. The adult group as described at 42 CFR 435.119.

5. Former foster care children younger than ~~the age of~~ 26 years of age who are not otherwise mandatorily eligible in another Medicaid classification, who were on Medicaid and in foster care when they turned ~~age~~ 18 years of age, or who aged out of foster care. Individuals qualifying under this eligibility group shall meet the following criteria:

a. They shall be younger than ~~the age of~~ 26 years of age;

b. They shall not be otherwise eligible for and enrolled for mandatory coverage under the state plan; and

c. They were in foster care under the responsibility of the ~~state of Virginia~~ Commonwealth or a federally recognized tribe and were enrolled in Virginia Medicaid under the state plan when they turned ~~age~~ 18 years of age or at the time of aging out of the foster care program.

~~5.~~ 6. Families terminated from coverage under § 1931 of the Act solely because of earnings or hours of employment shall be entitled to up to 12 months of extended benefits in accordance with § 1925 of the Act.

~~6.~~ 7. A child born to a woman who is eligible for and receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year from birth, as long as he remains a resident of the Commonwealth. A redetermination of eligibility must be completed on behalf of the deemed child at age one year and annually thereafter so long as he remains eligible.

~~7.~~ 8. Aged, blind, and disabled individuals receiving cash assistance.

a. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under § 1619(a) of the Act or who meet the eligibility requirements for SSI status under § 1619(b)(1) of the Act and who met the ~~state's~~ Commonwealth's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under § 1619(a) or met the requirements under § 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the § 1619(a) eligibility standard or the requirements of § 1619(b) of the Act.)

b. These persons include the aged, the blind, and the disabled.

c. Protected SSI children (pursuant to § 1902(a)(10)(A)(i)(II) of the Act) (P.L. 105-33 § 4913). Children who meet the pre-welfare reform definition of childhood disability who lost their SSI coverage solely as a result of the change in the definition of childhood disability, and who also meet the more restrictive requirements for Medicaid than the SSI requirements.

d. The more restrictive categorical eligibility criteria are described in 12VAC30-30-40.

Financial criteria are described in 12VAC30-40-10.

~~8.~~ 9. Qualified severely impaired blind and disabled individuals ~~under age~~ younger than 65 years of age who:

a. For the month preceding the first month of eligibility under the requirements of § 1905(q)(2) of the Act, received SSI, a state supplementary payment (SSP) under § 1616 of the Act or under § 212 of P.L. 93-66 or benefits under § 1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under § 1619(b) of the Act and were eligible for Medicaid. These individuals must:

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under § 1611(b) of the Act;

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for ~~himself~~ themselves a reasonable equivalent of the Medicaid, SSI (including any federally administered SSP), or public funded attendant care services that would be available if ~~he~~ they did have such earnings.

The state applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under § 1619(a) of the Act or individuals described ~~above~~ in this section who meet the eligibility requirements for SSI benefits under § 1619(b)(1) of the Act and who met the state's more restrictive requirements in the month before the month they qualified for SSI under § 1619(a) or met the requirements of § 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under § 1619(a) of the Act or meet the SSI requirements under § 1619(b)(1) of the Act.

~~9.~~ 10. Except in states that apply more restrictive requirements for Medicaid than under SSI, blind or disabled individuals who:

a. Are at least 18 years of age; and

b. Lose SSI eligibility because they become entitled to Old Age, Survivor, and Disability Insurance (OASDI) child's benefits under § 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absence their OASDI eligibility.

The ~~state~~ Commonwealth does not apply more restrictive income eligibility requirements than those under SSI.

~~10.~~ 11. Except in states that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional state supplements (if the agency provides Medicaid under § 435.230 of the Act), because of requirements that do not apply under Title XIX of the Act.

~~11.~~ 12. Individuals receiving mandatory state supplements.

~~12.~~ 13. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as a spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the ~~state's~~ Commonwealth's approved plan for Old Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled, or Aid to the Aged, Blind, and Disabled and the spouse continues to meet the December 1973 requirements for ~~have~~ his needs to be included in computing the cash payment. In December 1973, Medicaid coverage of the essential spouse was limited to the aged, the blind, and the disabled.

~~13.~~ 14. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of Title XIX medical institutions or residents of Title XIX intermediate care facilities, if, for each consecutive month after December 1973, they:

a. Continue to meet the December 1973 Medicaid State Plan eligibility requirements;

b. Remain institutionalized; and

c. Continue to need institutional care.

~~14.~~ 15. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

~~15.~~ 16. Individuals who would be ~~SSI/SSP~~ SSI or SSP eligible except for the increase in OASDI benefits under P.L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. This includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this state's August 1972 plan), and persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this state's August 1972 plan).

~~16.~~ 17. Individuals who:

a. Are receiving OASDI and were receiving ~~SSI/SSP~~ SSI or SSP but became ineligible for ~~SSI/SSP~~ SSI or SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under § 215(i) of the Act received after the last month for which the individual was eligible for and received ~~SSI/SSP~~ SSI or SSP and OASDI, concurrently, were deducted from income.

The state applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused ~~SSI/SSP~~ SSI or SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

~~17.~~ 18. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by § 134 of P.L. 98-21 and who are deemed, for purposes of Title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under § 1634(b) of the Act.

The state does not apply more restrictive income eligibility standards than those under SSI.

~~18.~~ 19. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least 10 years before the divorce became effective, who have attained the age of 50, who are receiving Title II payments, and who because of the receipt of Title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive Title II payments, who would be eligible for SSI or SSP if the amount of the Title II benefit were not counted as income, and who are not entitled to Medicare Part A.

The state applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

~~19.~~ 20. Qualified Medicare beneficiaries:

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under § 1818 of the Act);

b. Whose income does not exceed 100% of the federal level; and

c. Whose resources do not exceed twice the maximum standard under SSI or, effective January 1, 2010, the resource limit set for the Medicare Part D Low Income Subsidy Program.

Medical assistance for this group is limited to Medicare cost sharing as defined in item 3.2 of this plan.

~~20.~~ 21. Qualified disabled and working individuals:

a. Who are entitled to hospital insurance benefits under Medicare Part A under § 1818A of the Act;

b. Whose income does not exceed 200% of the federal poverty level;

c. Whose resources do not exceed twice the maximum standard under SSI; and

d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

Medical assistance for this group is limited to Medicare Part A premiums under §§ 1818 and 1818A of the Act.

~~21.~~ 22. Specified low-income Medicare beneficiaries:

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under § 1818A of the Act);

b. Whose income for calendar years 1993 and 1994 exceeds the income level in subdivision 25 b of this section, but is less than 110% of the federal poverty level, and whose income for calendar years beginning 1995 is less than 120% of the federal poverty level; and

c. Whose resources do not exceed twice the maximum standard under SSI or, effective January 1, 2010, the resource limit set for the Medicare Part D Low Income Subsidy Program.

Medical assistance for this group is limited to Medicare Part B premiums under § 1839 of the Act.

~~22.~~ 23. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of ~~clause (i) or (v) of § 1611(e)(3)(A)~~ § 1611(e)(3)(A)(i) or (v) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

b. The state applies more restrictive eligibility standards than those under SSI. Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of ~~clause (i) or (v) of § 1611(e)(3)(A)~~ § 1611(e)(3)(A)(i) or (v) and who continue to meet the more restrictive requirements for Medicaid eligibility under the state plan, are eligible for Medicaid as categorically needy.

12VAC30-40-348. Adult group individual income-based determinations.

A. Methodology for identification of applicable federal medical assistance percentages (FMAP) rates. DMAS will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals and, as applicable, appropriate population-based adjustments.

B. Adult group individual income-based determinations. For individuals eligible in the adult group, the Commonwealth will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the Modified Adjusted Gross Income (MAGI) Conversion Plan (Part 2) approved by Centers for Medicare and Medicaid Services (CMS) on February 11, 2014. In general, and subject to any adjustments described in this section, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available.

C. Population-based adjustments to the newly eligible population based on resource test, enrollment cap, or special circumstances.

1. The Commonwealth does not apply a resource proxy adjustment.

2. The Commonwealth does not apply an enrollment cap.

3. The Commonwealth does not apply a special circumstance adjustment.

4. The Commonwealth does not apply any additional adjustment to the adult group FMAP methodology.

D. Individuals previously eligible for Medicaid coverage through a § 1115 demonstration program or a mandatory or optional State Plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan or a § 1902(e)(14)(A) waiver.

E. Applicability of special FMAP rates.

1. The Commonwealth does not meet the definition of an expansion state in 42 CFR 433.204(b).

2. The Commonwealth does not qualify for a temporary 2.2% increase in FMAP under 42 CFR 433.10(c)(7).

F. The Commonwealth attests to the following:

1. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

2. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

VA.R. Doc. No. R19-5692; Filed January 10, 2022, 2:25 p.m.

Fast-Track Regulation

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

12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-61, 12VAC30-60-143).

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

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: March 2, 2022.

Effective Date: March 17, 2022.

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.

Purpose: This regulatory action is essential to protect the health, safety, or welfare of citizens in that it supports member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

Rationale for Using Fast-Track Rulemaking Process: The action is expected to be noncontroversial because it implements changes that were announced in a Medicaid Memo released on November 20, 2018, and that took effect on January 1, 2019. Providers subject to these changes have not submitted comments or complaints about the changes and have smoothly transitioned from the service specific provider intake (SSPI) to the comprehensive needs assessment (CNA).

Substance: In the past, providers of community mental health services were required to conduct a separate SSPI for each community mental health service, even if the same provider offered more than one service. This regulatory package changes the SSPI to a CNA. The CNA will be used by providers to screen individuals for any service offered by a provider. Allowing one CNA in place of multiple SSPIs is intended to support member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

Issues: The primary advantage to the public, the agency, and the Commonwealth is that the CNA supports member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

The primary disadvantage to Medicaid providers who offer more than one service is that they cannot bill for a separate intake for each community mental health service. Instead, one comprehensive needs assessment is used to determine which of the services offered by the provider may be needed by the individual. However, this is not likely to cause a decrease in the provider's total billing, because providers will initiate care more quickly, and the billing that might have come from an additional assessment is likely to be replaced by billing from service provision. In addition, individual treatment will not differ due to these changes. Even under the old SSPI process, providers can reassess individuals progress and needs and can bill for that using the billing code for the service.

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), on behalf of the Board of Medical Assistance Services, proposes to reflect in regulation the revised

community mental health intake process that has been in effect since 2019 in practice.

Background. Prior to January 2019, Medicaid mental health providers were required to conduct a separate service-specific provider intake for each community mental health service they offered. For example, if a community mental health provider offered both intensive in-home treatment and therapeutic day treatment, the provider was required to complete two intake assessments for the same patient. At the request of Virginia Community Services Boards, DMAS revised the intake process to a comprehensive needs assessment approach, which allowed providers to screen individuals for any service offered by the provider and start providing the services needed by the individual based on that assessment. These changes were announced in a Medicaid Memo released on November 20, 2018, and took effect on January 1, 2019.[1] Thus, the proposed action aligns regulations with practices that were previously implemented at the agency's discretion.

Estimated Benefits and Costs. The economic impact of the change implemented in 2019 includes a likely reduction in provider revenues due to a decrease in the number of needs assessments that are conducted, but a likely increase in revenues due to the ability to provide additional mental health services based on the same needs assessment. The degree to which one effect upon provider revenues affects the other cannot be determined with available data.

An additional important factor to consider is the fact that community mental health services have been exclusively provided through managed care networks since a few months before the comprehensive needs assessment was implemented. Managed care services are those where the managed care provider is paid a fixed monthly capitation fee for providing the covered services the Medicaid enrollee needs. Therefore, unlike the fee-for-service reimbursement model, in the short run there is no direct correlation between the amount of services provided in a given month and the amount paid to the managed care network. In the long run, however, increased utilization in a managed care model may eventually lead to higher capitation rates if and when the actuary determines that higher capitation rates are indicated.

DMAS believes that the increase in provider revenue due to the ability to provide additional services following a comprehensive needs assessment would have been offset by the reduction in provider revenues from the decrease in the number of assessments. Additionally, DMAS states that the managed care capitation rate was not adjusted based on this change, and on this basis concludes that there was no fiscal impact to the agency.

In the end, the magnitude of these effects cannot be determined because insufficient data are available with which to ascertain the magnitude of opposing impacts on provider revenues, or whether there was (or will be) an impact on managed care capitation rates. Notwithstanding the lack of data on revenue impacts, it appears that the use of a single assessment would be administratively more efficient and improve access to needed services. Finally, aligning the regulatory text to reflect the practices that are actually followed in the provision of community mental health services would likely improve clarity regarding what the rules are that mental health providers must follow.

Businesses and Other Entities Affected. The use of a single comprehensive needs assessment has been part of the business practices of approximately 1,138 community mental health providers since 2019.[2] Due to lack of data, it cannot be ascertained whether the 2019 change has had an adverse economic impact[3] on community mental health providers.

Small Businesses[4] Affected.

Types and Estimated Number of Small Businesses Affected. Most of the 1,138 community mental health service providers are likely small businesses. However, whether the 2019 change in practice has had an adverse impact on these providers cannot be assessed due to lack of data.

Costs and Other Effects. The change in needs assessment that occurred in 2019 would have likely had offsetting effects on provider revenues. However, the lack of data does not allow to assess magnitude and hence the net of the opposing potential revenue effects.

Localities[5] Affected.[6] The proposed amendments do not appear to directly introduce costs for local governments.

Projected Impact on Employment. Given the inability to determine the net impact on provider revenues, the impact on employment also cannot be assessed.

Effects on the Use and Value of Private Property. Given the inability to determine the net impact on provider revenues, the impact on asset values of providers also cannot be assessed. The proposed changes do not appear to affect real estate development costs.

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[1]See https://www.magellanofvirginia.com/media/3777/11-21-18-updates-to-cmhrs-memo-from-dmas.pdf

[2]Data Source: DMAS

[3]Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined.

[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."

[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.

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 change the process by which a Medicaid provider gathers information about an individual so that an individual may receive a Department of Medical Assistance Services community mental health service. The new method, a comprehensive needs assessment (CNA) will be used by providers to screen individuals for any service offered by a provider, and one CNA will replace multiple service specific provider intake forms, which formerly served the same purpose.

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.~~ Reserved.

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, LMHP-Rs, LMHP-RPs, and LMHP-Ss who are practicing within the scope of their licenses and (ii) ~~are~~ shall be reflected in provider records and on providers' 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:

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

~~"Adolescent" or "child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual 12 through 20 years of age; child means an individual from birth up to 12 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 ~~who are~~ involved with an individual's health care to improve the care.

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

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

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

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

"Comprehensive needs assessment" means the face-to-face interaction in which the provider obtains information from the youth and parent or other family member, as appropriate, about the youth's mental health status. Requirements for the comprehensive needs assessment are set out in 12VAC30-60-143.

"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, LMHP-R, LMHP-RP, or LMHP-S 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 DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013~~.

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

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

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

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

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

"Peer recovery specialist" or "PRS" means the same as defined in ~~12VAC35-250-10~~ 12VAC30-130-5160.

"Peer recovery support services" means the same as defined in 12VAC35-250-10.

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

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

~~content of each progress note shall corroborate the units or hours billed. Progress notes shall be documented for each service that is billed.~~

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

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

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in ~~12VAC35-105-20~~ § 54.1-3500 of the Code of Virginia.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as ~~the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590~~ "qualified mental health professional – trainee" as defined in § 54.1-3500 of the Code of Virginia.

~~"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.~~

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

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

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

"Youth" means an individual younger than 21 years of age.

2. Intensive in-home services (IIH) to ~~children and adolescents younger than 21 years of age~~ youth shall be time-limited interventions provided in the ~~individual's~~ youth'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 psychoeducational benefits in the home setting of ~~an individual~~ a youth 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~~ youth. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the ~~individual~~ youth and the ~~individual's~~ youth'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 at the onset of services and~~ Services must be recommended as part of a comprehensive needs assessment prior to the start of services. ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated ~~service specific provider intakes~~ comprehensive needs assessments or ISPs shall be denied reimbursement. Requirements for ~~service specific provider intakes~~ comprehensive needs assessments and ISPs are set out in ~~this section~~ 12VAC30-60-61.

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 at the onset of services, and~~ Services must be recommended as part of a comprehensive needs assessment prior to the start of services. ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated ~~service-specific provider intakes~~ comprehensive needs assessments or ISPs shall be denied reimbursement. Requirements for ~~service-specific provider intakes~~ comprehensive needs assessments and ISPs are set out in ~~this section~~ 12VAC30-60-61.

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~~ youth.

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).

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

"Activities of daily living restoration" or "ADL restoration" means a face-to-face interaction provided on an individual or group basis to assist youth in the restoration of lost ADL skills that are necessary to achieve the goals established in the youth's plan of care. Services address performance deficits related to a lack of physical, cognitive, or psychosocial skills which hinder the ability of the youth to complete ADLs. Services include (i) restoring acceptable habits, behaviors, and attitudes related to daily health activities and personal care or hygiene and (ii) assisting the youth restoring and regaining functional ADL skills and appropriate behavior related to health and safety.

"ADL supervisor" means a child care supervisor with a baccalaureate degree in social work or psychology and two years of professional experience working with children one year of which must have been in a residential facility for children; or a high school diploma or General Education Development Certificate (GED) and a minimum of five years professional experience working with children with at least two years in a residential facility for children.

"ADL technician" means a child care worker at least 21 years of age who has a baccalaureate degree in human services (as defined by the Department of Health Professions); has an associate's degree and three months experience working with children; or is a high school graduate or has a GED and has six months of experience working with children. A trainee with a high school diploma or a GED may count experience working directly alongside a staff member who is, at a minimum, an ADL technician with at least one year of professional experience with children if the trainee is within sight and sound of the supervising staff member and does not work alone. An individual can only be classified as an ADL technician if they are supervised by an ADL supervisor, QMHP-C, LMHP, LMHP-R, LMHP-RP, or LMHP-S.

"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~~ youth 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~~ youth'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~~ youth'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~~ youth 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~~ youth. ~~Individuals~~ Youth 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~~ youth 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~~ youth 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,~~ youth and families. Family engagement requires ongoing opportunities for ~~an individual~~ a youth to build and maintain meaningful relationships with family members, for example, frequent, unscheduled, and noncontingent telephone calls and visits between ~~an individual~~ the youth and family members. Family engagement may also include enhancing or facilitating the development of the ~~individual's~~ youth's relationship with other family members and supportive adults responsible for the ~~individual's~~ youth'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~~ youth'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~~ youth, (ii) the counseling is not aimed at addressing treatment needs of the ~~individual's~~ youth's family or significant others, and (iii) the ~~individual~~ youth is present except when it is clinically appropriate for the ~~individual~~ youth to be absent in order to advance the ~~individual's~~ youth's treatment goals. Family therapy shall be aligned with the goals of the ~~individual's~~ youth's plan of care. All family therapy services furnished are for the direct benefit of the ~~individual~~ youth, in accordance with the ~~individual's~~ youth's needs and treatment goals identified in the ~~individual's~~ youth's plan of care, and for the purpose of assisting in the ~~individual's~~ youth'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 and adolescent psychiatry; has knowledge of the ~~individual's~~ youth's situation; and is composed of at least one physician and one LMHP, LMHP-R, LMHP-RP, or LMHP-S. 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~~ youth'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~~ included in the individualized plan of care to help the youth achieve the youth's plan of care goals and objectives. Interventions may include individual or group psychoeducation; skills restoration; ADL restoration; individual, group, and family therapy; 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~~ youth's ability to acquire coping and functional or self-regulating behavior skills; ~~day and overnight~~ therapeutic passes; and family engagement activities. Interventions shall not include ~~individual, group, and family therapy;~~ 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~~ are provided in the therapeutic group home or PRTF and, when clinically necessary, may occur in a community setting or as part of a therapeutic pass if the setting is documented in the plan of care. ~~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~~ a youth in order to prevent or minimize the need for more intensive treatment.

"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.

"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~~ youth in the restoration of lost skills that are necessary to achieve the goals established in the ~~beneficiary's~~ youth's plan of care. Services include assisting the ~~individual~~ youth 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~~ youth.

"Therapeutic services" means the structured therapeutic program designed to restore appropriate skills necessary to promote prosocial behavior and healthy living to include: the restoration of coping skills; family living and health awareness; interpersonal skills; communication skills; and stress management skills. Therapeutic services also engage families and reflect family-driven practices that correlate to sustained positive outcomes post-discharge for youth and their family members. Therapeutic services include assessment, individualized treatment planning, and interventions.

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

"Youth" means an individual younger than 21 years of age.

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~~ youth 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, community integration skills, coping 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. Therapeutic services may occur in group settings, in one-on-one interactions, or in the home setting during a therapeutic pass. Each component of therapeutic group home services is provided for the direct benefit of the ~~individual~~ youth, in accordance with the ~~individual's~~ youth's needs and treatment goals identified in the ~~individual's~~ youth's plan of care, and for the purpose of assisting in the ~~individual's~~ youth'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.~~ Therapeutic group home services providers shall be licensed by the Department of Behavioral Health and Developmental Services under the Regulations for Children's Residential Facilities (12VAC35-36). 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, an ADL supervisor, or an ADL technician.

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~~ youth'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~~ youth; (ii) proper treatment of the ~~individual's~~ youth'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~~ youth'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~~ youth'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~~ youth's treatment needs and the reasons for that are discussed in the certificate of need.

(e) The ~~individual's~~ youth'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~~ youth does not require a more intensive level of care.

(f) The ~~individual~~ youth 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, LMHP-R, LMHP-RP, or LMHP-S 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~~ youth.

(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~~ youth; or (iii) a treatment intervention when other less restrictive alternatives are available.

(c) The ~~individual's~~ youth's treatment goals are included in the ~~service specific provider intake~~ plan of care 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~~ youth's community resources, including schools and FAPT as appropriate, with the goal of transitioning the ~~individual~~ youth 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~~ youth 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~~ youth's plan of care or the ~~individual~~ youth 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~~ youth shall meet one of the following criteria: (i) the ~~individual~~ youth has achieved initial ~~CIPOC~~ plan of care goals, but additional goals are indicated that cannot be met at a lower level of care; (ii) the ~~individual~~ youth 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~~ youth 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~~ youth 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~~ passes.

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

(g) Less restrictive treatment options have been considered but cannot yet meet the ~~individual's~~ youth'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~~ youth'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~~ youth can reasonably be expected to maintain these gains at a lower level of treatment; (ii) the ~~individual~~ youth 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 shall 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~~ youth'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~~ youth and a family member or legally authorized representative. The IPOC shall include all of the following:

(a) ~~Individual~~ Youth 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~~ youth;

(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~~ youth;

(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~~ youth'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~~ youth, 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 clear action steps and target dates, including necessary, clinically appropriate community services to ensure continuity of care upon discharge with the ~~individual's~~ youth'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~~ youth 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~~ youth or a family member or legally authorized representative. The review shall include all of the following:

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

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

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

(7) 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 youth'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.

(8) Crisis management, clinical assessment, and individualized therapy shall be provided to address both ~~behavioral~~ mental 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)~~ (9) 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~~ youth as included in the plan of care. Documentation of this care coordination shall be maintained by the facility or group home in the youth's

record. The documentation shall include who was contacted, when the contact occurred, what information was transmitted, and recommended next steps.

~~(9)~~ (10) Weekly individual therapy shall be provided in the therapeutic group home, or other settings as appropriate for the ~~individual's~~ youth's needs, by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements for progress notes in 12VAC30-60-61 B.

~~(10) Weekly (or more frequently if clinically indicated) group~~ (11) Group therapy shall be provided at a minimum of weekly and as documented in the plan of care by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, ~~which~~ and shall be documented in progress notes in accordance with the requirements for progress notes in 12VAC30-60-61 ~~and as planned and documented in the plan of care~~ B.

~~(11)~~ (12) Family involvement begins immediately upon admission to the therapeutic group home. Family ~~treatment~~ therapy shall be provided as clinically indicated~~,~~ and as documented in the plan of care and shall be provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, and documented in progress notes in accordance with the requirements for progress notes in 12VAC30-60-61 ~~and as planned and documented in the plan of care~~ B.

~~(12)~~ (13) 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~~ youth's engagement with the ~~individual's~~ youth'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 or its contractor. When family engagement is not possible, the therapeutic group home shall collaborate with DMAS or its contractor on a weekly basis to develop individualized family engagement strategies and document the revised strategies in the plan of care.

~~(13)~~ (14) 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~~ youth 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 end date 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~~ youth, per admission, without authorization as approved by the treating LMHP, LMHP-R, LMHP-RP, and LMHP-S 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)~~ (15) Discharge planning shall begin at admission and continue throughout the ~~individual's~~ youth'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~~ youth and family upon discharge and available services in the community. Prior to discharge, the therapeutic group home shall submit ~~an active and viable~~ a comprehensive 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~~ a comprehensive needs assessment 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~~ youth 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~~ youth's discharge date from the therapeutic group home.

~~(15)~~ (16) 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.

e. Service exclusions include the following:

(1) 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~~ (2) Therapeutic group home services shall not be covered when treatment goals are met or other less intensive services may achieve stabilization.

~~(18)~~ (3) 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~~ a youth in order to prevent or minimize the need for more intensive 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~~ youth, 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~~ youth 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~~ youth'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; and (viii) dental, oral surgery, and orthodontic services; (ix) nonemergency transportation services; and (x) emergency services~~.

~~f.~~ e. PRTF services shall include assessment and reassessment; room and board; daily supervision; ~~combined treatment~~ therapeutic 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~~)~~ availability; specialty services; and discharge planning that meets the medical and clinical needs of the ~~individual~~ youth.

~~g.~~ f. 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~~ youth 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~~ youth would be a risk to self or others if the ~~individual~~ youth were not in a PRTF or (ii) as a result of the ~~individual's~~ youth's mental disorder, there is an inability for the ~~individual~~ youth 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~~ youth 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~~ youth to live outside of a PRTF setting.

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

(f) The ~~individual~~ youth 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~~ youth 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~~ youth's community resources, including the local school division and FAPT case manager, as appropriate, with the goal of returning the ~~individual~~ youth 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~~ youth 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~~ youth'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~~ g (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 youth can reasonably be expected to maintain these gains at a lower level of treatment; (ii) the ~~individual~~ youth 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.~~ g. 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~~ youth;

(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~~ youth;

(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~~ youth, 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~~ youth'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 h of this subsection who are employed by or provide services to the ~~individual~~ youth in the facility in consultation with the ~~individual~~ youth, family member, or legally authorized representative, or appropriate others into whose care the ~~individual~~ youth 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~~ youth 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~~ youth's family, school, and community.

(5) The CIPOC shall be reviewed every 30 calendar days by the team specified in subdivision 3 ~~d 4~~ h 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~~ youth's overall adjustment during the time away from home. The CIPOC shall include the signature and date from the ~~individual~~ youth, parent, or legally authorized representative, a physician, and treatment team members.

(6) Individual therapy shall be provided a minimum of 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 the requirements for progress notes in 12VAC30-60-61 B.

(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 and the requirements for progress notes in 12VAC30-60-61 B.

(8) Family therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and ~~shall be~~ as 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 and requirements for progress notes in 12VAC30-60-61 B.

(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~~ youth'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 non-psychotherapy 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~~ youth.

(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. Twenty-four therapeutic passes shall be permitted per ~~individual~~ youth, 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 or its contractor. Any unauthorized therapeutic passes not approved by the provider or DMAS or its contractor shall result in retraction for those days of service.

(12) Discharge planning shall begin at admission and continue throughout the ~~individual's~~ youth'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~~ youth and family upon discharge and identify the available services in the community. Prior to discharge, the PRTF shall submit ~~an active~~ a comprehensive 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~~ comprehensive needs assessments 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~~ youth 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~~ youth's discharge date from the PRTF.

(13) 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.

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

~~i.~~ h. 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~~ and adolescent psychiatry, the team must be capable of all of the following: assessing the ~~individual's~~ youth's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the ~~individual's~~ youth'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~~ youth'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~~ youth'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~~ the youth and the ~~individual's~~ youth's parent or legally authorized representative within two business days from a request to assess the ~~individual's~~ youth'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~~ the youth and the ~~individual's~~ youth'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~~ youth 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~~ youth and the ~~individual's~~ youth's parent or legally authorized representative shall have the right to freedom of choice of service providers.

j. If the ~~individual~~ youth or the ~~individual's~~ youth'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, LMHP-R, LMHP-RP, or LMHP-S, as part of the independent certification team, determines that the ~~individual~~ youth is in immediate need of treatment, the LMHP, LMHP-R, LMHP-RP, or LMHP-S shall refer the ~~individual~~ youth 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~~ youth for emergency admission to a PRTF or therapeutic group home under subdivision 4 m of this subsection and shall

also alert the ~~individual's~~ youth's managed care organization.

l. For ~~individuals~~ youth 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 and adolescent psychiatry, and have knowledge of the ~~individual's~~ youth's situation and service availability in the ~~individual's~~ youth's local service area. The team shall be composed of at least one physician and one LMHP, including LMHP-S, LMHP-R, ~~and~~ or LMHP-RP. ~~An individual's~~ The youth'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~~ youth'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.~~ n. For ~~individuals~~ youth 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~~ youth's enrollment into the Medicaid program, the therapeutic group home, PRTF, or IMD shall notify the DMAS contractor of the ~~individual's~~ youth's status as being under the care of the facility within five calendar days of the ~~individual~~ youth 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 or its contractor using medical necessity criteria specified in this subsection.

b. ~~An individual~~ The youth 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~~ youth will require a mental health evaluation prior to admission by an LMHP, LMHP-R, LMHP-RP, or LMHP-S 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~~ youth 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 completed no more than 30 calendar days prior to the date of submission;

(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~~ youth;

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

(c) Proper treatment of the ~~individual's~~ youth'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~~ youth'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, LMHP-R, LMHP-RP, or LMHP-S that has been completed within 30 calendar days of admission or (ii) a diagnosis confirmed in writing by an LMHP, LMHP-R, LMHP-RP, or LMHP-S after review of a previous evaluation completed within one year of admission;

(4) A description of the ~~individual's~~ youth'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~~ youth'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~~ youth 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 or its contractor. 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 or its contractor 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~~ if updated since the last service authorization request;

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~~ youth'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~~ youth 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 or its contractor 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~~ youth. Treating service providers authorized to deliver medically necessary EPSDT services in therapeutic group homes and PRTFs on behalf of a Medicaid-enrolled ~~individual~~ youth shall adhere to the individualized interventions and evidence-based progress measurement criteria described in the plan of care and approved for reimbursement by DMAS or its contractor. 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~~ youth 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~~ youth 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~~ youth'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~~ the youth'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~~ youth (defined as an 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~~ youth must be directed exclusively toward the benefit of the Medicaid-eligible ~~individual~~ youth. Services are expected to improve outcomes for ~~individuals younger than 21 years of age~~ youth with complex needs who are involved with multiple systems and increase the ~~individual's~~ youth'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~~ youth 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, LMHP-R, LMHP-RP, or LMHP-S ~~completing the assessment recommending~~ 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 assessment of the LMHP, LMHP-R, LMHP-RP, or LMHP-S for service, the ~~individual's~~ youth's and the caregiver's perceived recovery needs, and any clinical assessments or ~~service specific provider intakes~~ comprehensive needs assessments as defined in ~~this section~~ subsection C of 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~~ youth and the ~~individual's~~ youth's caregiver. Individualized goals and strategies shall be focused on the ~~individual's~~ youth'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 (i) the LMHP, LMHP-R, LMHP-RP, or LMHP-S; (ii) the PRS; (iii) the direct supervisor; (iv) the ~~individual~~ youth; and (v) the ~~individual's~~ youth's caregiver within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the ~~individual~~ youth, encouraging the ~~individual~~ youth 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 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~~ youth who qualify to receive mental health family support partners shall (i) care for ~~an individual~~ a youth with a mental health disorder who requires recovery assistance and (ii) meet two or more of the following:

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

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

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

d. ~~Individual~~ The youth and his caregiver need assistance to help the ~~individual~~ youth and caregiver assume responsibility for recovery.

6. ~~Individuals~~ Youth who are 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, an assessment shall be conducted and documented by an LMHP, LMHP-R, LMHP-RP, or LMHP-S who is acting within his scope of practice under state law. The assessment shall verify that the ~~individual~~ youth meets the medical necessity criteria set forth in subdivision 5 of this subsection. The assessment shall be included as part of the recovery, resiliency, and wellness plan and medical record. Services shall be initiated within 30 calendar days from when the assessment was complete.

11. Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, experience, and certification required by DBHDS in accordance with 12VAC35-250. Peer recovery specialists shall be registered by the Virginia 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, LMHP-R, LMHP-RP, or LMHP-S who ~~assessed the individual and made the recommendation for services and providing~~ shall provide 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~~ youth 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)~~ 12 of this subsection shall be eligible to bill and receive reimbursement from DMAS or its contractor for mental health family support partner services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined not to be in compliance with DMAS requirements.

14. Supervision of the PRS shall meet the requirements set forth in 12VAC30-50-226 B 7 l and m.

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~~ youth. 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~~ youth's home and community settings as deemed by DMAS or its contractor 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.

"Youth" means an individual younger than 21 years of age who is receiving behavioral therapy services.

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~~ youth's family or caregiver is trained to effectively manage the ~~individual's~~ youth'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~~ youth's primary care provider or other licensed physician, licensed physician assistant, or licensed nurse practitioner and determined by DMAS or its contractor 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~~ A behavioral therapy assessment shall be required ~~at the onset of~~ prior to 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~~ youth without a disability, such as the ~~individual's~~ youth'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~~ youth's home and the larger community within which the ~~individual~~ youth resides. Covered behavioral therapy services shall include:

a. Initial and periodic ~~service-specific provider intake~~ behavioral therapy assessment 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~~ youth'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~~ Youth enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these ~~children~~ individuals.

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 ~~a child~~ 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.

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

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

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

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

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

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

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

"Certified prescreener assessment" means an assessment for crisis intervention and crisis stabilization completed by a certified prescreener that meets the elements of a comprehensive needs assessment.

"Code" means the Code of Virginia.

"Comprehensive needs assessment" means the same as defined in 12VAC30-50-130 and also includes individuals who are older than 21 years of age. Requirements for the comprehensive needs assessment are set out in 12VAC30-60-143.

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

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

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

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

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

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

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

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

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

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

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

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

"Peer recovery specialist" or "PRS" means the same as defined in 12VAC35-250-10.

"Peer recovery support services" means the same as defined in 12VAC35-250-10.

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

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in ~~12VAC35-105-20~~ § 54.1-3500 of the Code.

"Qualified mental health professional-child" or "QMHP-C" means the same as defined in ~~12VAC35-105-20~~ § 54.1-3500 of the Code.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term ~~defined in 12VAC35-105-20~~ "qualified mental health professional – trainee" as defined in § 54.1-3500 of the Code.

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

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

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

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

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

~~"Review of ISP" means that the provider evaluates and updates the individual's progress toward meeting the individualized service plan objectives and documents the~~

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

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

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

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

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

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

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

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

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

b. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. A unit shall equal 15 minutes.

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

4. Intensive community treatment (ICT) shall be provided based on a written ~~intake~~ comprehensive needs assessment and certification of need by ~~a licensed mental health provider (~~ an LMHP~~)~~, LMHP-S, LMHP-R, ~~and~~ or LMHP-RP and shall include medical psychotherapy, psychiatric assessment, medication management, and care coordination activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community. Authorization is required for Medicaid reimbursement.

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

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

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

b. A written~~, service-specific provider intake, as defined at 12VAC30-50-130,~~ comprehensive needs assessment that documents the individual's eligibility and the need for this service must be completed prior to the initiation of services. This ~~intake~~ comprehensive needs assessment must be maintained in the individual's records.

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

d. A unit shall equal one hour.

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

f. ICT services shall be reviewed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S for all individuals who have received at least six months of ICT to determine the continued need for this service.

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

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

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

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

d. This service shall not be reimbursed for (i) individuals with medical conditions that require hospital care; (ii) individuals with a primary diagnosis of substance abuse; or (iii) individuals with psychiatric conditions that cannot be managed in the community (i.e., individuals who are of imminent danger to themselves or others).

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

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

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

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

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

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

6. Mental health skill-building services (MHSS) shall be defined as goal-directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed. These services may be authorized up to six consecutive months as long as the individual meets the coverage criteria for this service. The

~~service-specific provider intake, as defined at 12VAC30-50-130,~~ comprehensive needs assessment shall document the individual's behavior and describe how the individual meets criteria for this service. These services shall provide goal-directed training in the following areas in order to be reimbursed by Medicaid or the DMAS contractor: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring of health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities. Providers shall be reimbursed only for training activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and this section. A review of MHSS services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individuals who have received at least six months of MHSS to determine the continued need for this service.

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

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

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

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

(b) Major depressive disorder;

(c) Recurrent Bipolar I or Bipolar II; or

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

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

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

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

c. Individuals 18 ~~to 21~~, 19, and 20 years of age shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

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

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

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

(b) Major depressive disorder;

(c) Recurrent Bipolar I or Bipolar II; or

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

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

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

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

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

d. ~~Service-specific provider intakes~~ Comprehensive needs assessments shall be required at the onset of services and individual service plans (ISPs) shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated ~~service-specific provider intakes~~ comprehensive needs assessment or ISPs shall be denied reimbursement. Requirements for ~~service-specific provider intakes~~ comprehensive needs assessments and ISPs are set out in ~~12VAC30-50-130~~ 12VAC30-60-143.

e. Only direct face-to-face contacts and services to the individual shall be reimbursable. One unit is 1 to 2.99 hours per day, and two units is 3 ~~to 4.99~~ or more hours per day.

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

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

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

i. Limits and exclusions.

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

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

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

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

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

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

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

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

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

(9) Mental health skill-building services shall not be duplicative of other services. Providers shall be required to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or QPPMH to avoid duplication of services.

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

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

7. Mental health peer support services.

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

b. Under the clinical oversight of the LMHP, LMHP-R, LMHP-RP, or LMHP-S assessing the individual and making the recommendation for mental health support services, the peer recovery specialist in consultation with his direct supervisor shall develop a recovery, resiliency, and wellness plan based on the recommendation of the LMHP, LMHP-R, LMHP-RP, or LMHP-S for service, the individual's perceived recovery needs, and any clinical assessments or ~~service specific provider intakes~~ comprehensive needs assessments as defined in this

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

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

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

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

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

(2) Have a documented mental health disorder diagnosis.

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

f. To qualify for continued mental health peer support services, 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.

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

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

i. Prior to service initiation, an assessment shall be conducted and documented by an LMHP, LMHP-R, LMHP-RP, or LMHP-S within the scope of practice under state law. The assessment shall verify that the individual meets the medical necessity criteria set forth in subdivision 7 e of this subsection. The assessment shall be included as part of the recovery, resiliency, and wellness plan and medical record. Services shall be initiated within 30 calendar days from when the assessment was complete.

j. Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, experience, and certification established by DBHDS in accordance with 12VAC35-250. ~~Effective December 18, 2017,~~ Peer Recovery Specialists shall ~~also~~ be registered with the Virginia Board of Counseling ~~registration of peer recovery specialists by the Board of Counseling shall be required~~. The PRS shall perform mental health peer support services under the oversight of the LMHP, LMHP-R, LMHP-RP, or LMHP-S who ~~assessed the individual and made the recommendation for services and providing~~ shall provide the clinical oversight of the recovery, resiliency, and wellness plan. The PRS shall be employed by or have a contractual relationship with an enrolled provider licensed for one of the following:

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

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

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

(4) Outpatient psychiatric services provider.

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

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

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

(a) Day treatment or partial hospitalization;

(b) Psychosocial rehabilitation;

(c) Crisis intervention;

(d) Intensive community treatment;

(e) Crisis stabilization;

(f) Mental health skill building; or

(g) Mental health case management.

k. Only the licensed and enrolled provider referenced in subdivision 7 j of this subsection shall be eligible to bill mental health peer support services. Payments shall not be permitted to providers that fail to enter into an enrollment

agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

l. Supervision of the PRS shall be required as set forth in the definition of "supervision" in 12VAC30-130-5160. Supervision of the PRS shall also meet the following requirements: the direct supervisor shall perform direct supervision of the PRS as needed based on the level of urgency and intensity of service being provided. The direct supervisor shall have an employment or contract relationship with the same provider entity that employs or contracts with the PRS. Direct supervisors shall maintain documentation of all supervisory sessions. In no instance shall supervisory sessions be performed less than as provided in subdivisions 7 l (1) and 7 l (2) of this subsection:

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

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

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

12VAC30-60-61. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health and behavioral therapy services for ~~children~~ youth.

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

"At risk" means one or more of the following: (i) within the two weeks before the ~~intake~~, comprehensive needs assessment, the individual shall be screened by ~~an~~ a licensed mental health professional (LMHP), licensed mental health professional-resident (LMHP-R), licensed mental health professional--resident in psychology LMHP-RP, or licensed mental health professional-supervisee (LMHP-S) for escalating behaviors that have put either the individual or others at immediate risk of physical injury; (ii) the parent or guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement; (iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, ~~as defined in 12VAC35-105-20,~~ LMHP-R, LMHP-RP, or LMHP-S, and who is neither an employee of nor consultant to the intensive in-home (IIH) services or therapeutic day treatment (TDT) provider, has recommended an out-of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident; (iv) the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health ~~support)~~ skill-building) within the past 30 calendar days; or (v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either: (a) transitioning out of psychiatric residential treatment facility (PRTF) services, (b) transitioning out of a therapeutic group home, (c) transitioning out of acute psychiatric hospitalization, or (d) transitioning between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

~~"Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the services did not treat or resolve the individual's mental health or behavioral issues.~~

~~"Individual" means the Medicaid eligible person receiving these services and for the purpose of this section includes children from birth up to 12 years of age and adolescents ages 12 through 20 years.~~

"Comprehensive needs assessment" means the same as defined in 12VAC30-50-130.

"Licensed assistant behavior analyst" means a person who has met the licensing requirements of 18VAC85-150 and holds a valid license issued by the Department of Health Professions.

"Licensed behavior analyst" means a person who has met the licensing requirements of 18VAC85-150 and holds a valid license issued by the Department of Health Professions.

~~"New service" means a community mental health rehabilitation service for which the individual does not have a current service authorization in effect as of July 17, 2011.~~

"Out-of-home placement" means placement in one or more of the following: (i) therapeutic group home; (ii) regular foster home if the individual is currently residing with the individual's biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services; (iii) treatment foster care if the individual is currently residing with the individual's biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care; (iv) psychiatric residential treatment facility; (v) emergency shelter for the individual only due either to his mental health or behavior or both; (vi) psychiatric hospitalization; or (vii) juvenile justice system or incarceration.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress or lack of progress toward goals and objectives in the plan of care. ~~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 required to deliver the service. The content of each progress note shall corroborate the time or units billed. Progress notes shall be documented for each service that is billed.~~

~~"Service specific provider intake" means the evaluation that is conducted according to the Department of Medical Assistance Services (DMAS) intake definition set out in 12VAC30-50-130.~~

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

"Unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the services did not treat or resolve the individual's mental health or behavioral issues.

"Youth" means an individual younger than 21 years of age who is receiving community mental health or behavioral therapy services.

B. Utilization review requirements for all services in this section.

1. The services described in this section shall be rendered consistent with the definitions, service limits, and requirements described in this section and in 12VAC30-50-130.

2. Providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

3. Individual service plans (ISPs) shall meet all of the requirements set forth in 12VAC30-60-143 B ~~7~~ 8.

4. The provider shall meet the federal and state requirements for administrative and financial management capacity. The provider shall obtain, prior to delivery of services, and shall maintain and update periodically as the Department of Medical Assistance Services (DMAS) or its contractor requires, a current provider enrollment agreement for each Medicaid service the provider offers. DMAS shall not reimburse providers who do not enter into a provider enrollment agreement for a service prior to offering that service.

5. The provider shall document and maintain individual case records in accordance with state and federal requirements.

6. The provider shall ensure eligible individuals have free choice of providers of mental health services and other medical care under the individual service plan.

7. The comprehensive needs assessment shall include documented history of the severity, intensity, and duration of mental health care problems and issues. all of the following elements: (i) the presenting issue or reason for referral; (ii) mental health history or history of 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.

8. Progress notes shall 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 or hours required to deliver the service. The content of each progress note shall corroborate

the units or hours billed. Progress notes shall be documented for each service that is billed.

C. Utilization review of intensive in-home (IIH) services for ~~children and adolescents~~ youth.

1. The service definition for intensive in-home (IIH) services is contained in 12VAC30-50-130.

2. ~~Individuals~~ Youth qualifying for this service shall demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness that results in significant functional impairments in major life activities. ~~Individuals~~ Youth must meet at least two of the following criteria on a continuing or intermittent basis to be authorized for these services:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

b. Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services or judicial system are or have been necessary.

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

3. Prior to admission, an appropriate ~~service-specific provider intake, as defined in 12VAC30-50-130,~~ comprehensive needs assessment shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the ~~individual's~~ youth's diagnosis and describing how service needs can best be met through intervention provided typically but not solely in the ~~individual's~~ youth's residence. The ~~service-specific provider intake~~ comprehensive needs assessment shall describe how the ~~individual's~~ youth's clinical needs put the ~~individual~~ youth at risk of out-of-home placement and shall be conducted face-to-face ~~in the individual's residence~~. ~~Claims for services that are based upon service-specific provider intakes that are incomplete, outdated (more than 12 months old), or missing shall not be reimbursed.~~ Comprehensive needs assessments shall meet all of the requirements set forth in 12VAC30-60-143 B 7.

4. An individual service plan (ISP) shall be fully completed, signed, and dated by either an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a qualified mental health professional-child (QMHP-C), or a qualified mental health professional-eligible (QMHP-E) and the ~~individual~~ youth and ~~individual's~~ youth's parent or guardian within 30 calendar days of initiation of services. ~~The ISP shall meet all of the requirements as defined in 12VAC30-50-226.~~

5. DMAS shall not reimburse for dates of services in which the progress notes are not individualized ~~and child-specific~~ to the specific youth. Duplicated progress notes shall not constitute the required ~~child-specific~~ individualized progress notes. Each progress note shall demonstrate unique differences particular to the ~~individual's~~ youth's circumstances, treatment, and progress. Claim payments shall be retracted for services that are supported by documentation that does not demonstrate unique differences particular to the ~~individual~~ youth.

6. Services shall be directed toward the treatment of the eligible ~~individual~~ youth and delivered primarily in the family's residence with the ~~individual~~ youth present. As clinically indicated, the services may be rendered in the community if there is documentation, on that date of service, of the necessity of providing services in the community. The documentation shall describe how the alternative community service location supports the identified clinical needs of the ~~individual~~ youth and describe how it facilitates the implementation of the ISP. For services provided outside of the home, there shall be documentation reflecting therapeutic treatment as set forth in the ISP provided for that date of service in the appropriately signed and dated progress notes.

7. These services shall be provided when the clinical needs of the ~~individual~~ youth put ~~the individual~~ youth at risk for out-of-home placement, as these terms are defined in this section:

a. When services that are far more intensive than outpatient clinic care are required to stabilize the ~~individual~~ youth in the family situation; or

b. When the ~~individual's~~ youth's residence as the setting for services is more likely to be successful than a clinic.

The ~~service-specific provider intake~~ comprehensive needs assessment shall describe how the ~~individual~~ youth meets either subdivision 7 a or 7 b of this subsection.

8. Services shall not be provided if the ~~individual~~ youth is no longer a resident of the home.

9. Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The ~~individual~~ youth and responsible parent or guardian shall be available and in agreement to participate in the transition.

10. At least one parent or legal guardian or responsible adult with whom the ~~individual~~ youth is living must be willing to participate in the intensive in-home services with the goal of keeping the individual youth with the family. In the instance of this service, a responsible adult shall be an adult who lives in the same household with the ~~child~~ youth and is responsible for engaging in therapy and service-related activities to benefit the ~~individual~~ youth.

11. The enrolled provider shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of intensive in-home

services. The provider shall also have a provider enrollment agreement with DMAS or its contractor in effect prior to the delivery of this service that indicates that the provider will offer intensive in-home services.

12. Services must only be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C, or QMHP-E. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH ~~as defined in 12VAC35-105-20~~.

13. The billing unit for intensive in-home service shall be one hour. Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to ~~individuals~~ youth for whom there is an ISP in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per ~~individual~~ youth or family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the ~~individual~~ youth and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans shall incorporate an individualized discharge plan that describes transition from intensive in-home to less intensive or nonhome based services.

14. The ISP, as defined in 12VAC30-50-226, shall be updated as the ~~individual's~~ youth's needs and progress changes and signed by either the parent or legal guardian and the ~~individual~~ youth. Documentation shall be provided if the ~~individual~~ youth, who is a minor child, is unable or unwilling to sign the ISP. If there is a lapse in services that is greater than 31 consecutive calendar days without any communications from family members or legal guardian or the ~~individual~~ youth with the provider, the provider shall discharge the ~~individual~~ youth. ~~If the individual continues to need services, then a new intake or admission shall be documented and a new service authorization shall be required.~~

15. The provider shall ensure that the maximum staff-to-caseload ratio fully meets the needs of the ~~individual~~ youth.

16. If an ~~individual~~ youth receiving services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall contact the case manager and provide notification of the provision of services. In addition, the provider shall send monthly updates to the case manager on the ~~individual's~~ youth's status. A discharge summary shall be sent to the case manager within 30 calendar days of the service discontinuation date. Providers and case managers who are using the same electronic health record for the ~~individual~~ youth shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of the information in the electronic health records.

17. Emergency assistance shall be available 24 hours per day, seven days a week.

18. Providers shall comply with DMAS marketing requirements at 12VAC30-130-2000. Providers that DMAS determines violate these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.

19. The provider shall determine who the primary care provider is and, upon receiving written consent from the ~~individual~~ youth or guardian, shall inform the primary care provider of the ~~individual's~~ youth's receipt of IIH services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

D. Utilization review of therapeutic day treatment for ~~children and adolescents~~ youth.

1. The service definition for therapeutic day treatment (TDT) for ~~children and adolescents~~ youth is contained in 12VAC30-50-130.

2. Therapeutic day treatment is appropriate for ~~children and adolescents~~ youth who meet one of the following criteria:

a. ~~Children and adolescents~~ Youth who require year-round treatment in order to sustain behavior or emotional gains.

b. ~~Children and adolescents~~ Youth whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:

(1) This programming during the school day; or

(2) This programming to supplement the school day or school year.

c. ~~Children and adolescents~~ Youth who would otherwise be placed on homebound instruction because of severe ~~emotional/behavior~~ emotional or behavior problems that interfere with learning.

d. ~~Children and adolescents~~ Youth who (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; or (iv) are extremely depressed or marginally connected with reality.

e. Children in preschool enrichment and early intervention programs when the children's emotional or behavioral problems are so severe that the children cannot function in these programs without additional services.

3. The ~~service-specific provider intake~~ comprehensive needs assessment shall document the ~~individual's~~ youth's behavior and describe how the ~~individual~~ youth meets these specific service criteria in subdivision 2 of this subsection.

4. Prior to admission to this service, a ~~service-specific provider intake~~ comprehensive needs assessment shall be conducted by ~~the~~ an LMHP ~~as defined in 12VAC35-105-20~~, LMHP-R, LMHP-RP, or LMHP-S who shall make and document the diagnosis. Comprehensive needs assessments

shall meet all of the requirements set forth in 12VAC30-60-143 B 7.

5. An ISP shall be fully completed, signed, and dated by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E and by the ~~individual~~ youth or the parent or guardian within 30 calendar days of initiation of services ~~and shall meet all requirements of an ISP as defined in 12VAC30-50-226~~. Individual progress notes shall be required for each contact with the ~~individual~~ youth and shall meet all of the requirements as defined in this section.

6. Such services shall not duplicate those services provided by the school.

7. ~~Individuals~~ The youth qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. ~~Individuals~~ The youth shall meet at least two of the following criteria on a continuing or intermittent basis:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

b. Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services, or judicial system are or have been necessary.

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

8. The enrolled provider of therapeutic day treatment for ~~child and adolescent~~ youth services shall be licensed by DBHDS to provide day support services. The provider shall also have a provider enrollment agreement in effect with DMAS prior to the delivery of this service that indicates that the provider offers therapeutic day treatment services for ~~children and adolescents~~ youth.

9. Services shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

10. The minimum staff-to-individual ratio as defined by DBHDS licensing requirements shall ensure that adequate staff is available to meet the needs of the ~~individual~~ youth identified on the ISP.

11. The program shall operate a minimum of two hours per day and may offer flexible program hours (i.e., before or after school or during the summer). One unit of service shall be defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

12. Time required for academic instruction when no treatment activity is going on shall not be included in the billing unit.

~~13. Services shall be provided following a service specific provider intake that is conducted by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. An LMHP, LMHP-supervisee, or LMHP-resident shall make and document the diagnosis. The service specific provider intake shall include the elements as defined in 12VAC30-50-130.~~

~~14.~~ 13. If ~~an individual~~ a youth receiving services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager and provide notification of the provision of services. In addition, the provider shall send monthly updates to the case manager on the ~~individual's~~ youth's status. A discharge summary shall be sent to the case manager within 30 calendar days of the service discontinuation date. Providers and case managers using the same electronic health record for the ~~individual~~ youth shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

~~15.~~ 14. The provider shall determine who the primary care provider is and, upon receiving written consent from the ~~individual~~ youth or the ~~individual's~~ youth's parent or legal guardian, shall inform the primary care provider of the ~~individual's~~ youth's receipt of community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted. The parent or legal guardian shall be required to give written consent that this provider has permission to inform the primary care provider of the ~~child's or adolescent's~~ youth's receipt of community mental health rehabilitative services.

~~16.~~ 15. Providers shall comply with DMAS marketing requirements as set out in 12VAC30-130-2000. Providers that DMAS determines have violated these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.

~~17.~~ 16. If there is a lapse in services greater than 31 consecutive calendar days, the provider shall discharge the ~~individual~~ youth. ~~If the individual continues to need services, a new intake or admission documentation shall be prepared and a new service authorization shall be required.~~

E. Utilization review of therapeutic group home ~~for children and adolescents younger than 21 years of age~~ services.

1. The staff ratio must be approved by the Office of Licensure at the Department of Behavioral Health and Developmental Services. The clinical director shall be a licensed mental health professional. The caseload of the

clinical director must not exceed 16 individuals including all sites for which the same clinical director is responsible.

2. The program director shall be full time and meet the requirements for a program director as defined in 12VAC35-46-350.

3. For Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff at the therapeutic group home shall meet DBHDS qualified paraprofessional in mental health (QPPMH) criteria, as defined in 12VAC35-105-20. The therapeutic group home shall coordinate services with other providers.

4. All therapeutic group home services shall be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

5. Services must be provided in accordance with a comprehensive individual plan of care as defined in 12VAC30-50-130, which shall be fully completed within 30 calendar days of authorization for Medicaid reimbursement.

6. Prior to admission, an assessment shall be performed using all elements specified by DMAS in 12VAC30-50-130.

7. Such assessments shall be performed by an LMHP, an LMHP-supervisee, LMHP-resident, or LMHP-RP.

8. If ~~an individual~~ a youth receiving therapeutic group home services ~~for children and adolescents younger than 21 years of age~~ is also receiving case management services, the therapeutic group home services provider must collaborate with the care coordinator/case manager by notifying him of the provision of therapeutic group home services and the therapeutic group home services provider shall send monthly updates on the ~~individual's~~ youth's treatment status.

9. The provider shall determine who the primary care provider is and~~, upon receiving written consent from the individual or parent or legally authorized representative,~~ shall inform the primary care provider of the ~~individual's~~ youth's receipt of therapeutic group home services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted. ~~If these individuals are children or adolescents, then the parent or legally authorized representative shall be required to give written consent that this provider has permission to inform the primary care provider of the individual's receipt of community mental health rehabilitative services.~~

F. Utilization review of behavioral therapy services for ~~individuals younger than 21 years of age~~ youth.

1. In order for Medicaid to cover behavioral therapy services, the provider shall be enrolled with DMAS or its contractor as a Medicaid provider. The provider enrollment agreement shall be in effect prior to the delivery of services for Medicaid reimbursement.

2. Behavioral therapy services shall be covered for ~~individuals younger than 21 years of age~~ youth when recommended by the ~~individual's~~ youth's primary care provider, licensed physician, licensed physician assistant, or licensed nurse practitioner and determined by DMAS or its contractor to be medically necessary to correct or ameliorate significant impairments in major life activities that have resulted from either developmental, behavioral, or mental disabilities.

3. Behavioral therapy services require service authorization. Services shall be authorized only when eligibility and medical necessity criteria are met.

4. Prior to treatment, an appropriate ~~service-specific provider intake~~ behavioral therapy assessment shall be conducted, documented, signed, and dated by a licensed behavior analyst (LBA), licensed assistant behavior analyst (LABA), LMHP, LMHP-R, LMHP-RP, or LMHP-S, acting within the scope of his practice, documenting the ~~individual's~~ youth's diagnosis (including a description of the behaviors targeted for treatment with their frequency, duration, and intensity) and describing how service needs can best be met through behavioral therapy. The ~~service-specific provider intake~~ behavioral therapy assessment shall be conducted face-to-face in the ~~individual's~~ youth's residence with the ~~individual~~ youth and parent or guardian.

5. The ISP shall be developed upon admission to the service and reviewed within 30 days of admission to the service to ensure that all treatment goals are reflective of the ~~individual's~~ youth's clinical needs and shall describe each treatment goal, targeted behavior, one or more measurable objectives for each targeted behavior, the behavioral modification strategy to be used to manage each targeted behavior, the plan for parent or caregiver training, care coordination, and the measurement and data collection methods to be used for each targeted behavior in the ISP. The ISP as defined in ~~12VAC30-50-130~~ 12VAC30-50-226 shall be fully completed, signed, and dated by an LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S. Every three months, the LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S shall review the ISP, modify the ISP as appropriate, and update the ISP, and all of these activities shall occur with the ~~individual~~ youth in a manner in which the ~~individual~~ youth may participate in the process. The ISP shall be rewritten at least annually.

6. Reimbursement for the initial ~~service-specific provider intake~~ behavioral therapy assessment and the initial ISP shall be limited to five hours without service authorization. If additional time is needed to complete these documents, service authorization shall be required.

7. Clinical supervision shall be required for Medicaid reimbursement of behavioral therapy services that are rendered by an LABA, LMHP-R, LMHP-RP, or LMHP-S or unlicensed staff consistent with the scope of practice as

described by the applicable Virginia Department of Health Professions regulatory board. Clinical supervision of unlicensed staff shall occur at least weekly. As documented in the ~~individual's~~ youth's medical record, clinical supervision shall include a review of progress notes and data and dialogue with supervised staff about the ~~individual's~~ youth's progress and the effectiveness of the ISP. Clinical supervision shall be documented by, at a minimum, the contemporaneously dated signature of the clinical supervisor.

8. Family training involving the ~~individual's~~ youth's family and significant others to advance the treatment goals of the ~~individual~~ youth shall be provided when (i) the training with the family member or significant other is for the direct benefit of the ~~individual~~ youth, (ii) the training is not aimed at addressing the treatment needs of the ~~individual's~~ youth family or significant others, (iii) the ~~individual~~ youth is present except when it is clinically appropriate for the ~~individual~~ youth to be absent in order to advance the ~~individual's~~ youth's treatment goals, and (iv) the training is aligned with the goals of the ~~individual's~~ youth's treatment plan.

9. The following shall not be covered under this service:

a. Screening to identify physical, mental, or developmental conditions that may require evaluation or treatment. Screening is covered as an EPSDT service provided by the primary care provider and is not covered as a behavioral therapy service under this section.

b. Services other than the initial ~~service-specific provider intake~~ behavioral therapy assessment that are provided but are not based upon the ~~individual's~~ youth's ISP or linked to a service in the ISP. Time not actively involved in providing services directed by the ISP shall not be reimbursed.

c. Services that are based upon an incomplete, missing, or outdated ~~service-specific provider intake~~ behavioral therapy assessment or ISP.

d. Sessions that are conducted for family support, education, recreational, or custodial purposes, including respite or child care.

e. Services that are provided by a provider but are rendered primarily by a relative or guardian who is legally responsible for the ~~individual's~~ youth's care.

f. Services that are provided in a clinic or provider's office without documented justification for the location in the ISP.

g. Services that are provided in the absence of the ~~individual~~ youth or a parent or other authorized caregiver identified in the ISP with the exception of treatment review processes described in subdivision 12 e of this subsection, care coordination, and clinical supervision.

h. Services provided by a local education agency.

i. Provider travel time.

10. Behavioral therapy services shall not be reimbursed concurrently with community mental health services described in 12VAC30-50-130 C or 12VAC30-50-226 B, or behavioral, psychological, or psychiatric therapeutic consultation described in 12VAC30-120-756, 12VAC30-120-1000, or 12VAC30-135-320.

11. If the ~~individual~~ youth is receiving targeted case management services under the State Plan (defined in 12VAC30-50-410 through 12VAC30-50-491), the provider shall notify the case manager of the provision of behavioral therapy services unless the parent or guardian requests that the information not be released. In addition, the provider shall send monthly updates to the case manager on the ~~individual's~~ youth's status pursuant to a valid release of information. A discharge summary shall be sent to the case manager within 30 days of the service discontinuation date. A refusal of the parent or guardian to release information shall be documented in the medical record for the date the request was discussed.

12. Other standards to ensure quality of services:

a. Services shall be delivered only by an LBA, LABA, LMHP, LMHP-R, LMHP-RP, LMHP-S, or clinically supervised unlicensed staff consistent with the scope of practice as described by the applicable Virginia Department of Health Professions regulatory board.

b. Individual-specific services shall be directed toward the treatment of the eligible individual and delivered in the family's residence unless an alternative location is justified and documented in the ISP.

c. Individual-specific progress notes shall be created contemporaneously with the service activities and shall document the name and Medicaid number of each ~~individual~~ youth; the provider's name, signature, and date; and time of service. Documentation shall include activities provided, length of services provided, the ~~individual's~~ youth's reaction to that day's activity, and documentation of the ~~individual's~~ youth's and the parent or caregiver's progress toward achieving each behavioral objective through analysis and reporting of quantifiable behavioral data. Documentation shall be prepared to clearly demonstrate efficacy using baseline and service-related data that shows clinical progress and generalization for the ~~child~~ youth and family members toward the therapy goals as defined in the service plan.

d. Documentation of all billed services shall include the amount of time or billable units spent to deliver the service and shall be signed and dated on the date of the service by the practitioner rendering the service.

e. Billable time is permitted for the LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S to better define behaviors and develop documentation strategies to measure treatment performance and the efficacy of the ISP

objectives, provided that these activities are documented in a progress note as described in subdivision 12 c of this subsection.

13. Failure to comply with any of the requirements in 12VAC30-50-130 or in this section shall result in retraction.

12VAC30-60-143. Mental health services utilization criteria; definitions.

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

~~"Child or adolescent" means the same as "adolescent or child" defined in 12VAC30-50-130.~~

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

"Certified prescreener assessment" means an assessment for crisis intervention and crisis stabilization completed by a certified prescreener that meets the elements of a comprehensive needs assessment.

"Comprehensive needs assessment" means the same as defined in 12VAC30-50-130 and also includes individuals who are older than 21 years of age.

"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.

"Licensed mental health professional" or "LMHP" means the same as defined in 12VAC30-50-130.

"LMHP-resident" or "LMHP-R" means the same as defined in 12VAC30-50-130.

"LMHP-resident in psychology" or "LMHP-RP" means the same as defined in 12VAC30-50-130.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as defined in 12VAC30-50-130.

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in 12VAC30-50-130.

"Qualified mental health professional-child" or "QMHP-C" means the same as defined in 12VAC30-50-130.

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

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

B. Utilization reviews shall include determinations that providers meet the following requirements:

1. The provider shall meet the federal and state requirements for administrative and financial management capacity. The provider shall obtain, prior to the delivery of services, and shall maintain and update periodically as the Department of Medical Assistance Services (DMAS) or its contractor requires, a current provider enrollment agreement for each Medicaid service that the provider offers. DMAS shall not reimburse providers who do not enter into a provider enrollment agreement for a service prior to offering that service.

2. The provider shall document and maintain individual case records in accordance with state and federal requirements.

3. The provider shall ensure eligible individuals have free choice of providers of mental health services and other medical care under the Individual Service Plan.

4. Providers shall comply with DMAS marketing requirements as set out in 12VAC30-130-2000. Providers that DMAS determines have violated these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E. Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

5. If an individual receiving community mental health rehabilitative services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager by notifying the case manager of the provision of community mental health rehabilitative services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the care coordinator/case manager within 30 calendar days of the discontinuation of services. Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

6. The provider shall determine who the primary care provider is and inform him of the individual's receipt of community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

7. Prior to admission, an appropriate comprehensive needs assessment shall be conducted by the licensed mental health professional (LMHP), LMHP-S, LMHP-R, or LMHP-RP. The comprehensive needs assessment shall include documented history of the severity, intensity, and duration of mental health care problems and issues. all of the following elements: (i) the presenting issue or reason for referral; (ii) mental health history or history of 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.

a. A single comprehensive needs assessment shall be used to document the medical necessity for one or more community mental health rehabilitative service provided by the same DBHDS licensed agency.

b. The comprehensive needs assessment shall be: completed face to face and signed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S; include all required elements as defined in 12VAC30-50-130; describe how each recommended community mental health rehabilitative service is medically necessary; and be reviewed and updated at a minimum of annually or as the individual's needs change.

c. The comprehensive needs assessment shall be reviewed and updated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S within 31 days if there is a clinical indication based on the medical, psychiatric, or behavioral symptoms of the individual.

d. An LMHP, LMHP-R, LMHP-RP, or LMHP-S shall conduct an annual face to face review and update of the comprehensive needs assessment that includes: a review of the comprehensive needs assessment; any necessary updates to the 15 required elements of the comprehensive needs assessment to reflect the individual's current level of functioning; an updated description of how the individual meets medical necessity criteria for all recommended services; and a contemporaneously dated signature of the LMHP, LMHP-R, LMHP-RP, or LMHP-S.

e. The comprehensive needs assessment is outdated if any of the following occurs: an LMHP, LMHP-R, LMHP-RP, or LMHP-S has not completed the annual review and update; within the past 31 calendar days, the provider has not provided a community mental health rehabilitative service or a case management activity (as defined in 12VAC30-50-420 or 12VAC30-50-430) as recommended by the comprehensive needs assessment, or, within the past 31 days, the comprehensive needs assessment has not been updated to reflect a change in the individual's current level of functioning.

f. If the comprehensive needs assessment is outdated, a new comprehensive needs assessment is required prior to resuming a community mental health rehabilitative service that lapsed for more than 31 calendar days. If the comprehensive needs update is not outdated, it must, at a minimum, be updated to document the medical necessity for a community mental health rehabilitative service that lapsed for more than 31 calendar days.

g. Providers shall only bill under the community mental health rehabilitative service assessment codes for the initial comprehensive needs assessment and for comprehensive needs assessments that replace an outdated assessment. Providers of multiple community mental health rehabilitative services shall only bill one community mental health rehabilitative service assessment code per individual.

h. Claims for services that are based upon comprehensive needs assessments that are incomplete, outdated, or missing shall not be reimbursed.

i. For crisis intervention and crisis stabilization services, a certified prescreener assessment may be used in place of the comprehensive needs assessment.

8. The provider shall include the individual and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated annually or as the needs and progress of the individual changes. An ISP that is not updated either annually or as the treatment interventions based on the needs and progress of the individual change shall be considered outdated. An ISP that does not include all required elements specified in 12VAC30-50-226 shall be considered incomplete. Claims for services that are based upon ISPs that are incomplete, outdated, or missing shall not be reimbursed. All ISPs shall be completed, signed, and contemporaneously dated by the ~~LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E~~ appropriate professional for the service, who is preparing the ISP within a maximum of 30 days of the date of the completed ~~intake~~ assessment unless otherwise specified. ~~The child's or adolescent's~~ A youth's ISP shall also be signed by the ~~parent/legal guardian~~ parent or legal guardian and the adult individual shall sign his own. If the individual~~, whether a child, adolescent, or an adult,~~ is unwilling to sign the ISP, then the service provider shall document the clinical or other reasons why the individual was not able or willing to sign the ISP. Signatures shall be obtained unless there is a clinical reason that renders the individual unable to sign the ISP.

~~(a)~~ a. Every three months, the ~~LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E~~ appropriate professional for the service shall review the ISP, modify the ISP as appropriate, and update the ISP, and all of these activities shall occur with the individual in a manner in which the individual may participate in the process. The ISP shall be rewritten at least annually.

~~(b)~~ b. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs as well as any newly-identified problems.

~~(c)~~ c. Documentation of ISP review shall be added to the individual's medical record no later than 15 days from the calendar date of the review as evidenced by the dated signatures of the ~~LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E,~~ appropriate professional for the service and the individual.

9. Progress notes shall 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 or hours required to deliver the service. The content of each progress note shall corroborate the units or hours billed. Progress notes shall be documented for each service that is billed.

10. Services described in this section shall be rendered consistent with the definitions, service limits, and requirements described in this section and in 12VAC30-50-226.

C. Day treatment/partial hospitalization services shall be provided following a ~~service-specific provider intake and be authorized~~ comprehensive needs assessment completed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S. An ISP, as defined in 12VAC30-50-226, shall be fully completed, signed, and dated by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, the QMHP-A, QMHP-E, or QMHP-C and ~~reviewed/approved~~ reviewed or approved by the LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 days of service initiation.

1. The enrolled provider of day treatment/partial hospitalization shall be licensed by DBHDS as providers of day treatment services.

2. Services shall only be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, a QMHP-A, a QMHP-C, a QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, QMHP-C, QMHP-E, or an LMHP, LMHP-R, LMHP-RP, or LMHP-S ~~as defined at 12VAC35-105-20, except for LMHP-R, LMHP-RP, and LMHP-S, which are defined in 12VAC30-50-226~~.

3. The program shall operate a minimum of two continuous hours in a 24-hour period.

4. Individuals shall be discharged from this service when other less intensive services may achieve or maintain psychiatric stabilization.

D. Psychosocial rehabilitation services shall be provided to those individuals who have experienced long-term or repeated psychiatric hospitalization, or who experience difficulty in activities of daily living and interpersonal skills, or whose support system is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term services are needed to maintain the individual in the community.

1. Psychosocial rehabilitation services shall be provided following a ~~service-specific provider intake~~ comprehensive needs assessment that clearly documents the need for services. ~~This intake~~ The comprehensive needs assessment shall be completed by either an LMHP, LMHP-R, LMHP-RP, or LMHP-S. An ISP shall be completed by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, or the QMHP-A, QMHP-E, or QMHP-C and be ~~reviewed/approved~~ reviewed or approved by either an LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 calendar days of service initiation. At least every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, the QMHP-A, QMHP-C, or QMHP-E must review, modify as appropriate, and update the ISP.

2. Psychosocial rehabilitation services of any individual that continue more than six months shall be reviewed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S who shall document the continued need for the service. The ISP shall be rewritten at least annually.

3. The enrolled provider of psychosocial rehabilitation services shall be licensed by DBHDS as a provider of psychosocial rehabilitation services.

4. Psychosocial rehabilitation services may be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, LMHP-R, LMHP-RP, or LMHP-S.

5. The program shall operate a minimum of two continuous hours in a 24-hour period.

6. Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the individual's understanding or ability to access community resources.

E. Initiation of crisis intervention services shall be indicated following a ~~service-specific provider intake~~ comprehensive needs assessment completed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, or a certified prescreener assessment that documents a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress. In order to receive reimbursement, providers shall register this service with DMAS or its contractor within one business day of the completion of the ~~service-specific provider intake~~ comprehensive needs assessment to avoid duplication of services and to ensure informed care coordination.

1. The crisis intervention services provider shall be licensed as a provider of emergency services by DBHDS.

2. Client-related activities provided in association with a face-to-face contact are reimbursable.

3. An individual service plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be

required for the service to be provided on an emergency basis.

4. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP shall be developed or revised to reflect the short-term counseling goals by the fourth face-to-face contact.

5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. There are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

6. Crisis intervention services may be provided to eligible individuals outside of the clinic and reimbursed, provided the provision of out-of-clinic services is ~~clinically/programmatically~~ clinically or programmatically appropriate. Travel by staff to provide out-of-clinic services shall not be reimbursable. Crisis intervention may involve contacts with the family or significant others. If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.

7. An LMHP, LMHP-R, LMHP-RP, or LMHP-S~~,~~ shall conduct a comprehensive needs assessment, or a certified prescreener shall conduct a face-to-face ~~service-specific provider intake. The intake shall document~~ comprehensive assessment that documents the need for and the anticipated duration of the crisis service.

8. Crisis intervention shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, or a certified prescreener.

9. For an admission to a freestanding inpatient psychiatric facility for individuals younger than age 21, federal regulations (42 CFR 441.152) require certification of the admission by an independent team. The independent team must include mental health professionals, including a physician. These preadmission screenings cannot be billed unless the requirement for an independent team certification, with a physician's signature, is met.

10. Services shall be documented through daily notes and a daily log of time spent in the delivery of services.

F. Case management services pursuant to 12VAC30-50-420 (seriously mentally ill adults and emotionally disturbed children) or 12VAC30-50-430 (youth at risk of serious emotional disturbance).

1. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is an ISP in effect that requires regular direct or client-related contacts or activity or communication with the individuals or families, significant others, service providers, and others including a minimum of one face-to-face individual contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. The Medicaid eligible individual shall meet the DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

3. There shall be no maximum service limits for case management services. Case management shall not be billed for persons in institutions for mental disease.

4. The ISP shall document the need for case management and be fully completed within 30 calendar days of initiation of the service. The case manager shall review the ISP at least every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

5. The ISP shall also be updated at least annually.

6. The provider of case management services shall be licensed by DBHDS as a provider of case management services.

G. Intensive community treatment (ICT).

1. A ~~service-specific provider intake~~ comprehensive needs assessment that documents eligibility and the need for this service shall be completed by either the LMHP, LMHP-R, LMHP-RP, or LMHP-S prior to the initiation of services. ~~This intake~~ The comprehensive needs assessment documentation shall be maintained in the individual's records.

2. An individual service plan, based on the needs as determined by the ~~service-specific provider intake~~ comprehensive needs assessment, must be initiated at the time of admission and must be fully developed by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and approved by the LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 days of the initiation of services.

3. ICT may be billed if the individual is brought to the facility by ICT staff to see the psychiatrist. Documentation must be present in the individual's record to support this intervention.

4. The enrolled ICT provider shall be licensed by the DBHDS as a provider of intensive community services or as a program of assertive community treatment, and must provide and make available emergency services 24-hours

per day, seven days per week, 365 days per year, either directly or on call.

5. ICT services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives as outlined on the ISP.

H. Crisis stabilization services.

1. This service shall be initiated following a face-to-face ~~service-specific provider intake~~ comprehensive needs assessment by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, or an assessment completed by a certified prescreener~~, as defined in 12VAC30-50-226~~ that documents the need for crisis stabilization services.

2. In order to receive reimbursement, providers shall register this service with DMAS or its contractor within one business day of the completion of the ~~service-specific provider intake~~ provider's assessment to avoid duplication of services and to ensure informed care coordination.

3. ~~The service-specific provider intake must document the need for crisis stabilization services.~~

~~4.~~ The Individual Service Plan (ISP) must be developed or revised within three calendar days of admission to this service. The LMHP, LMHP-R, LMHP-RP, LMHP-S, certified prescreener, QMHP-A, QMHP-C, or QMHP-E shall develop the ISP.

~~5.~~ 4. Room and board, custodial care, and general supervision are not components of this service.

~~6.~~ 5. Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

~~7.~~ 6. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization.

~~8.~~ 7. Providers of residential crisis stabilization shall be licensed by DBHDS as providers of residential or nonresidential crisis stabilization services. Providers of community-based crisis stabilization shall be licensed by DBHDS as providers of mental health nonresidential crisis stabilization.

I. Mental health skill-building services as defined in 12VAC30-50-226 B 6.

1. At admission, an appropriate face-to-face ~~service-specific provider intake~~ comprehensive needs assessment must be conducted, documented, signed, and dated by the LMHP, LMHP-R, ~~or~~ LMHP-RP, or LMHP-S. Providers shall be reimbursed one unit for each intake utilizing the appropriate billing code. ~~Service-specific provider intakes shall be repeated upon any lapse in services of more than 30 calendar days.~~ Services of any individual that continue more than six months shall be reviewed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S who shall document the continued need for the service in the individual's medical record.

2. The primary ~~psychiatric~~ mental health diagnosis shall be documented as part of the ~~intake. The~~ comprehensive needs assessment by the LMHP, LMHP-R, LMHP-RP, or LMHP-S performing the ~~intake shall document the primary mental health diagnosis on the intake form~~ comprehensive needs assessment.

3. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall complete, sign, and date the ISP within 30 days of the admission to this service. The ISP shall include documentation of how many days per week and how many hours per week are required to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual's ISP. The ISP shall indicate the dated signature of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished, and criteria for discharge as part of a discharge plan that includes the projected length of service. If the individual refuses to sign the ISP, this shall be noted in the individual's medical record documentation.

4. Every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review with the individual in a manner in which he may participate with the process, modify as appropriate, and update the ISP. The ISP must be rewritten at least annually.

a. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs as well as any newly identified problem.

b. Documentation of this review shall be added to the individual's medical record no later than 15 calendar days from the date of the review, as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual.

5. The ISP shall include discharge goals that will enable the individual to achieve and maintain community stability and independence. The ISP shall fully support the need for interventions over the length of the period of service requested from the service authorization contractor.

6. Reauthorizations for service shall only be granted if the provider demonstrates to either DMAS or the service authorization contractor that the individual is benefitting

from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.

7. If the provider knows or has reason to know of the individual's nonadherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP. If the care is delivered by the qualified paraprofessional, the supervising LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall be informed of any nonadherence to the prescribed medication regimen. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall coordinate care with the prescribing physician regarding any concerns about medication nonadherence (provided that the individual has consented to such sharing of information). The provider shall document the following minimum elements of the contact between the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C and the prescribing physician:

a. Name and title of caller;

b. Name and title of professional who was called;

c. Name of organization that the prescribing professional works for;

d. Date and time of call;

e. Reason for the care coordination call;

f. Description of medication regimen issue or issues to be discussed; and

g. Whether or not there was a resolution of medication regimen issue or issues.

8. Discharge summaries shall be prepared by providers for all of the individuals in their care. Documentation of prior psychiatric services history shall be maintained in the individual's mental health skill-building services medical record.

9. Documentation of prior psychiatric services history shall be maintained in the individual's mental health skill-building services medical record. The provider shall document evidence of the individual's prior psychiatric services history, as required by 12VAC30-50-226 B 6 b (3) and 12VAC30-50-226 B 6 c (4), by contacting the prior provider or providers of such health care services after obtaining written consent from the individual. Documentation of telephone contacts with the prior provider shall include the following minimum elements:

a. Name and title of caller;

b. Name and title of professional who was called;

c. Name of organization that the professional works for;

d. Date and time of call;

e. Specific placement provided;

f. Type of treatment previously provided;

g. Name of treatment provider; and

h. Dates of previous treatment.

Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

10. The provider shall document evidence of the psychiatric medication history, as required by 12VAC30-50-226 B 6 b (4) and 12VAC30-50-226 B 6 c (5), by maintaining a photocopy of prescription information from a prescription bottle or by contacting the current or previous prescribing provider of health care services or pharmacy after obtaining written consent from the individual. Prescription lists or medical records, including discharge summaries, obtained from the pharmacy or current or previous prescribing provider of health care services that contain (i) the name of the prescribing physician, (ii) the name of the medication with dosage and frequency, and (iii) the date of the prescription shall be sufficient to meet these criteria. Family member statements shall not suffice to meet this requirement.

11. In the absence of such documentation, the current provider shall document all contacts (i.e., telephone, faxes, electronic communication) with the pharmacy or provider of health care services with the following minimum elements: (i) name and title of caller, (ii) name and title of prior professional who was called, (iii) name of organization that the professional works for, (iv) date and time of call, (v) specific prescription confirmed, (vi) name of prescribing physician, (vii) name of medication, and (viii) date of prescription.

12. Only direct face-to-face contacts and services to an individual shall be reimbursable.

13. Any services provided to the individual that are strictly academic in nature shall not be billable. These include, but are not limited to, such basic educational programs as instruction or tutoring in reading, science, mathematics, or GED.

14. Any services provided to individuals that are strictly vocational in nature shall not be billable. However, support activities and activities directly related to assisting an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.

15. Room and board, custodial care, and general supervision are not components of this service.

16. Provider qualifications. The enrolled provider of mental health skill-building services must be licensed by DBHDS as a provider of mental health community support (defined in 12VAC35-105-20). Individuals employed or contracted

by the provider to provide mental health skill-building services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. Mental health skill-building services shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, a QMHP-A, a QMHP-C, a QMHP-E, or a QPPMH. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C will supervise the care weekly if delivered by the QMHP-E or QPPMH. Documentation of supervision shall be maintained in the mental health skill-building services record.

17. Mental health skill-building services shall be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided. The provider shall clearly document services provided to detail what occurred during the entire amount of the time billed.

18. If mental health skill-building services are provided in a therapeutic group home or assisted living facility, effective July 1, 2014, there shall be a yearly limit of up to 416 units per fiscal year and a weekly limit of up to ~~8~~ eight units per week, with at least half of each week's services provided outside of the group home or assisted living facility. There shall be a daily limit of a maximum of ~~2~~ two units. Prior to July 1, 2014, the previous limits shall apply. DMAS or its contractor may authorize additional units of mental health skill-building services that exceed this limit based on documented medical necessity. The ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall attempt to coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

19. Limits and exclusions.

a. Therapeutic group home and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the provider's respective facility. Individuals residing in facilities may, however, receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside.

b. Mental health skill-building services shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability Waiver or Individual and Family Developmental Disabilities Support Waiver.

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

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

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

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

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

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

i. Mental health skill-building services shall not be duplicative of other services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E to avoid duplication of services.

j. Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving

mental health skill-building services unless their physicians issue a signed and dated statement indicating that the individuals can benefit from this service.

k. Individuals who are not diagnosed with a serious mental health disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability, will not be excluded from the mental health skill-building services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in 12VAC30-50-226 B 6 b (1) or 12VAC30-50-226 B 6 c (2) and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health support services.

J. Except as noted in subdivision I 18 of this section and in 12VAC30-50-226 B 6 e, the limits described in this section and in 12VAC30-50-226 shall apply to all service authorization requests submitted to either DMAS or the behavioral health services agency as of July 27, 2016. As of July 27, 2016, all annual limits, weekly limits, daily limits, and reimbursement for services shall apply to all services described in 12VAC30-50-226 regardless of the date upon which service authorization was obtained.

VA.R. Doc. No. R22-5564; Filed January 10, 2022, 2:16 p.m.

Emergency Regulation

Title of Regulation: **12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-301 through 12VAC30-60-315).**

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

Effective Dates: February 16, 2022, through August 15, 2023.

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

Preamble:

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

The amendments (i) allow qualified nursing facility staff to complete long-term services and supports (LTSS) screening for individuals who apply for or request LTSS and who are receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital and (ii) include the protection of individual choice for the setting and provider of LTSS services for every individual who applies for or requests institutional or community based services. The amendments conform regulation to Chapters 304 and 365 of the 2020 Acts of Assembly.

12VAC30-60-301. Definitions.

The following words and terms as used in 12VAC30-60-302 through 12VAC30-60-315 shall have the following meanings unless the context clearly indicates otherwise:

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

"Acute care hospital" or "hospital" means an acute care hospital, a rehabilitation hospital, a rehabilitation unit in an acute care hospital, or a psychiatric unit in an acute care hospital.

"Adult" means a person age 18 years or older who may need Medicaid-funded long-term services and supports (LTSS) or who becomes functionally eligible to receive Medicaid-funded LTSS.

"Appeal" means the processes used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20.

"At risk" means the need for the level of care provided in a hospital~~,~~ or nursing facility~~, or an intermediate care facility for individuals with intellectual disability (ICF/IID)~~ when there is reasonable indication that the individual is expected to need the services ~~in the near future (that is, 30 days or less)~~ within the next 30 days in the absence of home or community-based services.

"Child" means a person up to the age of 18 years who may need Medicaid-funded LTSS or who becomes functionally eligible to receive Medicaid-funded LTSS.

"Choice" means the individual is provided the option of either ~~home and community-based waiver services~~ the Commonwealth Coordinated Care (CCC) Plus Waiver, the Program of All-Inclusive Care for the Elderly (PACE), if available and appropriate, or institutional services and supports~~, including the Program of All-Inclusive Care for the Elderly (PACE), if available and appropriate,~~ after the individual has been determined likely to need LTSS.

"Communication" means all forms of sharing information and includes oral speech and augmented or alternative communication used to express thoughts, needs, wants, and ideas, such as the use of a communication device, interpreter, gestures, and picture or symbol communication boards.

"Community-based team" or "CBT" means (i) a registered nurse or nurse practitioner; (ii) a social worker or other assessor designated by DMAS; and (iii) a physician. The CBT

members are employees of, or contracted with, the Virginia Department of Health or the local department of social services. The authorization or denial for Medicaid LTSS (DMAS-96 form) is signed and attested to by the screener and a physician.

"CSB" means a local community services board.

"DARS" means the Virginia Department for Aging and Rehabilitative Services.

"Day" means calendar day unless specified otherwise.

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

"DMAS" means the Department of Medical Assistance Services.

"DMAS designee" means the public or private entity with ~~an agreement~~ a contract with the Department of Medical Assistance Services to complete ~~preadmission~~ LTSS screenings pursuant to § 32.1-330 of the Code of Virginia when a community-based hospital or nursing facility LTSS screening team cannot complete LTSS screenings within the required 30 days of the LTSS screening request date.

~~"ePAS"~~ "eMLS" means the DMAS ~~automated system or a DMAS approved~~ electronic Medicaid long-term services and supports screening record system ~~for use~~ used by LTSS screening entities ~~contracted by DMAS~~ to ~~perform~~ record results from LTSS screenings pursuant to § 32.1-330 of the Code of Virginia.

"Face-to-face" means an in-person meeting with the individual seeking Medicaid-funded LTSS.

"Feasible alternative" means a range of services that can be provided in the community via waiver or PACE, for less than the cost of comparable institutional care, in order to enable an individual to continue living in the community.

"Functional capacity" means the degree of independence that an individual has in performing ADLs, ~~ambulation, and instrumental ADLs~~ as measured on the UAI and as used as a basis for differentiating levels of long-term ~~care~~ services and supports.

"Functional eligibility" means the demonstrable degree to which an individual requires assistance with activities of daily living.

"Home and community-based services" means community-based waiver services or the Program of All-Inclusive Care for the Elderly (PACE).

"Home and community-based services provider" means a provider or agency enrolled with Virginia Medicaid to offer services to individuals eligible for ~~home and community-based waivers~~ the Commonwealth Coordinated Care (CCC) Plus waiver services or PACE.

"Home and community-based services waiver," "HCBS," or "waiver services" means the range of community services and supports, ~~including PACE,~~ approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to § 1915(c) of the Social Security Act to be offered to individuals as an alternative to institutionalization.

"Hospital team" means persons designated by the hospital who are responsible for conducting and submitting the LTSS screening documents for inpatients to ~~ePAS~~ eMLS. The authorization or denial for Medicaid LTSS (DMAS-96 form) is signed and attested to by the screener and a physician.

"Inpatient" means an individual who has a physician's order for admission to an acute care hospital, rehabilitation hospital, or a rehabilitation unit in an acute care hospital and shall not apply to outpatients, patients in observation beds, and patients of the hospital's emergency department.

"Local department of social services" or "LDSS" means the entity established under § 63.2-324 of the Code of Virginia by the governing city or county in the Commonwealth.

"Local health department" or "LHD" means the entity established under § 32.1-31 of the Code of Virginia.

"Long-term services and supports" or "LTSS" means a variety of services that help individuals with health or personal care needs and ADLs over a period of time that can be provided in the home, the community, or nursing facilities.

"Long-term services and supports screening" or "LTSS screening" means the face-to-face process to (i) evaluate the functional, medical or nursing, and social support needs and at-risk status of individuals referred for certain long-term services requiring nursing facility level of care eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual's needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility, PACE plan services, or the Commonwealth Coordinated Care (CCC) Plus waiver for those individuals who meet nursing facility level of care.

"Long-term services and supports screening team" or "LTSS team" means the hospital screening team, community-based team (CBT), nursing facility LTSS team, or DMAS designee contracted to perform screenings pursuant to § 32.1-330 of the Code of Virginia.

"Managed care organization" or "MCO" means a health plan selected to participate in the Commonwealth's CCC Plus program and that is a party to a contract with DMAS.

"Medicaid" means the program set out in the 42 USC § 1396 et seq. and administered by the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Medical or nursing need" means (i) the individual's condition requires observation and assessment to ensure evaluation of needs due to an inability for self-observation or evaluation; (ii) the individual has complex medical conditions that may be unstable or have the potential for instability; or (iii) the individual requires at least one ongoing medical or nursing service.

"Medicare" means the Health Insurance for the Aged and Disabled program as administered by the Centers for Medicare and Medicaid Services pursuant to 42 USC 1395ggg.

"Minimum data set" or "MDS" means the ~~evaluation~~ assessment form used by nursing facilities, as federally required, for the purpose of documenting ongoing level of care required for all of an NF's residents.

"Nursing facility" or "NF" means any nursing home as defined in § 32.1-123 of the Code of Virginia.

"Nursing facility LTSS screening team" means nursing facility staff trained and certified in the use of the LTSS screening tools who are responsible for performing LTSS screenings for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid and after discharge from a hospital. Nursing facility LTSS screening teams include at least one registered nurse and a certifying physician. The authorization or denial for Medicaid LTSS (DMAS-96 form) is signed and attested to by the screeners and a physician.

"Ongoing" means continuous medical or nursing needs that shall not be temporary.

"Other assessor designated by DMAS" means an employee of the local department of social services holding the occupational title of family services specialist or an employee of a DMAS designee.

~~"Preadmission screening" or "screening" means the face-to-face process to (i) evaluate the functional, medical or nursing, and social support needs of individuals referred for screening for certain long-term care services requiring NF eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual's needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home and community-based services for those individuals who meet nursing facility level of care.~~

"Private pay individual" means individuals who are not eligible for Medicaid or not expected to become eligible for Medicaid ~~within six months following admission~~ and have alternate payment sources for care.

"Program of All-Inclusive Care for the Elderly" or "PACE" means the community-based service pursuant to § 32.1-330.3 of the Code of Virginia.

"Provider" means an individual professional or an agency enrolled with Virginia Medicaid to offer services to eligible individuals.

"Referral for LTSS screening" means information obtained from an interested person or other third party having knowledge of an individual who may need Medicaid-funded LTSS and may include, for example, a physician, PACE provider, service provider, family member, or neighbor who is able to provide sufficient information to enable contact with the individual.

"Representative" means a person who is legally authorized to make decisions on behalf of the individual.

"Request date for LTSS screening" or "request date" means the date (i) that an individual, an emancipated child, the individual's representative, an adult protective services worker, child protective services worker, physician, or the managed care organization (MCO) (health plan) care coordinator contacts the LTSS screening entity in the jurisdiction where the individual resides asking for assistance with LTSS, or (ii) for hospital inpatients, that a physician orders case management consultation or a hospital's case management service determines the need for LTSS upon discharge from the hospital.

"Request for LTSS screening" means (i) communication from an individual, an emancipated child, individual's representative, adult protective services worker, child protective services worker, physician, managed care organization (MCO) care coordinator, or CSB support coordinator, expressing the need for LTSS or (ii) for hospital inpatients, a physician order for case management consultation or case management determination of the need for LTSS upon discharge from a hospital.

"Residence" means the location in which an individual is living, for example, an individual's private home, apartment, assisted living facility, nursing facility, jail or correctional facility.

"Screening entity" means the employer of the hospital screening team, community-based team, nursing facility LTSS screening team, or DMAS designee contracted to perform screenings pursuant to § 32.1-330 of the Code of Virginia.

"Significant change in condition" means a change in an individual's condition that is expected to last longer than 30 days and shall not include (i) short-term changes that resolve with or without intervention; (ii) a short-term illness or episodic event; or (iii) a well-established, predictive, cyclic pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

"Submission" means the transmission of the LTSS screening findings via ~~ePAS~~ eMLS, the electronic portal for LTSS screenings.

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional assessment instrument that is completed by the LTSS screening ~~entity~~ team that assesses an individual's physical health, mental health, and psycho/social and functional abilities to determine if the individual meets the nursing facility level of care.

"VDH" means the Virginia Department of Health.

12VAC30-60-302. Access to Medicaid-funded long-term services and supports.

A. Medicaid-funded long-term services and supports (LTSS) may be provided in either home and community-based or institutional-based settings. To receive LTSS, the individual's condition shall first be evaluated using the designated assessment instrument, the Uniform Assessment Instrument (UAI), and other DMAS-designated forms. ~~Screening entities~~ LTSS screening teams shall also use the DMAS-designated forms (~~DMAS-95,~~ DMAS-96~~,~~ and DMAS-97)~~,~~ if selecting nursing facility placement, the DMAS-95 Level I ~~(MI/IDD/RC), as appropriate, the DMAS-108, and the DMAS-109. If~~ screening must be completed and if indicated by the DMAS-95 Level I results, the individual shall be referred to DBHDS for completion of the DMAS-95 Level II ~~(for nursing facility placements only)~~ evaluation and determination prior to admission to the nursing facility. For private duty nursing services under the Commonwealth Coordinated Care (CCC) Plus waiver, the DMAS-108 (adult), or the DMAS-109 (pediatric), shall be used to document needs.

1. An individual's need for LTSS shall meet the established criteria (12VAC30-60-303) before any authorization for reimbursement by Medicaid or its designee is made for LTSS.

2. Appropriate home and community-based services shall be evaluated as an option for long-term services and supports prior to consideration of nursing facility placement.

B. The evaluation shall be the LTSS screening as designated in § 32.1-330 of the Code of Virginia, which, if eligible, shall preauthorize a continuum of LTSS covered by Medicaid. These LTSS screenings shall be conducted face to face.

1. Such LTSS screenings, using the UAI, shall be conducted by teams of representatives of (i) acute care hospitals for individuals (adults and children) who are inpatients; (ii) local departments of social services and local health departments, known ~~herein~~ in this part as CBTs, for adults and children residing in the community and who are not inpatients; (iii) a DMAS designee for adults and children residing in the community ~~who are not inpatients;~~ or are hospital inpatients and cannot be screened by the LTSS screening team within 30 days of the request date; and (iv) ~~a DMAS designee for adults residing in the community who are not inpatients and who cannot be screened by the CBT within 30 days of the request date~~ nursing facility LTSS screening teams for individuals who apply for or request LTSS while receiving skilled or rehabilitative nursing services in a setting not covered by Medicaid and after discharge from an acute care hospital. ~~All of these entities~~ Hospitals, CBTs, and DMAS designees shall be contracted with DMAS or authorized by DMAS to perform this activity and be reimbursed by DMAS.

2. All LTSS screenings shall be comprehensive, accurate, standardized, and reproducible evaluations of individual functional capacities, medical or nursing needs, and whether the individual is at risk for institutional placement within 30 days of the LTSS screening.

C. Individuals shall not be required to be financially eligible for receipt of Medicaid or have submitted an application for Medicaid in order to be screened for LTSS for admission to either ~~a~~ an NF or home and community-based services.

D. Pursuant to § 32.1-330 of the Code of Virginia, ~~individuals shall be screened if they are financially eligible for Medicaid or are anticipated to become financially eligible for Medicaid reimbursement of their NF care within six months of NF admission or Medicaid reimbursement of home and community-based services and supports~~ every individual who applies for or requests Medicaid community or institutional long-term services and supports shall be screened prior to admission to such community or institutional LTSS to determine their need for long-term services and supports, including nursing facility services.

E. Special circumstances.

1. Private pay individuals who ~~will not become financially eligible for Medicaid within six months from admission~~ seek admission to a Virginia nursing facility shall not be required to have ~~a~~ an LTSS screening in order to be admitted to the NF.

2. Individuals who reside out of state and seek direct admission to a Virginia nursing facility shall not be required to have ~~a~~ an LTSS screening. Individuals who need ~~a~~ an LTSS screening for HCBS waiver or PACE programs and request the LTSS screening shall be screened by the CBT ~~or DMAS designee, as appropriate,~~ serving the locality in which the individual resides once the individual has relocated to the Commonwealth.

3. Individuals who are inpatients in an out-of-state hospital, in-state or out-of-state veteran's hospital, or in-state or out-of-state military hospital and seek direct admission to a Virginia NF shall not be required to have ~~a~~ an LTSS screening. Individuals who need ~~a~~ an LTSS screening for HCBS waiver or PACE programs and request the LTSS screening shall be referred, upon discharge from one of the identified facilities, to the CBT ~~or DMAS designee, as appropriate,~~ serving the locality in which the individual resides once the individual has relocated to the Commonwealth.

4. Individuals who are patients or residents of a state owned or operated facility ~~that is licensed~~ by DBHDS and seek direct admission to a Virginia NF shall not be required to have ~~a~~ an LTSS screening. Individuals who need ~~a~~ an LTSS screening for HCBS waiver or PACE and request the LTSS screening shall be referred, upon discharge from the facility, to the CBT ~~or DMAS designee, as appropriate,~~ serving the locality in which the individual resides.

5. ~~A~~ An LTSS screening shall not be required for enrollment in Medicaid hospice services as set out in 12VAC30-50-270 or home health services as set out in 12VAC30-50-160.

~~6. Wilson Workforce Rehabilitation Center (WWRC) staff shall perform screenings of the WWRC clients.~~

F. Failure to comply with DMAS requirements, including competency and training requirements applicable to staff, may result in retraction of Medicaid payments.

12VAC30-60-303. Screening criteria for Medicaid-funded long-term services and supports.

A. Functional capacity alone shall not be deemed sufficient to demonstrate the need for nursing facility care admission or authorization for home and community-based services and supports. An individual shall be determined to meet the nursing facility level of care criteria when:

1. The individual has ~~both~~ limited functional capacity~~,~~ and medical or nursing needs~~,~~ and is at risk of NF admission within 30 days according to the requirements of this section; or

2. The individual is rated dependent in some functional limitations~~,~~ but does not meet the functional capacity requirements, and the individual requires the daily direct services or supervision of a licensed nurse that cannot be managed on an outpatient basis (e.g., clinic, physician visits, home health services).

B. In order to qualify for Medicaid-funded LTSS, the individual shall meet the following criteria:

1. The criteria for screening an individual's eligibility for Medicaid reimbursement of NF services shall consist of three components: (i) functional capacity (the degree of assistance an individual requires to complete ADLs); (ii) medical or nursing needs; and (iii) the individual is at risk of NF admission within 30 days of the LTSS screening date. The rating of functional dependency on the UAI shall be based on the individual's ability to function in a community environment and exclude all institutionally induced dependencies.

2. In order for Medicaid-funded community-based LTSS to be authorized, an individual shall not be required to be physically admitted to ~~a~~ an NF. The criteria for screening an individual's eligibility for Medicaid reimbursement of community-based services shall consist of three components: (i) functional capacity; (ii) medical or nursing needs; and (iii) the individual's risk of NF placement within 30 days in the absence of community-based services.

C. Functional capacity.

1. When documented on a UAI that is completed in a manner consistent with the definitions of activities of daily living (ADLs) and directions provided by DMAS for the rating of those activities, individuals may be considered to meet the functional capacity requirements for nursing facility care when one of the following describes their functional capacity:

a. Rated dependent in two ~~to four~~ or more of the ADLs, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and semi-dependent or dependent in Joint Motion or dependent in Medication Administration.

b. Rated dependent in five to seven of the ADLs, and also rated dependent in Mobility.

c. Rated semi-dependent or dependent in two to seven of the ADLs, and also rated dependent in Mobility and Behavior Pattern and Orientation.

2. The rating of functional capacity on the LTSS screening instrument shall be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. The following abbreviations shall mean: I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

a. Bathing.

(1) Without help (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Performed by Others (D)

(6) Is not Performed (D)

b. Dressing.

(1) Without help (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Performed by Others (D)

(6) Is not Performed (D)

c. Toileting.

(1) Without help day or night (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Performed by Others (D)

(6) Is not Performed (D)

d. Transferring.

(1) Without help (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Performed by Others (D)

(6) Is not Performed (D)

e. Bowel function.

(1) Continent (I)

(2) Incontinent less than weekly (d)

(3) External/Indwelling Device/Ostomy -- ~~self-care~~ self-care (d)

(4) Incontinent weekly or more (D)

(5) Ostomy -- not ~~self-care~~ self-care (D)

f. Bladder function.

(1) Continent (I)

(2) Incontinent less than weekly (d)

(3) External device/Indwelling Catheter/Ostomy -- ~~self-care~~ self-care (d)

(4) Incontinent weekly or more (D)

(5) External device -- not ~~self-care~~ self-care (D)

(6) Indwelling catheter -- not ~~self-care~~ self-care (D)

(7) Ostomy -- not ~~self-care~~ self-care (D)

g. Eating/Feeding.

(1) Without help (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Spoon fed (D)

(6) Syringe or tube fed (D)

(7) Fed by IV or clysis (D)

h. Behavior pattern and orientation.

(1) Appropriate or Wandering/Passive less than weekly + Oriented (I)

(2) Appropriate or Wandering/Passive less than weekly + Disoriented -- Some Spheres (I)

(3) Wandering/Passive Weekly/or more + Oriented (I)

(4) Appropriate or Wandering/Passive less than weekly + Disoriented -- All Spheres (d)

(5) Wandering/Passive Weekly/Some or more + Disoriented -- All Spheres (d)

(6) Abusive/Aggressive/Disruptive less than weekly + Oriented or Disoriented ~~(d)~~ (I)

(7) Abusive/Aggressive/Disruptive weekly or more + Oriented (d)

(8) Abusive/Aggressive/Disruptive + Disoriented -- All Spheres (D)

i. Mobility.

(1) Goes outside without help (I)

(2) Goes outside MH only (d)

(3) Goes outside HH only (D)

(4) Goes outside MH and HH (D)

(5) Confined -- moves about (D)

(6) Confined -- does not move about (D)

j. Medication administration.

(1) No medications (I)

(2) Self administered -- monitored less than weekly (I)

(3) By lay persons, Administered/Monitored (D)

(4) By Licensed/Professional nurse Administered/Monitored (D)

k. Joint motion.

(1) Within normal limits or instability corrected (I)

(2) Limited motion (d)

(3) Instability -- uncorrected or immobile (D)

D. Medical or nursing needs. An individual with medical or nursing needs is an individual whose health needs require medical or nursing supervision or care above the level that could be provided through assistance with ADLs, medication administration, and general supervision and is not primarily for the care and treatment of mental diseases. Medical or nursing supervision or care beyond this level is required when any one of the following describes the individual's need for medical or nursing supervision:

1. The individual's medical condition requires observation and assessment to ensure evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to ~~self-observe~~ self-observe or evaluate the need to contact skilled medical professionals;

2. Due to the complexity created by the individual's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists; or

3. The individual requires at least one ongoing medical or nursing service. The following is a nonexclusive list of medical or nursing services that may, but need not necessarily, indicate a need for medical or nursing supervision or care:

a. Application of aseptic dressings;

b. Routine catheter care;

c. Respiratory therapy;

d. Supervision for adequate nutrition and hydration for individuals who show clinical evidence of

malnourishment or dehydration or have recent history of weight loss or inadequate hydration that, if not supervised, would be expected to result in malnourishment or dehydration;

e. Therapeutic exercise and positioning;

f. Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;

g. Use of physical (e.g., side rails, ~~poseys,~~ posey vests, geri-chairs, locked ~~wards~~ units) or chemical restraints (e.g., overuse of sedatives), or both;

h. Routine skin care to prevent pressure ulcers for individuals who are immobile or whose medical condition increases the risk of skin breakdown;

i. Care of small uncomplicated pressure ulcers and local skin rashes;

j. Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;

k. Chemotherapy;

l. Radiation;

m. Dialysis, including observation of and care of the access port;

n. Suctioning;

o. Tracheostomy care;

p. Infusion therapy; or

q. Oxygen.

E. When screening a child, the screening entity who is conducting the screening for LTSS shall utilize the electronic Uniform Assessment Instrument (UAI) ~~interpretive~~ guidance ~~as referenced in DMAS' Medicaid Memo dated November 22, 2016, entitled "Reissuance of the Pre Admission~~ provided in the Screening ~~(PAS) Provider~~ for Medicaid Long Term Services and Supports Manual, Chapter IV,~~"~~ which can be accessed on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/MedicaidMemostoProviders

12VAC30-60-304. Requests and referrals for LTSS screening for adults and children living in the community ~~and~~; adults and children in hospitals; and adults and children in nursing facilities.

A. ~~Screenings~~ LTSS screenings for adults living in the community. ~~Screenings~~ LTSS screenings for adults who are residing in the community ~~but~~ and who are not hospital inpatients shall be completed and submitted by the CBT to ~~ePAS~~ eMLS. If the individual, or any of the other persons permitted to make such requests, requests ~~a~~ an LTSS screening, the CBT shall be required to perform the requested LTSS screening~~; otherwise, CBTs shall not be required to screen individuals who are not expected to become financially eligible for Medicaid-funded LTSS within six months of the screening~~. Every individual who applies for or request LTSS shall have the opportunity to choose the setting and provider of services, and have this choice documented.

1. Requests for LTSS screenings shall be accepted from either an individual, the individual's representative, an adult protective service worker, the individual's physician, or an MCO care coordinator having an interest in the individual. The CBT in the jurisdiction where the individual resides shall conduct such LTSS screening. For the LTSS screening to be scheduled by the CBT, the individual shall either agree to participate or, if refusing, shall be under order of a court of appropriate jurisdiction to have ~~a~~ an LTSS screening. Medicaid payment for services cannot be considered without agreement of the individual or the individual's representative to participate in the LTSS screening.

a. The LDSS or LHD in receipt of the request for ~~a~~ an LTSS screening shall contact the individual or ~~his~~ the individual's representative within seven days of the request date for screening to schedule ~~a~~ an LTSS screening with the individual and any other persons whom the individual selects to attend the screening.

b. When the CBT has not scheduled ~~a~~ an LTSS screening to occur within 21 days of the request date for screening, and the LTSS screening is not anticipated to be complete within 30 days of the request date for screening due to the screening entity's inability to conduct the LTSS screening, the LDSS and LHD shall, no later than seven days after the request date for screening, notify DARS and VDH staff designated for technical assistance.

2. Referrals for LTSS screenings may also be accepted by LDSS or LHD from an interested person having knowledge of an individual who may need LTSS. When the LDSS or LHD receives such a referral, the LDSS or LHD shall obtain sufficient information from the referral source to initiate contact with the individual or ~~his~~ the individual's representative to discuss the LTSS screening process. Within seven days of the referral date, the LDSS or LHD shall contact the individual or ~~his~~ the individual's representative to determine if the individual is interested in receiving LTSS and would participate in the LTSS screening. If the LDSS or LHD is unable to contact the individual or ~~his~~ the individual's representative, ~~it~~ the LDSS or LHD shall document the attempt to contact the individual or ~~his~~ the individual's representative using the method adopted by the CBT.

a. After contact with the individual or ~~his~~ the individual's representative, or if the LDSS or LHD is unable to contact the individual or ~~his~~ the individual's representative, the LDSS or LHD shall advise the referring interested person that contact or attempt to contact has been made in response to the referral for an LTSS screening.

b. Information about the results of the contact shall only be shared by the LDSS or LHD with the interested person who made the referral when the LDSS or LHD has the

individual's written consent or the written consent of ~~his~~ the individual's legal representative who has such authority on behalf of the individual.

B. ~~Screenings~~ LTSS screenings for children living in the community. ~~Screenings~~ LTSS screenings for children who are residing in the community ~~but~~ and who are not hospital inpatients shall be completed and submitted via ~~ePAS~~ eMLS. If the individual or parent or guardian, or any of the other persons permitted to make such requests, requests ~~a~~ an LTSS screening, the DMAS community screening designee shall perform the requested LTSS screening~~; otherwise, the DMAS designee shall not be required to screen individuals who are not expected to become financially eligible for Medicaid funded LTSS within six months of the screening~~. Every individual who applies for or requests LTSS shall have the opportunity to choose the setting and provider of services and have this choice documented.

1. A child who is residing in the community and is not an inpatient shall receive ~~a~~ an LTSS screening from a DMAS community screening designee. The DMAS community screening designee may receive requests for LTSS screenings directly. Any requests for LTSS screenings for a child received by the CBT shall be forwarded directly to the DMAS designee. For the LTSS screening to be scheduled by the ~~CBT~~ DMAS community screening designee, the child shall either agree to participate or, if refusing, shall be under order of a court of appropriate jurisdiction to have ~~a~~ an LTSS screening. Medicaid payment for services cannot be considered without agreement of the individual or the individual's representative to participate in the LTSS screening.

2. The request for LTSS screening of a child residing in the community shall be accepted from the parent, legal guardian, the entity having legal custody of that child, an emancipated child, a physician, an MCO care coordinator, or a child protective service worker having an interest in the child.

3. Referrals for LTSS screenings may also be accepted from an interested person having knowledge of a child who may need LTSS. The process, timing, and limitations on the sharing of the results for referrals for LTSS screenings for children shall be the same as that set out for adults in subdivision A 2 of this section.

C. ~~Screenings~~ LTSS screenings in hospitals for adults and children who are inpatients. ~~Screenings~~ LTSS screenings in hospitals shall be completed when an adult or child who is an inpatient is discharged directly to an NF or may need LTSS in the community upon discharge or when the individual, MCO, or representative requests ~~a~~ an LTSS screening. Medicaid payment for services cannot be considered without agreement of the individual or the individual"s representative to participate in the LTSS screening. Every individual who applies for or requests LTSS shall have the opportunity to choose the setting and provider of services and have this choice documented.

1. As a part of the discharge planning process, the hospital team shall ~~also~~ complete a face-to-face LTSS screening when:

a. The individual's physician, in collaboration with the individual or the individual's representative if there is one, makes a request of the hospital team. If the individual is a child, the LTSS screening shall be completed when the individual's physician, in collaboration with the child's parent, legal guardian, the entity having legal custody of the child, the emancipated child, adult protective services worker, child protective services worker, or MCO care coordinator makes a request of the hospital team; or

b. The individual, the individual's representative if there is one, parent, legal guardian, entity having legal custody, emancipated child, adult protective services worker, child protective services worker, or MCO care coordinator requests a consultation with hospital case management.

2. When there is a request, such individual shall receive ~~a~~ an LTSS screening conducted by the hospital team regardless of if ~~he~~ the individual is eligible for Medicaid or is anticipated to become eligible for Medicaid within six months after admission to ~~a~~ an NF.

3. The hospital team shall exclude all institutionally-induced dependencies from the face-to-face LTSS screening documentation.

D. LTSS screenings for individuals needing LTSS after a skilled or rehabilitation nursing facility services admission. LTSS screenings for individuals who need LTSS after receiving skilled or rehabilitation nursing facility services that are not covered by the Commonwealth's program of medical assistance services after discharge from an acute care hospital shall be completed and submitted via eMLS by NF LTSS screening teams. Medicaid payment for services cannot be considered without agreement of the individual or the individual's representative to participate in the LTSS screening. Every individual who applies for or requests LTSS shall have the opportunity to choose the setting and provider of services and have this choice documented.

1. Requests for LTSS screening shall be accepted from either an individual, the individual's representative, the individual's physician, the NF LTSS screening team, or a MCO care coordinator having an interest in the individual. The nursing facility LTSS screening team shall contact the individual or the individual's representative prior to enrollment in LTSS to schedule an LTSS screening with the individual and any other persons whom the individual selects to attend the LTSS screening.

2. Nursing facility LTSS screening teams must include at least one registered nurse and physician but may include a social worker or other members of the interdisciplinary

team. The authorization or denial for Medicaid LTSS (DMAS-96 form) must be signed and attested to by the nursing facility LTSS screener and a physician.

~~D. Screenings~~ E. LTSS screenings shall be submitted via ~~e-PAS~~ eMLS within 30 days of the screening request.

12VAC30-60-305. Screenings in the community and hospitals and nursing facilities for Medicaid-funded long-term services and supports.

A. Community LTSS screenings for adults.

1. Medical or nursing and functional eligibility for Medicaid-funded LTSS shall be determined by the CBT after completion of ~~a~~ an LTSS screening of the individual's needs and available supports. The CBT shall consider all the supports available for that individual in the community (i.e., the immediate family, other relatives, other community resources), and other services in the continuum of LTSS. The LTSS screening shall be documented on the DMAS-designated forms identified in 12VAC30-60-306.

2. ~~Screenings~~ Upon receipt of an LTSS screening request, the CBT shall schedule an appointment to complete the requested LTSS screening. LTSS screenings shall be completed in the individual's residence unless the residence presents a safety risk for the individual or the CBT, or unless the individual or the representative requests that the LTSS screening be performed in an alternate location within the same jurisdiction. ~~The individual shall be permitted to have another person present at the time of the screening. Other than situations when a court has issued an order for a screening, the individual shall also be afforded the right to refuse to participate. The CBT shall determine the appropriate degree of participation and assistance given by other persons to the individual during the screening and accommodate the individual's preferences to the extent feasible.~~ Community settings where LTSS screenings may occur include the individual's residence, other residences, residential facilities, or other settings with the exception of inpatients in acute care hospitals, rehabilitation units of acute care hospitals, and rehabilitation hospitals.

3. The individual shall be permitted to have another person present at the time of the screening. Other than situations when a court has issued an order for an LTSS screening, the individual shall also be afforded the right to refuse to participate. The CBT shall determine the appropriate degree of participation and assistance given by other persons to the individual during the LTSS screening and accommodate the individual's preferences to the extent feasible.

4. The CBT shall:

a. Observe the individual's ability to perform appropriate ADLs according to 12VAC30-60-303 and consider the individual's communication or responses to questions or ~~his~~ the individual's representative's communication or responses;

b. Observe, assess, and report the individual's medical, nursing, and functional condition. This information shall be used to ensure accurate and comprehensive evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization even when the individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals;

c. Identify the medical or nursing needs, and functional needs of the individual; and

d. Consider services and settings that may be needed by the individual in order for the individual to safely perform ADLs.

~~4.~~ 5. Upon completion of the LTSS screening and in consideration of the communication from the individual or ~~his~~ the individual's representative, if appropriate, and observations obtained during the LTSS screening, the CBT shall determine whether the individual meets the criteria set out in 12VAC30-60-303. If the individual meets the criteria for LTSS, the CBT shall inform the individual or ~~his~~ the individual's representative, if appropriate, of this determination in writing and provide choice of the ~~feasible alternatives~~ the setting and provider of LTSS, such as PACE or ~~home and community-based~~ Commonwealth Coordinated Care (CCC) Plus waiver services, as alternative options to placement in ~~a~~ an NF.

~~5.~~ 6. If waiver services or PACE, where available, are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form. The CBT shall have this document signed by either the individual or ~~his~~ the individual's representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or ~~his~~ the individual's representative's signature shall be retained in the individual's record by the LTSS screening entity.

~~6.~~ 7. If the individual meets criteria and selects home and community-based services, the CBT shall also document that the individual is at risk of NF placement in the absence of home and community-based services by finding that at least one of the following conditions exists:

a. The individual has been cared for in the home prior to the screening and evidence is available demonstrating a deterioration in the individual's health care condition, a significant change in condition, or a change in available supports. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

b. There has been no significant change in condition or available support but evidence is available that demonstrates the individual's functional, medical, or nursing needs are not being met. Examples of such evidence may include (i) recent hospitalizations, (ii)

attending physician documentation, or (iii) reported findings from medical or social service agencies.

~~7.~~ 8. If the individual selects NF placement, the CBT shall follow the Level I identification and Level II evaluation process as outlined in Part III (12VAC30-130-140 et seq.) of 12VAC30-130.

~~8.~~ 9. If the CBT determines that the individual does not meet the criteria set out in 12VAC30-60-303, the CBT shall notify the individual or the individual's representative, as may be appropriate, in writing that LTSS are being denied for the individual. The denial notice shall include the individual's right to appeal consistent with DMAS client appeals regulations (12VAC30-110).

~~9.~~ 10. For those LTSS screenings conducted in accordance with clause iv of 12VAC30-60-302 B 1, the ~~DMAS designee~~ CBT shall follow the process outlined in this subsection.

B. Community LTSS screenings for children.

1. Medical or nursing and functional eligibility for Medicaid-funded LTSS shall be determined by the DMAS community screening designee after completion of ~~a~~ an LTSS screening of the child's needs and available supports. The DMAS community screening designee shall consider all the supports available for that child in the community (i.e., the immediate family, other community resources), and other services in the continuum of LTSS. The LTSS screening shall be documented on the designated DMAS forms identified in 12VAC30-60-306.

2. Upon receipt of ~~a~~ an LTSS screening request, the DMAS community screening designee shall schedule an appointment to complete the requested LTSS screening. LTSS screenings shall be completed in the child's residence unless the residence presents a safety risk for the child or the DMAS community screening designee, or unless the child's representative request that the LTSS screening be performed in an alternate location within the same jurisdiction. Community settings where LTSS screenings may occur include the child's residence, other residences, children's residential facilities, or other settings with the exception of acute care hospitals, rehabilitation units of inpatients in acute care hospitals, and rehabilitation hospitals.

3. The child shall be permitted to have another person present at the time of the LTSS screening. The DMAS community screening designee shall determine the appropriate degree of participation and assistance given by other persons to the child during the LTSS screening and accommodate the individual's preferences to the extent feasible.

4. The DMAS community screening designee shall:

a. Determine the appropriate degree of participation and assistance given by other persons to the individual during the LTSS screening in recognition of the individual's preferences to the extent feasible;

b. Observe the child's ability to perform appropriate ADLs according to 12VAC30-60-303 and consider the parent's, legal guardian's, or emancipated child's communications or responses to questions;

c. Observe, assess, and report the child's medical or nursing and functional condition. This information shall be used to ensure accurate and comprehensive evaluation of the child's need for modification of treatment or additional medical procedures to prevent destabilization even when the child has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals;

d. Identify the medical or nursing and the functional needs of the child; and

e. Consider services and settings that may be needed by the child in order for the child to safely perform ADLs in the community.

~~4.~~ 5. Upon completion of the LTSS screening and in consideration of the communication from the child or ~~his~~ the child's representative, if appropriate, and observations obtained during the LTSS screening, the DMAS community screening designee shall determine whether the child meets the criteria set out in 12VAC30-60-303. If the child meets the criteria for Medicaid-funded LTSS, the DMAS community screening designee shall inform the child and ~~his~~ the child's representative, if appropriate, of this determination in writing and provide choice of the ~~feasible alternatives~~ setting and provider of LTSS, such as PACE or ~~home and community-based~~ Commonwealth Coordinated Care Plus waiver services, as alternative options to ~~NF~~ placement in an NF.

~~5.~~ 6. If waiver services are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form. The DMAS community screening designee shall have this document signed by either the emancipated child or ~~his~~ the child's representative. In addition to the electronic document, a paper copy of the DMAS-97 form with the child's or ~~his~~ the child's representative's signature shall be retained in the child's record by the LTSS screening entity.

~~6.~~ 7. If the child meets criteria and selects home and community-based services, the DMAS community screening designee shall also document that the individual is at risk of NF placement in the absence of home and community-based services by finding that at least one of the following conditions exists:

a. The child has been cared for in the home prior to the LTSS screening and evidence is available demonstrating a deterioration in the child's health care condition, a significant change in condition, or a change in available supports. Examples of such evidence may include (i)

recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

b. There has been no significant change in condition or available support but evidence is available that demonstrates the child's functional, medical, or nursing needs are not being met. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

~~7.~~ 8. If the parent, legal guardian, entity having legal custody of the child, or emancipated child selects NF placement, the DMAS community screening designee shall follow the Level I identification and Level II evaluation process as set out in Part III (12VAC30-130-140 et seq.) of 12VAC30-130.

~~8.~~ 9. If the DMAS community screening designee determines that the child does not meet the criteria to receive Medicaid-funded LTSS as set out in 12VAC30-60-303, the DMAS community screening designee shall notify the parent, legal guardian, entity having legal custody of the child, or the emancipated child and representative, as may be appropriate, in writing that Medicaid-funded LTSS are being denied for the child. The denial notice shall include the child's right to appeal consistent with DMAS client appeals regulations (12VAC30-110).

C. Screenings for adults and children in hospitals. For the purpose of this subsection, the term "individual" shall mean either an adult or a child.

1. Medical or nursing and functional eligibility for Medicaid-funded LTSS shall be determined by the hospital LTSS screening team after completion of ~~a~~ an LTSS screening of the individual's medical or nursing and functional needs and available supports. The hospital LTSS screening team shall consider all the supports available for that individual in the community (i.e., the immediate family, other relatives, other community resources), and other services in the continuum of LTSS. The LTSS screening shall be documented on the DMAS-designated forms identified in 12VAC30-60-306 and entered into the eMLS system.

2. ~~Screenings~~ LTSS screenings shall be completed in the hospital prior to discharge. ~~The individual shall be permitted to have another person present at the time of the screening. Except when a court has issued an order for a screening, the individual shall also be afforded the right to refuse to participate. The hospital screening team shall determine the appropriate degree of participation and assistance given by other persons to the individual during the screening and accommodate the individual's preferences to the extent feasible.~~

3. The individual shall be permitted to have another person present at the time of the LTSS screening. Except when a court has issued an order for an LTSS screening, the individual shall also be afforded the right to refuse to participate. The hospital LTSS screening team shall determine the appropriate degree of participation and assistance given by other persons to the individual during the screening and accommodate the individual's preferences to the extent feasible.

4. The hospital LTSS screening team shall:

a. Observe the individual's ability to perform appropriate ADLs according to 12VAC30-60-303, excluding all institutionally induced dependencies, and consider the individual's communication or responses to questions or ~~his~~ the individual's representative's communication or responses;

b. Observe, assess, and report the individual's medical or nursing and functional condition. This information shall be used to ensure accurate and comprehensive evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization even when the individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals;

c. Identify the medical, nursing, and functional needs of the individual; and

d. Consider services and settings that may be needed by the individual in order for the individual to safely perform ADLs.

~~4.~~ 5. Upon completion of the LTSS screening and in consideration of the communication from the individual or ~~his~~ the individual's representative, if appropriate, and observations obtained during the LTSS screening, the hospital LTSS screening team shall determine whether the individual meets the criteria set out in 12VAC30-60-303. If the individual meets the criteria for Medicaid-funded LTSS, the hospital LTSS screening team shall inform the individual or ~~his~~ the individual's representative, if appropriate, of this determination in writing and provide choice of the ~~feasible alternatives~~ setting and provider of LTSS, such as PACE or ~~home and community based~~ Commonwealth Coordinated Care (CCC) Plus waiver services, as alternative options to placement in ~~a~~ an NF.

~~5.~~ 6. If waiver services or PACE, where available, are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form. The hospital LTSS screening team shall have this document signed by either the individual or ~~his~~ the individual's representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or ~~his~~ the individual's representative's signature shall be retained in the individual's record.

~~6.~~ 7. If the individual meets criteria and selects home and community-based services, the hospital LTSS screening

team shall also document that the individual is at risk of NF placement in the absence of home and community-based services by finding that at least one of the following conditions exists:

a. Prior to the inpatient admission, the individual was cared for in the home and evidence is available demonstrating a deterioration in the individual's health care condition, a significant change in condition, or a change in available supports. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

b. There has been no significant change in condition or available support but evidence is available that demonstrates the individual's functional, medical, or nursing needs are not being met. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

~~7.~~ 8. If the individual selects NF placement, the hospital LTSS screening team shall follow the Level I identification and Level II evaluation process as outlined in Part III (12VAC30-130-140 et seq.) of 12VAC30-130.

~~8.~~ 9. If the hospital LTSS screening team determines that the individual does not meet the criteria set out in 12VAC30-60-303, the hospital LTSS screening team shall notify the individual or the individual's representative, as may be appropriate, in writing that LTSS are being denied for the individual. The denial notice shall include the individual's right to appeal consistent with DMAS client appeals regulations (12VAC30-110).

D. LTSS screenings for individuals receiving skilled or rehabilitation nursing services in a setting not covered by Medicaid and after discharge from an acute care hospital.

1. Medical or nursing and functional eligibility for Medicaid-funded LTSS shall be determined by the NF LTSS screening team after completion of an LTSS screening of the individual's medical or nursing and functional needs and available supports. The NF LTSS screening team shall consider all the supports available for that individual in the community (i.e., the immediate family, other relatives, other community resources) and other services in the continuum of LTSS. The LTSS screening shall be documented on the DMAS forms identified in 12VA30-60-306 and entered into the eMLS system.

2. LTSS screenings shall be completed prior to the enrollment or initiation of LTSS.

3. The individual shall be permitted to have another person present at the time of the LTSS screening. Except when a court has issued an order for an LTSS screening, the individual shall also be afforded the right to refuse to participate. The NF LTSS screening team shall determine the appropriate degree of participation and assistance given by other persons to the individual during the LTSS screening and accommodate the individual's preferences to the extent feasible.

4. The nursing facility LTSS screening team shall:

a. Observe the individual's ability to perform appropriate ADLs according to 12VAC30-60-303, excluding all institutionally induced dependencies, and consider the individual's communication or responses to questions or the individual's representative's communication or responses;

b. Observe, assess, and report the individual's medical or nursing and functional condition. This information shall be used to ensure accurate and comprehensive evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization even when the individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals;

c. Identify the medical, nursing, and functional needs of the individual; and

d. Consider services and settings that may be needed by the individual in order for the individual to safely perform ADLs.

5. Upon completion of the LTSS screening and in consideration of the communication from the individual or the individual's representative, if appropriate, and observations obtained during the LTSS screening, the NF LTSS screening team shall determine whether the individual meets the criteria set out in 12VAC30-60-303. If the individual meets the criteria for Medicaid-funded LTSS, the NF LTSS screening team shall inform the individual or the individual's representative, if appropriate, of this determination in writing and provide choice of the setting and provider of LTSS, such as PACE or Commonwealth Coordinated Care (CCC) Plus waiver services, as alternative options to placement in an NF.

6. If waiver services or PACE, where available, are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form. The NF LTSS screening team shall have this document signed by either the individual or the individual's representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or the individual's representative's signature shall be retained in the individual's record.

7. If the individual meets criteria and selects home and community-based services, the NF LTSS screening team shall also document that the individual is at risk of NF placement in the absence of home and community-based services by finding that at least one of the following conditions exists:

a. Prior to the admission to the acute care hospital, the individual was cared for in the home and evidence is available demonstrating a deterioration in the individual's health care condition, a significant change in condition, or a change in available supports. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

b. There has been no significant change in condition or available support but evidence is available that demonstrates the individual's functional, medical, or nursing needs are not being met. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

8. If the individual selects NF placement, the NF LTSS screening team shall follow the Level I identification and Level II evaluation process as outlined in Part III (12VAC30-130-140 et seq.) of 12VAC30-130.

9. If the NF LTSS screening team determines that the individual does not meet the criteria set out in 12VAC30-60-303, the NF LTSS screening team shall notify the individual or the individual's representative, as may be appropriate, in writing that LTSS are being denied for the individual. The denial notice shall include the individual's right to appeal consistent with DMAS client appeals regulations (12VAC30-110).

12VAC30-60-306. Submission of LTSS screenings.

A. The LTSS screening entity shall complete and submit the following forms to DMAS electronically via ~~ePAS~~ eMLS:

1. DMAS-95 - ~~MI/IDD/RC~~ MI/ID/RC (Supplemental ~~Assessment Process Form~~ Level I Screening for Mental Illness, Intellectual Disability, or Related Conditions form and follow up information), as appropriate;

2. DMAS-96 (Medicaid-Funded Long-Term ~~Care Service~~ Services and Supports Authorization Form);

3. DMAS-97 (Individual Choice - ~~Institutional Care or Waiver Services~~ Home and Community-Based or Institutional Care form), as applicable;

4. UAI (Uniform Assessment Instrument);

5. DMAS-108 (~~Tech Waiver Adult Referral~~ Private Duty Nursing Adult form), as appropriate; and

6. DMAS-109 (~~Tech Waiver Pediatric Referral~~ Private Duty Nursing Pediatric form), as appropriate.

B. For LTSS screenings performed in the community, the LTSS screening entity shall submit to DMAS via ~~ePAS~~ eMLS each applicable screening form listed in subsection A of this section within 30 days of the individual's request date for screening.

C. For LTSS screenings performed in a hospital, the hospital team shall submit to DMAS via ~~ePAS~~ eMLS each applicable screening form listed in subsection A of this section, which shall be completed prior to the individual's discharge to LTSS.

D. For LTSS screenings performed in a skilled or rehabilitation NF setting, the NF LTSS screening team shall submit to DMAS via eMLS each applicable screening form listed in subsection A of this section, which shall be completed prior to the individual's level of care change or enrollment in LTSS from skilled nursing or rehabilitation services.

12VAC30-60-308. Nursing facility admission for LTSS and level of care determination requirements.

Prior to an individual's for LTSS admission, the NF shall review the completed LTSS screening forms to ensure that applicable NF admission criteria have been met, documented, and submitted via e-PAS unless the individual meets any of the special circumstances set out in 12VAC30-60-302 E. NFs shall not accept ~~paper~~ handwritten LTSS screening forms as proof that admission criteria have been met and documented.

The NF LTSS screening team shall be responsible for screening individuals admitted directly from a hospital for skilled nursing or rehabilitation not covered by the Commonwealth's program of medical assistance and have a change in level of care requiring LTSS.

12VAC30-60-310. Competency training and testing requirements.

By June 30, 2019, each person performing LTSS screenings on behalf of a screening entity shall complete required training and competency tests. A score of at least 80% on each module for each person who is required to give final approval on LTSS screenings on behalf of the screening entity shall constitute satisfactory competency test results. The most current competency test results shall be kept in the screening entity's personnel records for each person performing LTSS screenings for the screening entity. Such documentation results shall be provided to DMAS upon its request.

1. All persons who are required by the screening entity to give final approval of LTSS screenings shall complete the DMAS-approved training and pass the corresponding competency tests with a score of at least 80% for each module of the training prior to performing LTSS screenings. Each LTSS Screener who has passed the competency training will be provided a certification number that shall be entered into the eMLS upon final approval of the Medicaid LTSS screening.

2. Upon successful completion of the initial training, each person who is required to give final approval of LTSS screenings on behalf of the screening entity shall complete the shortened refresher course no less than every three years. A score of at least 80% on the refresher module shall be required for a person to continue to perform LTSS

screenings or give final approval of LTSS screenings on behalf of the screening entity.

3. Failure to satisfy the training and competency tests requirements may result in the retraction of Medicaid payment.

12VAC30-60-313. Individuals determined to not meet criteria for Medicaid-funded long-term services and supports.

Notwithstanding 12VAC30-60-302 E, an individual shall be determined not to meet the ~~medical or nursing and functional criteria~~ level of care for Medicaid-funded LTSS when there is no LTSS screening or MDS to document the individual meets the medical or nursing ~~and~~, functional, or risk criteria or when one of the following specific care needs solely describes the individual's condition:

1. The individual requires minimal assistance with ADLs, including those individuals whose only need in all areas of functional capacity is for prompting to complete the activity;

2. The individual independently uses mechanical devices such as a wheelchair, walker, crutch, or cane;

3. The individual requires limited diets such as a mechanically altered, low-salt, low-residue, diabetic, reducing, or other restrictive diets;

4. The individual requires medications that can be independently self-administered or administered by the caregiver;

5. The individual requires protection to prevent him from obtaining alcohol or drugs or to address a social or environmental problem;

6. The individual requires minimal staff observation or assistance for confusion, memory impairment, or poor judgment; or

7. The individual's primary need is for behavioral management that can be provided in a community-based setting.

12VAC30-60-315. Periodic evaluations for individuals receiving Medicaid-funded long-term services and supports.

A. Once an individual is enrolled in home and community-based services, the home and community-based services provider shall be responsible for conducting periodic evaluations to ensure that the individual meets, and continues to meet, the waiver program or PACE criteria, if appropriate. These periodic evaluations shall be conducted using the Level of Care Review tab in the Medicaid portal at (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal). The home and community-based services provider shall promptly evaluate the individual after he experiences a significant change in his condition, as defined in 12VAC30-60-301.

B. Once an individual ~~is admitted to a~~ has been screened for LTSS and is enrolled in LTSS in an NF, the NF shall be responsible for conducting periodic evaluations to ensure that the individual meets, and continues to meet, the NF criteria. For this purpose, the NF shall use the federally required Minimum Data Set (MDS) form (see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html). ~~The post-admission evaluation shall be conducted~~ For individuals screened for LTSS by hospitals teams and CBT's and admitted directly into NF LTSS, the individual shall be evaluated using the MDS no later than 14 days after the date of NF admission ~~and promptly after an~~. All individual's receiving NF LTSS and experiencing a significant change in his condition, as defined in 12VAC30-60-301, shall be evaluated using the MDS.

For individuals admitted to skilled or rehabilitation services in an NF, the NF shall be responsible for conducting periodic evaluations to ensure that the individual meets, and continues to meet criteria. For this purpose, the NF shall use the federally required MDS form (see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html). The post enrollment evaluation shall be conducted no later than 14 days after the date of the NF admission and promptly after an individual's significant change in his condition, as defined in 12VAC30-60-301.

C. For individuals who are enrolled in an MCO that is responsible for providing LTSS, the MCO shall conduct periodic evaluations by qualified MCO staff to ensure the individual continues to meet criteria for LTSS. The MCO shall promptly evaluate the individual after he experiences a significant change in his condition, as defined in 12VAC30-60-301.

D. If an individual has been screened for LTSS and enrollment in LTSS has not occurred within one year of the completion date of the LTSS screening, a new LTSS screening shall be conducted to document the level of care and assure continued need for services.

NOTICE: The following forms used in administering the regulation have been filed by the agency. Amended or added forms are reflected in the listing and are published following the listing. Online users of this issue of the Virginia Register of Regulations may also click on the name to access a form. The forms are also available from the agency contact or may be viewed at the Office of Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (12VAC30-60)

DMAS-95, Level I Screening for Mental Illness, Intellectual Disability, or Related Conditions Form (rev. 4/2019)

DMAS-95, MI/ID/RC Supplement: Level II (rev. 12/2015)

DMAS-96, Medicaid Funded Long-Term Services and Supports (LTSS) Authorization Form (rev. 4/2019)

DMAS-97, Individual Choice - Home and Community-Based Services or Institutional Care Form (rev. 4/2019)

DMAS-108, Private Duty Nursing Adult Referral for the Commonwealth Coordinated Care Plus (CCC Plus) Waiver (rev. 4/2019)

DMAS-109, Private Duty Nursing Pediatric Referral for the Commonwealth Coordinated Care Plus (CCC Plus) Waiver (rev. 4/2019)

Virginia Individual Developmental Disabilities Eligibility Survey - Infants' Version, P235 (eff. 3/2016)

Virginia Individual Developmental Disabilities Eligibility Survey - Children's Version, P236 (eff. 3/2016)

Virginia Individual Developmental Disabilities Eligibility Survey - Adults' Version, P237 (eff. 3/2016)

Virginia Uniform Assessment Instrument (rev. 5/2000)

VA.R. Doc. No. R22-6578; Filed December 22, 2021, 9:37 p.m.

Emergency Regulation

Title of Regulation: **12VAC30-130. Amount, Duration and Scope of Selected Services (amending 12VAC30-130-140 through 12VAC30-130-260).**

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

Effective Dates: February 16, 2022, through August 15, 2023.

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

Preamble:

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

Chapters 304 and 365 of the 2020 Acts of Assembly allow qualified nursing facility staff to complete the long-term services and supports (LTSS) screening for individuals who apply for or request LTSS and who are receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital. The amendments align the regulation with statute and update terminology, including (i) adding information about assess appropriateness of community setting in meeting an individual's needs; (ii) requiring that a preadmission screening and resident review evaluator prioritize the physical and mental needs of an individual's severity of condition in determining placement and confirm an individual is accurately assessed for nursing facility level of care; and (iii) requiring that nursing facility placement determining data include evaluation of physical status, mental status, and function..

12VAC30-130-140. Definitions.

"Community Services Board ~~(CSB)~~" or "CSB" means the local governmental agency responsible for local mental health, ~~mental retardation~~ intellectual disability, and substance abuse services. Boards function as service providers, client advocates, and community educators.

"Dementia" means, as a major neurocognitive disorder, for the purposes described ~~herein~~ in this part, having a primary diagnosis of dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders, ~~3rd~~ 5th edition, ~~revised in 1987,~~ or a nonprimary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined ~~herein~~ in this part.

"Diagnostic and Statistical Manual of Mental Disorders, ~~3rd~~ 5th edition" or "DSM" means the ~~1987~~ 2013 publication of the American Psychiatric Association ~~classifying diagnoses of abnormal behavior~~ for identifying and classifying mental disorders using common language and standard criteria.

"Interfacility transfer" means when an individual is transferred from one nursing facility (NF) to another ~~nursing facility~~ NF, with or without an intervening hospital stay. ~~Interfacility transfers are subject to annual resident review rather than preadmission screening.~~ In cases of transfer of a resident with MI ~~or MR~~, ID, or a related condition ~~(MR/RC)~~ (RC) from ~~a~~ an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent preadmission screening and annual resident review ~~(PASARR)~~ (PASRR) and resident assessment reports shall accompany the transferring resident.

"Intellectual disability" or "ID" means the individual has a disability, with onset before 18 years of age, that is characterized by significant limitations in both intellectual functioning and adaptive behavior. The American Association on Intellectual and Developmental Disabilities document "Intellectual Disability: Definition, Classification, and Systems of Support, 11th edition" contains descriptions of significant limitations in both intellectual functioning and adaptive behavior. A person with related conditions (RCs) means the individual has a severe chronic disability that meets all of the following conditions:

1. The severe chronic disability is attributable to:

a. Cerebral palsy or epilepsy; or

b. Any other condition, other than mental illness, found to be closely related to ID because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of people with intellectual disabilities and requires treatment or services similar to those required for these persons;

2. The severe chronic disability is manifested before the person reaches 22 years of age;

3. The severe chronic disability is likely to continue indefinitely; and

4. The severe chronic disability results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

"Level I screening or identification" means the process performed to identify nursing facility applicants with a condition of mental illness or ~~mental retardation~~ ID.

"Level II evaluation and determination" means the evaluation and determination process for nursing facility (NF) applicants who are identified as having a condition of mental illness, ~~or mental retardation~~ ID, or related condition (RC) as defined ~~herein~~ in this section. The purpose of the Level II evaluation and determination is to ~~recommend placement of and services to nursing facility applicants with statutorily defined mental illness or mental retardation~~ confirm the existence of MI, ID, or RC and determine whether specialized services are needed, and if specialized services are needed, whether NF admission is the least restrictive environment and appropriate setting for receiving services.

"Long-term services and supports screening team" or "LTSS screening team" means the hospital screening team, community-based team, nursing facility long-term services and supports screening team, or Department of Medical Assistance Services designee contracted to perform screenings pursuant to § 32.1-330 of the Code of Virginia.

"Mental ~~Illness (MI)~~ illness" or "MI" means ~~a serious~~ mental illness meeting all of the following requirements:

1. The individual has ~~a major mental disorder diagnosable under~~, within the past year, had a serious and persistent mental disorder meeting the criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, ~~3rd~~ 5th edition, revised in ~~1987~~ 2013 that is ~~a schizophrenic, mood, paranoid, panic, or other severe anxiety disorder; somatoform disorder, personality disorder, other psychotic disorder, or another mental disorder that may lead to a chronic disability. The disorder is not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined here~~ not secondary to dementia;

~~2. The disorder results in functional limitations in major life activities within the past three to six months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis:~~

~~a. Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation;~~

~~b. Concentration, persistence, and pace. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work like structures, activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; and~~

~~c. Adaptation to change. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.~~ 2. The condition has been determined by a qualified clinician to be acute or in partial remission, has recurrent or persistent features, and if the DSM includes a severity scale for the disorder, the severity level of the disorder is moderate to severe;

~~3. The treatment history indicates that the individual has experienced at least one of the following:~~

~~a. Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization or inpatient hospitalization); or~~

~~b. Within the last two years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.~~

~~"Mental Retardation (MR)" means the presence of a level of retardation (mild, moderate, severe, or profound) described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983) or has a related condition. A person with related conditions (RC) means the individual has a severe chronic disability that meets all of the following conditions:~~

~~1. It is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, found to be closely~~

~~related to mental retardation because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons;~~

~~2. It is manifested before the person reaches age 22;~~

~~3. It is likely to continue indefinitely; and~~

~~4. It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.~~ 3. The disorder results in functional impairment that has substantially interfered with or limited one or more major life activity, including activities of daily living; instrumental activities of daily living; or functioning in social, family, and academic or vocational contexts or would have caused functional impairment without the benefit of treatment or other support services; and

4. A qualified clinician has found that the mental illness is not a secondary characteristic of a primary diagnosis of dementia or a neurocognitive disorder due to Alzheimer's disease or related conditions.

~~"MI/MR~~ "MI/ID Supplement" means the assessment form developed to meet the requirements of OBRA '87. Its purpose is to identify individuals with mental illness and ~~mental retardation~~ ID before their admission to a nursing facility.

"New admission" means an individual who is admitted to any nursing facility for the first time or does not qualify as a readmission. New admissions ~~are subject to~~ shall receive preadmission screening.

~~"Non-Medicaid-eligible Individuals" means persons who are not Medicaid-eligible or are not expected to be Medicaid eligible within 180 days of admission to a nursing facility.~~

~~"Nursing Home Preadmission Screening Committee (NHPASC)" means a committee established for the purpose of determining whether a Medicaid-eligible individual meets nursing facility criteria.~~

"Qualified ~~Mental Health Professional (QMHP)~~ mental health professional" or "QMHP" means a clinician in the health profession who is trained and experienced in providing psychiatric or mental health services to individuals who have a psychiatric diagnosis. In the Commonwealth, authorized professionals and minimal qualifications for a QMHP are as follows:

1. Physician: a doctor of medicine or osteopathy licensed in Virginia;

2. Psychiatrist: a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia;

3. Psychologist: an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience;

4. Social worker: an individual with a master's or bachelor's degree from a school of social work accredited or approved by the Council on Social Work Education with at least one year of clinical experience;

5. Registered nurse: a registered nurse licensed in the ~~State~~ Commonwealth of Virginia with at least one year of clinical experience; and

6. Mental health worker: an individual with professional education, training, ~~and/or~~ or a degree in human services or related field from an accredited college deemed equivalent to those described ~~above~~ in this definition and at least one year of clinical experience providing direct services to persons with a diagnosis of mental illness.

QMHPs who are certified by the Board of Counseling differ in regulatory requirements and scope of practice as indicated in 18VAC115-80. QMHPs holding a certification through the Board of Counseling are regulated by the Board of Counseling. QMHPs are clinicians or licensed professionals who perform duties within their scope of practice pursuant to their licensing or credentialing board.

"Readmission" means an individual who was readmitted to a facility from a hospital to which ~~he or she~~ the individual was transferred for the purpose of receiving care. Readmission includes being admitted to another nursing facility after a hospital admission. If an individual received a Level I screening or identification, and if needed, Level II evaluation and determination at the initial nursing facility admission, a new preadmission screening is not required. Readmissions are subject to annual resident review rather than preadmission screening.

"State ~~Mental Health~~ mental health authority or ~~Mental Retardation Authority (MH/MRA)~~ intellectual disability authority" or "SMHA/SIDA" means the designated representative of the Department of ~~Mental Health, Mental Retardation and Substance Abuse Services~~ Behavioral Health and Developmental Services who shall make determinations regarding placement of and services to nursing facility applicants who have conditions of mental illness or ~~mental retardation~~ intellectual disability.

12VAC30-130-150. Persons subject to nursing home preadmission screening and identification of conditions of mental illness ~~and mental retardation~~, intellectual disability, or related conditions (Level I).

A. As a condition of a nursing facility's Medicaid participation, all persons, regardless of financial status, applying for admission to a Medicaid-certified nursing facility shall be screened to determine whether they have a condition of mental illness (MI) or ~~mental retardation (MR)~~ intellectual

disability (ID) or a related condition (RC), and if so, whether they require the level of services provided by a nursing facility (NF). Nursing facilities shall ensure that applicants for admission have been screened, and those who are identified as being MI ~~or (MR/RC)~~, ID, or RC are not admitted until determinations have been made by the ~~State Mental Health or Mental Retardation Authority (MH/MHA)~~ SMHA/SIDA with respect to their placement and specialty services. ~~NHPASCs~~ LTSS screening teams complete the Level I process for individuals ~~who are Medicaid eligible or expect to become Medicaid eligible within 180 days~~ participating in the Medicaid long-term services and supports screening process and will refer for Level II evaluation and determination as needed. Nursing facilities are responsible for screening all other individuals who are seeking admission to a Medicaid-certified NF. Nursing facilities must ensure that the appropriate screenings are conducted ~~for non-Medicaid eligible applicants~~ prior to admitting an individual to a Medicaid-certified NF.

B. No individual, regardless of pay status, may be admitted to a nursing facility unless the Level I screening or identification has been completed, and~~,~~ if it is determined that the individual has a condition of MI ~~or (MR/RC)~~, ID, or RC as defined ~~herein~~ in this part, then ~~he or she~~ the individual shall not be admitted until the Level II evaluation and determination has been made.

C. The Level I identification function shall provide at least, in the case of first time identifications, for the issuance of written notice to the individual or resident and ~~his or her~~ the individual's or resident's legal representative if the individual is suspected of having MI ~~or (MR/RC)~~, ID, or RC and is being referred to the ~~MH/MRA~~ SMHA/SIDA for Level II ~~screening~~ evaluation and determination. The ~~NHPASC~~ LTSS screening team shall send this notice to ~~Medicaid eligible~~ individuals who participate in the Medicaid long-term services and supports screening process who are referred for a Level II ~~screening~~ evaluation and determination. The admitting NF shall send the notice to ~~non-Medicaid~~ all other individuals.

D. All Level I and Level II determinations shall be recorded in the individual's medical record.

E. When a preadmission screening has not been performed ~~timely,~~ prior to NF admission but is performed at a later date, federal financial participation ~~(FFP)~~ is available only for services furnished after the screening has been performed.

F. The state in which the individual is a resident (or will be at the time ~~he or she~~ the individual becomes eligible for Medicaid) must pay for the ~~PASARR~~ preadmission screening and resident review process and make the required determinations. In the case of non-Medicaid eligible applicants, the receiving NF is responsible to ensure that the appropriate screenings have been completed prior to the individual's admission.

12VAC30-130-160. Level II evaluation and determination.

A. For each resident of a ~~NF~~ nursing facility (NF) who has a condition of MI ~~or MR/RC~~, ID, or related conditions (RC), the ~~MH/MRA, as appropriate,~~ SMHA/SIDA must determine whether the individual requires the level of services provided by ~~a~~ an NF, an inpatient psychiatric hospital for individuals ~~under age~~ younger than 21 years of age, an institution for mental disease ~~(IMD)~~ providing medical assistance to individuals age 65 and older, an intermediate care facility for the ~~mentally retarded (ICF/MR)~~ intellectually disabled, or specialized services for either MI, ID, or ~~MR/RC~~ RC.

B. When a Level II evaluation is required, a determination shall be made within an annual average of ~~seven to~~ nine ~~working~~ days of the Level I referral for ~~screening~~ evaluation and determination. The ~~MH/MRA~~ SMHA/SIDA shall convey determinations verbally to ~~NFs~~ Level I screeners and the individual and confirm them in writing.

C. The ~~MH/MRA~~ SMHA/SIDA shall notify in writing the following entities of a Level II evaluation and determination:

1. The evaluated individual and ~~his or her~~ the evaluated individual's legal representative;

2. The admitting or retaining NF;

3. The ~~individual or~~ resident's attending physician; and

4. The discharging hospital or Level I screening or identification entity.

D. Each notice described ~~above~~ in this section shall include the following:

1. Whether ~~a~~ an NF level of services is needed;

2. Whether specialized services are needed;

3. The placement options available to the individual consistent with the determination; and

4. The rights of the individual to appeal the determination.

12VAC30-130-170. Categorical determinations.

A. For each individual for whom the Level I screening or identification has resulted in the determination that the individual meets nursing facility level of care and has a condition of MI, ID, or ~~MR/RC~~ related conditions as defined ~~herein~~ in this part, a Level II evaluation and determination does not have to be completed if one of the following categorical determinations are met:

1. The individual has a terminal illness in which a physician has documented that life expectancy is less than six months; or

2. The individual has a severe illness such as coma, functioning at brain stem level, or other conditions ~~which~~ that result in a level of impairment so severe that the individual could not be expected to benefit from specialized

services. When this category is used, documentation shall be available ~~which~~ that fully describes the severity of the condition.

B. These categorical determinations shall only be applied following the Level I review and only if existing data on the individual appear to be current and accurate and are sufficient to allow the evaluator readily to determine that the individual fits the category.

12VAC30-130-180. ~~Annual resident~~ Resident review.

A. A review and determination must be conducted for each resident of a ~~NF~~ nursing facility (NF) who has MI ~~or MR/RC not less often than annually. "Annually" is defined as occurring within every fourth quarter after the previous preadmission screening or annual resident review~~, ID, or related conditions upon change in the resident's physical or mental condition.

B. ~~When an annual resident review has not been performed timely, but is performed at a later date, federal financial participation (FFP) is available only for services furnished after the review has been performed~~ If an NF has notified the SMHA/SIDA that there has been a significant change in the resident's physical or mental condition, a review must be conducted promptly.

12VAC30-130-190. Determinations and placement of individuals with ~~MI or MR/RC~~ mental illness, intellectual disability, or related condition.

A. If the ~~MH/MRA~~ SMHA/SIDA determines that a resident or applicant for admission to a ~~NF~~ nursing facility (NF) requires ~~a~~ an NF level of services, the NF may admit or ~~retain~~ enroll the individual. If the ~~MH/MRA~~ SMHA/SIDA determines that a resident or applicant for admission requires both ~~a~~ an NF level of services and specialized services for MI, ID, or ~~MR/RC~~ related conditions (RC), the NF may admit or retain the individual and the state must provide or arrange for the provision of the specialized services needed by the individual while ~~he~~ the individual resides in the NF.

B. If the ~~MH/MRA~~ SMHA/SIDA determines that an applicant for admission to ~~a~~ an NF does not require NF services, the applicant cannot be admitted. ~~NF~~ Nursing facility services are not a covered Medicaid service for that individual, and further screening is not required.

C. If the ~~MH/MRA~~ SMHA/SIDA determines that a resident requires neither the level of services by ~~a~~ an NF nor specialized services for MI, ID, or ~~MR/RC~~ RC, regardless of the length of stay in the facility, the state must (i) arrange for the safe and orderly discharge of the resident from the facility; and (ii) prepare and orient the resident for discharge.

D. For any resident who has continuously resided in ~~a~~ an NF for at least 30 months before the date of the determination, and who requires only specialized services, the state must, in consultation with the resident's family or legal representative and caregivers, (i) offer the resident the choice of remaining in the facility or of receiving services in an alternative appropriate setting; (ii) inform the resident of the institutional and noninstitutional alternatives available; (iii) clarify the effect on eligibility for Medicaid services if the resident chooses to leave the facility, including its effect on readmission to the facility or eligibility for community-based services; and (iv) regardless of the resident's choice to remain in the NF or to be discharged to a community setting, provide for~~,~~ or arrange for the provision of specialized services for the MI ~~or MR~~, ID, or RC.

E. For any resident who has not continuously resided in ~~a~~ an NF for at least 30 months before the date of the determination, the state must, in consultation with the resident's family or legal representative and caregivers (i) arrange for the safe and orderly discharge of the resident from the facility; (ii) prepare and orient the resident for discharge; and (iii) provide for, or arrange for the provision of, specialized services for the MI ~~or MR~~, ID, or RC.

F. For the purposes of establishing length of stay in ~~a~~ an NF, the 30 months of continuous residence in the NF or longer is calculated back from the date of the first annual resident review determination ~~which~~ that finds that the individual is not in need of NF level of services. The 30 months of continuous residence in ~~a~~ an NF may include temporary absences for hospitalization ~~and~~ or therapeutic leave and may consist of consecutive residences in more than one NF.

G. Placement of an individual with MI, ID, or ~~MR/RC~~ RC in ~~a~~ an NF may be considered appropriate only when the individual's needs are such that ~~he or she~~ the individual meets the minimum standards for admission and ~~his or her needs for treatment~~ the individual's treatment needs do not exceed the level of services ~~which~~ that can be delivered in the NF to which the individual is admitted either through NF services alone or, where necessary, through NF services supplemented by specialized services provided by or arranged for by the state.

12VAC30-130-200. ~~PASARR~~ Preadmission screening and resident review evaluation criteria.

A. The state's ~~PASARR~~ preadmission screening and resident review (PASRR) program must identify all individuals who are suspected of having MI, ID, or ~~MR/RC~~ related conditions (RCs) as defined ~~herein~~ in this part. The identification function ~~and determination that NF criteria is met~~ is termed Level I. Level II is the function of evaluating and determining whether ~~NF placement is appropriate to meet the individual's MH/MR/RC needs and whether~~ nursing facility (NF) level of services and specialized services are needed.

B. Evaluations performed under ~~PASARR~~ PASRR and ~~PASARR~~ PASRR notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated. ~~PASARR~~ Preadmission screening and resident review evaluations must involve the individual being evaluated, the individual's legal representative~~,~~ if one has been designated

under state law, and the individual's family if available and the individual or the legal representative agrees to family participation. When parts of a ~~PASARR~~ PASRR evaluation are performed by more than one evaluator, there must be interdisciplinary coordination among the evaluators.

C. All information that is necessary for determining whether it is appropriate for the individual with MI, ID, or ~~MR/RC~~ RC to be placed in ~~a~~ an NF or in another appropriate setting should be gathered throughout all applicable portions of the ~~PASARR~~ PASRR evaluation. The determinations relating to the need for NF level of care and specialized services are interrelated and must be based upon a comprehensive analysis of all data concerning the individual.

D. Evaluators may use relevant evaluative data~~,~~ obtained prior to initiation of preadmission screening or ~~annual~~ resident review~~,~~ if the data are considered valid and accurate and reflect the current functional status of the individual. However, in the case of individualized evaluations, the ~~PASARR~~ PASRR program may need to gather additional information to supplement and verify the currency and accuracy of existing data and to assess proper placement and treatment.

E. For individualized ~~PASARR~~ PASRR determinations, findings must be issued in the form of a written evaluative report ~~which~~ that (i) identifies the name and professional title of ~~person(s)~~ the person who performed the ~~evaluation(s)~~ evaluation and the date on which each portion of the evaluation was administered; (ii) provides a summary of the medical and social history, including the positive traits or developmental strengths and weaknesses or developmental needs of the evaluated individual; (iii) if NF services are recommended, identifies the specific services ~~which~~ that are required to meet the evaluated individual's needs; (iv) if specialized services are not recommended, identifies any specific ~~MR/RC~~ ID, RC, or ~~MH~~ mental health services ~~which~~ that are of a lesser intensity than specialized services that are required to meet the evaluated individual's needs; (v) if specialized services are recommended, identifies the specific ~~MR/RC~~ ID, RC, or ~~MH~~ mental health services required to meet the evaluated individual's needs; and (vi) includes the basis for the report's conclusions.

F. For categorical ~~PASARR~~ PASRR determinations, findings must be issued in the form of an abbreviated written evaluative report ~~which~~ that (i) identifies the name and professional title of the person applying the categorical determination and the data on which the application was made; (ii) explains the categorical ~~determination(s)~~ determination that has ~~(have)~~ been made; (iii) identifies, to the extent possible~~,~~ based on the available data, NF services, including any mental health or specialized psychiatric rehabilitative services, that may be needed; and (iv) includes the bases for the report's conclusions.

G. For both categorical and individualized determinations, findings of the evaluation must correspond to the person's current functional status, mental health, and ~~mental retardation~~ ID status as documented in medical and social history records. Findings of the evaluation must be interpreted and explained to the individual and, where applicable, to a legal representative ~~designed~~ designated under state law by the assessment team or the ~~MH/MRA~~ SMHA/SIDA. The evaluation report must be sent to the individual and ~~his~~ the individual's legal representative, appropriate state authority in sufficient time to meet the required ~~time frames~~ timeframes, admitting or retaining NF, individual's attending physician, and the discharging hospital if the individual is seeking NF admission from a hospital. The determination decision must be provided to the Level I screener in a format enabling electronic entry and tracking of the results. The evaluation may be terminated at any time during the evaluation that the individual being evaluated does not have MI ~~or MR/RC~~, ID, or RC or has a primary diagnosis of dementia, including Alzheimer's Disease or a related disorder, or a nonprimary diagnosis of dementia without a primary diagnosis that is a serious mental illness~~,~~ and does not have a diagnosis of ~~MR~~ ID or a related condition.

12VAC30-130-210. Specialized services.

A. For mental illness, specialized services means the services specified by the state ~~which~~ that, combined with services provided by the ~~NF~~ nursing facility (NF), ~~results~~ result in the continuous and aggressive implementation of an individualized plan of care that:

1. Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals, and as appropriate, other professionals;

2. Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness ~~which~~ that necessitates supervision by trained mental health personnel;

3. Is directed toward diagnosing and reducing the resident's behavioral symptoms that may necessitate institutionalization, improving ~~his or her~~ the resident's level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time; and

4. Prescribes inpatient psychiatric services for any individual determined to be a danger to self or others. For ~~nursing facility~~ NF residents who are determined to be a danger to self or others due to mental illness, the ~~nursing facility~~ NF must coordinate admission to an inpatient psychiatric hospital.

B. For ~~mental retardation~~ ID or related conditions, specialized services means the services specified by the state ~~which~~ that, combined with services provided by the NF or other service providers, results in treatment ~~which~~ that includes aggressive, consistent implementation of a program of specialized and

generic training, treatment, health services, and related services that is directed toward the following;

1. The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and

2. The prevention or deceleration of regression or loss of current optimal functional status.

C. The state must provide or arrange for the provision of specialized services to all NF residents with MI ~~or MR/RC~~, ID, or RC whose needs are such that continuous supervision, treatment, and training by qualified ~~MH/MR~~ personnel is necessary as identified by their Level I and II assessments. The NF must provide ~~MH or MR/RC~~ MI, ID, or RC services ~~which~~ that are of a lesser intensity than specialized services to all residents who need such services.

1. Services that shall be the responsibility of the ~~nursing facility~~ NF to provide to residents shall include~~, but are not limited to~~:

a. Physical therapy;

b. Speech-language pathology services;

c. Occupational therapy;

d. Restorative nursing;

e. Behavior management interventions that do not require ongoing consultation and monitoring by a licensed psychiatrist or psychologist;

f. Basic grooming and hygiene needs;

g. Nutritional needs, including supplements and assistance with eating;

h. Adjustment needs resulting from admission to ~~a nursing facility~~ an NF and ongoing psychosocial emotional support; and

i. Noncustomized durable medical equipment and supplies.

2. Specialized services for the purposes of ~~PASARR~~ preadmission screening and resident review shall include the following. The ~~State Mental Health or Mental Retardation Authority~~ SMHA/SIDA shall ensure the provision of specialized services when they are provided by a non-Medicaid-enrolled provider or when the services are not covered by Medicaid.

a. Partial hospitalization;

b. Transportation to Medicaid-covered services or specialized services necessary to treat conditions of mental illness or ~~mental retardation~~ ID;

c. Day health and rehabilitation;

d. Psychosocial rehabilitation;

e. Crisis intervention;

f. Customized durable medical equipment, for residents without a patient pay~~,~~ that would allow the resident to participate in specialized services;

g. Behavior management interventions requiring ongoing consultation and monitoring by a licensed psychiatrist or psychologist;

h. One-to-one supervision necessary for behavior management;

i. Vision and hearing needs related to mental illness or ~~mental retardation~~ ID for persons ~~over age~~ older than 21 years of age;

j. Dental needs resulting from mental illness or ~~mental retardation~~ ID sequela for persons ~~over age~~ older than 21 years of age;

k. Habilitation;

l. Supported employment for persons with mental illness or ~~mental retardation~~ ID;

m. Case management services;

n. Individual psychotherapy;

o. Day treatment;

p. Individual and group counseling; and

q. Inpatient psychiatric care.

12VAC30-130-220. Placement options.

A. The placement options and required state actions resulting from ~~PASARR~~ preadmission screening and resident review (PASRR) are as follows:

1. Can be admitted to a ~~NF~~ nursing facility (NF). Any applicant for admission to ~~a~~ an NF who has MI ~~or MR/RC~~, ID, or related conditions (RCs) and who requires the level of services provided by ~~a~~ an NF, regardless of whether specialized services are also needed, may be admitted to ~~a~~ an NF~~,~~ if the placement is appropriate. If specialized services are also needed, the state is responsible for providing or arranging for the provision of the specialized services.

2. Cannot be admitted to ~~a~~ an NF. Any applicant for admission to ~~a~~ an NF who has MI ~~or MR/RC~~, ID, or RC and who does not require the level of services provided by ~~a~~ an NF, regardless of whether specialized services are also needed, is inappropriate for NF placement and must be not be admitted.

3. Can be considered appropriate for continued placement in ~~a~~ an NF. Any NF resident with MI ~~or MR/RC~~, ID, or RC who requires the level of services provided by ~~a~~ an NF, regardless of the length of ~~his or her~~ the resident's stay or the need for specialized services, can continue to reside in the NF~~,~~ if the placement is appropriate.

4. May choose to remain in the NF even though the placement would otherwise be inappropriate. Any NF resident with MI ~~or MR/RC~~, ID, or RC who does not require the level of services provided by the NF but does require

specialized services and who has continuously resided in ~~a~~ an NF for at least 30 consecutive months before the date of determination may choose to continue to reside in the facility or to receive covered services in an alternative appropriate institutional or noninstitutional setting. Wherever the resident chooses to reside, the state must meet ~~his or her~~ the resident's specialized services needs. The determination notice must provide information concerning how, when, and by whom the various placement options available to the resident will be fully explained to the resident.

5. Cannot be considered appropriate for continued placement in ~~a~~ an NF and must be discharged (short-term residents). Any NF resident with MI ~~or MR/RC~~, ID, or RC who does not require the level of services provided by ~~a~~ an NF but does require specialized services and who has resided in ~~a~~ an NF for less than 30 consecutive months must be discharged to an appropriate setting where the state must provide specialized services. The determination notice must provide information on how, when, and by whom the resident will be advised of discharge arrangements and of ~~his/her~~ the resident's appeal rights under both ~~PASARR~~ PASRR and discharge provisions.

6. Cannot be considered appropriate for continued placement in ~~a~~ an NF and must be discharged (short-term or long-term residents). Any NF resident with MI ~~or MR/RC~~, ID, or RC who does not require the level of services provided by ~~a~~ an NF and does not require specialized services regardless of ~~his or her~~ the resident's length of stay~~,~~ must be discharged. The determination notice must provide information on how, when, and by whom the resident will be advised of discharge arrangements and of ~~his or her~~ the resident's appeal rights under both ~~PASARR~~ PASRR and discharge provisions.

7. Specialized services needed in ~~a~~ an NF. If a determination is made to admit or allow to remain in ~~a~~ an NF any individual who requires specialized services, the determination must be supported by assurances that the specialized services that are needed can and will be provided or arranged for in a timely manner by the state in which the individual resides in the NF.

B. The state ~~PASARR~~ PASRR system shall maintain records of evaluations and determinations, regardless of whether they are performed categorically or individually, in order to support its determinations and actions and to protect the appeal rights of individuals subjected to ~~PASARR~~ PASRR. The state ~~PASARR~~ PASRR system shall establish and maintain a tracking system for all individuals with MI ~~or MR/RC~~, ID, or RC in NFs to ensure that appeals and future reviews are performed.

12VAC30-130-230. Evaluating the need for ~~NF~~ nursing facility services ~~and NF level of care (PASARR/NF)~~.

A. For each applicant for admission to a ~~NF~~ nursing facility (NF) and each NF resident who has MI ~~or MR/RC~~, ID, or RC, the evaluator must assess whether (i) the applicant's or resident's total needs are such that ~~his~~ the applicant's or resident's needs can be met in an appropriate community setting; (ii) the individual's total needs are such that they can be met only on an inpatient basis, which may include the option of placement in a home and community-based services waiver program, but for which the inpatient care would be required; (iii) if inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs; or (iv) if the inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the individual's needs, another setting such as an ~~ICF/MR~~ intermediate care facility for persons with intellectual and developmental disabilities (including small, community-based facilities), an ~~IMD~~ intermediate care facility providing services to individuals ages 65 or older, or a psychiatric hospital is an appropriate institutional setting for meeting those needs.

B. In determining appropriate placement, the evaluator must prioritize the physical and mental needs of the individual being evaluated, taking into account the severity of each condition.

C. For individuals for whom NF placement is considered an appropriate option by the evaluator, per the evaluation in subsections A and B of this section, the evaluator must assess what services for MI or ID the individual may need that are offered as part of standard NF services, including behavioral health services and specialized rehabilitative services as described in 42 CFR 483.30 and 42 CFR 483.65. At a minimum the data relied on to make a determination must include: (i) evaluation of physical status (for example, diagnoses, date of onset, medical history, and prognosis); (ii) evaluation of mental status (for example, diagnoses, date of onset, medical history, likelihood that the individual may be a danger to ~~himself/herself~~ self or others); and (iii) functional assessment (activities of daily living).

D. Based on the data compiled, the ~~MH/MRA~~ SMHA/SIDA must determine whether an NF level of services is needed.

12VAC30-130-240. Evaluating ~~whether an individual with MI requires specialized services (PASARR/MI)~~ the need for specialized services.

A. The purpose of this section is to identify the minimum data needs and process requirements for the ~~state MHA~~ SMHA/SIDA, which is responsible for determining whether or not the applicant or resident with MI needs a specialized services program for mental illness.

B. Minimum data collected must include:

1. A comprehensive history and physical examination of the person. If the history and physical examination are not performed by a physician, then a physician must review and concur with the conclusions. The following areas must be included (if not previously addressed): complete medical history; review of all body systems; specific evaluation of the person's neurological system in the areas of motor

functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; and in case of abnormal findings ~~which~~ that are the basis for ~~a NF~~ nursing facility (NF) placement, additional evaluations conducted by appropriate specialists.

2. A comprehensive drug history, including current or immediate past use of medications that could mask symptoms or mimic mental illness.

3. A psychological evaluation of the person, including current living arrangements and medical and support systems.

4. A comprehensive psychiatric evaluation, including a complete psychiatric history, evaluation of intellectual functioning, memory functioning, and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence and content of delusions) and hallucinations.

5. A functional assessment of the individual's ability to engage in activities of daily living and the level of support that would be needed to assist the individual to perform these activities while living in the community. The assessment must determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that NF placement is required. The functional assessment must address the following areas: ~~Self-monitoring~~ self-monitoring of health status~~,~~; self-administering and scheduling of medical treatment, including medication compliance, or both~~,~~; and self-monitoring of nutritional status, handling money, dressing appropriately, and grooming.

C. The state may designate the mental health professionals who are qualified to perform the evaluations required, including the comprehensive drug history~~;~~, psychosocial evaluation~~;~~, comprehensive psychiatric evaluation~~;~~, and functional assessment~~; and~~ to make the determination required.

D. Based on the data compiled, a qualified mental health professional, as designated by the state, must validate the diagnosis of mental illness and determine whether a program of psychiatric specialized services is needed.

12VAC30-130-250. Evaluating whether an individual with ~~MR/RC~~ mental illness, intellectual disability, or related conditions requires specialized services ~~(PASARR/MR)~~.

A. The purpose of this section is to identify the minimum data needs and process requirements for the ~~state MRA~~ SMHA/SIDA to determine whether or not the applicant or resident with ~~mental retardation~~ ID or a related condition needs a continuous specialized services program. Minimum data collected must include the individual's comprehensive history and physical examination results to identify the following information or, in the absence of data, must include information that permits a reviewer specifically to assess:

1. The individual's medical problems;

2. The level of impact these problems have on the individual's independent functioning;

3. All current medications used by the individual and the current response of the individual to any prescribed medications in the following drug groups: hypnotics, antipsychotics (neuroleptics), mood stabilizers and antidepressants, antianxiety-sedative agents, and anti-Parkinsonian agents~~.~~;

4. Self-monitoring of health status;

5. Self-administering and scheduling of medical treatments;

6. Self-monitoring of nutritional status;

7. Self-help development, such as toileting, dressing, grooming, and eating;

8. Sensorimotor development, such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity;

9. Speech and language (communication) development, such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which nonoral communication systems can improve the individual's function capacity, auditory functioning, and extent to which amplification devices (e.g., hearing aid) or a program of amplification can improve the individual's functional capacity;

10. Social development, such as interpersonal skills, recreation-leisure skills, and relationships with others;

11. ~~Academic/educational~~ Academic or educational development, including functional learning skills;

12. Independent living development, such as meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bed making, care of clothing, and orientation skills (for individuals with visual impairments);

13. Vocational development, including present vocational skills;

14. Affective development, such as interests~~,~~ and skills involved with expressing emotions, making judgments, and making independent decisions; and

15. The presence of identifiable maladaptive or inappropriate behaviors of the individual based on systematic observation ~~(~~, including~~, but not limited to,~~ the

frequency and intensity of identified maladaptive or inappropriate behaviors~~)~~.

B. The state must ensure that a licensed psychologist identifies the intellectual functioning measurement of individuals with ~~MR~~ ID or a related condition. Based on the data compiled, the ~~MRA~~ SMHA/SIDA, using appropriate personnel as designated by the state, must validate that the individual has ~~MR~~ ID or is a person with a related condition and must determine whether specialized services for ~~MR/RC~~ ID and related conditions are needed. In making this determination, the ~~MHA~~ SMHA/SIDA must make a qualitative judgment on the extent to which the person's status reflects, singly and collectively, the characteristics commonly associated with the need for specialized services, including:

1. Inability to take care of most personal care needs; understand simple commands; communicate basic needs and wants; be employed at a productive wage level without systematic long term supervision or support; learn new skills without aggressive and consistent training; apply skills learned in a training situation to other environments or settings without aggressive and consistent training; demonstrate behavior appropriate to the time, situation, or place without direct supervision; and make decisions requiring informed consent without extreme difficulty;

2. Demonstration of severe maladaptive ~~behavior(s)~~ behavior that place the person or others in jeopardy to health and safety; and

3. Presence of other skill deficits or specialized training needs that necessitate the availability of trained ~~MR~~ ID personnel, 24 hours per day, to teach the person functional skills.

12VAC30-130-260. Appeals.

A. Following notification to the ~~NF~~ nursing facility (NF) of the Level II ~~assessment~~ evaluation and determination by the ~~state MH/MRA~~ SMHA/SIDA, the NF must inform the individual of the decision indicating the reasons for acceptance or denial and the method of appeal. Any individual, regardless of method of payment, who wishes to appeal the decision of the Level II evaluation and determination may do so by sending written notification to the Department of Medical Assistance Services (DMAS), Division of Client Appeals.

B. Decisions made by the ~~annual~~ resident review teams shall also be appealable to DMAS. The reviewed individual shall send written notification to DMAS, Division of Client Appeals.

C. All appeal requests must be made within 30 days of the individual's notification of the review decision.

VA.R. Doc. No. R22-6611; Filed December 22, 2021, 9:41 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

VIRGINIA BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

Final Regulation

REGISTRAR'S NOTICE: The Virginia Board for Asbestos, Lead, and Home Inspectors is claiming an exemption from Article 2 of the Administrative Process Act in accordance with (i) § 2.2-4006 A 6 of the Code of Virginia, which excludes regulations of the regulatory boards served by the Department of Professional and Occupational Regulation pursuant to Title 54.1 of the Code of Virginia that are limited to reducing fees charged to regulants and applicants; and (ii) § 2.2-4006 A 3 of the Code of Virginia, which excludes regulations that consist only of changes in style or form or corrections of technical errors. The Virginia Board for Asbestos, Lead, and Home Inspectors will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **18VAC15-40. Home Inspector Licensing Regulations (amending 18VAC15-40-32, 18VAC15-40-35, 18VAC15-40-50).**

Statutory Authority: §§ 54.1-201 and 54.1-501 of the Code of Virginia.

Effective Date: March 2, 2022.

Agency Contact: Trisha L. Henshaw, Executive Director, Virginia Board for Asbestos, Lead, and Home Inspectors, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8595, FAX (866) 350-5354, or email alhi@dpor.virginia.gov.

Summary:

The amendments (i) reduce the renewal and reinstatement fees for home inspector licenses and home inspector with new residential structures specialty licenses until February 2024 to comply with § 54.1-113 of the Code of Virginia; and (ii) correct a technical error in regulatory text.

18VAC15-40-32. Qualifications for licensure.

A. An applicant for licensure as a home inspector shall furnish documentation acceptable to the board that one of the qualifications for licensure in Table 1 has been met.

TABLE 1

	Board-approved prelicense education course contact hours	Experience	Passed the board-approved examination
1.	35	Completion of 100 home inspections prior to July 1, 2017	Yes

2.	35	Completion of 50 home inspections under the direct supervision of a home inspector	Yes
3.	70	Completion of 50 home inspections prior to July 1, 2017	Yes
4.	70	Completion of 25 home inspections under the direct supervision of a home inspector	Yes
5.	None	Verification of 10 years' experience as a home inspector prior to July 1, 2017, with a minimum of 250 home inspections completed during such time period	Yes

B. Prelicense education courses must be approved by the board pursuant to Part VI (~~18VAC15-40-120~~ 18VAC15-40-200 et seq.) of this chapter. No more than half of the required hours may be completed using distance or online education technology.

C. Verification of home inspections completed under the direct supervision of a home inspector must be provided by an individual who was properly licensed or certified by the board during the applicable time period.

D. The National Home Inspector Examination provided by the Examination Board of Professional Home Inspectors is the board-approved examination pursuant to § 54.1-517.2 A 2 c of the Code of Virginia.

18VAC15-40-35. Qualifications for the new residential structure specialty.

To obtain the NRS specialty, the applicant shall submit the appropriate application form and fee pursuant to 18VAC15-40-50 and meet the following qualifications:

1. Hold a current and valid home inspector license. An applicant who does not hold a current and valid home inspector license shall apply for such licensure and meet the requirements contained in 18VAC15-40-30 and 18VAC15-40-32.

2. Submit proof of successful completion of an NRS training module approved by the board pursuant to Part VI (~~18VAC15-40-120~~ 18VAC15-40-200 et seq.) of this chapter and completed no more than two years prior to the date of application.

18VAC15-40-50. Fees.

Fee type	Fee amount	When due
Initial home inspector application	$80	With application for home inspector
Initial NRS specialty application	$80	With application for NRS specialty designation
Home inspector renewal	$45	With renewal application
Home inspector with NRS specialty renewal	$90	With renewal application
Home inspector reinstatement	$125	With reinstatement application
Home inspector with NRS specialty reinstatement	$170	With reinstatement application
Prelicense education course approval	$250	With prelicense education course approval application
NRS training module approval	$150	With NRS training module approval application
NRS CPE course approval	$150	With NRS CPE course approval application

~~For licenses expiring after February 1, 2018, and before February 1, 2020, the renewal fees shall be as follows:~~

~~Home inspector renewal~~	~~$25~~
~~Home inspector with NRS specialty renewal~~	~~$50~~

~~For reinstatement applications received after March 1, 2018, and on or before February 29, 2020, the reinstatement fees shall be as follows:~~

~~Home inspector reinstatement~~	~~$105~~
~~Home inspector with NRS specialty reinstatement~~	~~$130~~

For licenses expiring after February 1, 2020, and before February 1, 2022, the renewal fees shall be as follows:

Home inspector renewal	$40
Home inspector with NRS specialty renewal	$80

For reinstatement applications received after March 1, 2020, and on or before February 28, 2022, the reinstatement fees shall be as follows:

Home inspector reinstatement	$120
Home inspector with NRS specialty reinstatement	$160

For licenses expiring after February 1, 2022, and before February 1, 2024, the renewal fees shall be as follows:

Home inspector renewal	$25
Home inspector with NRS specialty renewal	$50

For reinstatement applications received after March 1, 2022, and on or before February 29, 2024, the reinstatement fees shall be as follows:

Home inspector reinstatement	$105
Home inspector with NRS specialty reinstatement	$130

NOTICE: The following forms used in administering the regulation have been filed by the agency. Amended or added forms are reflected in the listing and are published following the listing. Online users of this issue of the Virginia Register of Regulations may also click on the name to access a form. The forms are also available from the agency contact or may be viewed at the Office of Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (18VAC15-40)

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

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

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

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

~~Home Inspector Reinstatement Application, A506-3380REI-v3 (eff. 2/2020)~~

Home Inspector Reinstatement Application, A506-3380REI-v4 (eff. 2/2022)

Home Inspector - Course Approval Application, Prelicense Education Course/NRS Training Module/NRS CPE, A506-3331HICRS-v3 (eff. 2/2020)

VA.R. Doc. No. R22-6987; Filed January 3, 2022, 10:23 a.m.

BOARD OF DENTISTRY

Proposed Regulation

Title of Regulation: **18VAC60-21. Regulations Governing the Practice of Dentistry (amending 18VAC60-21-10, 18VAC60-21-60; adding 18VAC60-21-165).**

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

Public Hearing Information:

February 18, 2022 - noon - Department of Health Professions, Perimeter Building, 9960 Mayland Drive, 2nd Floor, Board Room 4, Henrico, VA 23233

Public Comment Deadline: April 1, 2022.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@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 Dentistry the authority to promulgate regulations to administer the regulatory system. Section 54.1-2708.5 of the Code of Virginia provides for digital scans for use in the practice of dentistry and the practice of digital scan technicians.

Purpose: Provisions of Chapters 37 and 220 of the 2020 Acts of the Assembly set out the safeguards that must be in place for the practice of teledentistry, including the training and supervision of a digital scan technician if used in the practice. The purpose of the regulation is to specify the responsibility of the dentist for such training and supervision in order to protect the safety and health of patients receiving dental care via teledentistry.

Substance: The proposed regulation will establish requirements for a training program approved by the board to take digital scans of intraoral and extraoral hard and soft tissues for use in teledentistry; set out the responsibilities of the dentist for the practice of teledentistry and the training and supervision of a digital scan technician; and establish requirements for records that may be requested by the board.

Issues: The primary advantage to private citizens is that digital scan technicians will be required to have board-approved training prior to performing digital scans on a patient, thereby ensuring the safety of patients who receive digital dental scans outside of a dentist's office. There are no disadvantages to the

public. There are no primary 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. In response to Chapters 37 and 220 of the 2020 Acts of Assembly,[1] the Board of Dentistry (Board) proposes to require dentists to ensure that digital scan technicians that engage in the practice of teledentistry are trained and supervised.

Background. According to the Department of Health Professions (DHP), the impetus for Chapters 37 and 220 was complaints expressed by Virginia residents who were improperly fitted for dental appliances provided by dental improvement companies. Dental scans taken of a patient's oral cavity serve as the blueprint for the fitting and fabricating of dental appliances. Improper or inaccurate dental scans often result in ill-fitting dental appliances, causing pain and discomfort. Although dental improvement companies fall under the Virginia definition of teledentistry, the Board does not regulate such businesses.

In response to these concerns, the Virginia General Assembly enacted Chapters 37 and 220. The legislation requires dental scan technicians to practice under the supervision of a dentist licensed in Virginia and to complete training approved by the Board. Although the legislation authorizes the Board to approve training programs for digital scan technicians and require dentists to ensure technicians have received appropriate training, it does not authorize the direct regulation of digital scan technicians. According to DHP, "the board does not have the statutory authority to license, certify, or register digital scan technicians. The [Virginia] Code requires the board to approve training and does not grant authority to regulate digital scan technicians."

Instead, the Board is authorized to regulate dentists and the Board proposes to require dentists to supervise and ensure that technicians complete training offered by any of the following: 1) Any sponsor listed in subsection C of 18VAC60-21-250;[2] 2) The American Association of Orthodontists and their constituent and component/branch associations, including the Virginia Association of Orthodontists; or 3) A training program certified by the manufacturer of the digital scanner.

Estimated Benefits and Costs. As evident from the consumer complaints the Board has received, the use of digital scans in the dental industry is not new, though DHP does not have data to assess its extent. For a variety of concerns such as consumer satisfaction, liability, and productivity, it would be reasonable to assume that it is also in the best interests of dentists and manufacturers of the scans that such technicians are equipped with proper training. Thus, it is likely most digital scan technicians are already provided some basic skills. The main purpose and effect of the legislation and the proposed regulatory language is to strengthen enforcement. Currently, the Board does not have authority to take action against dentists who may be employing untrained technicians in the practice of teledentistry.[3] To the extent the proposed changes deter unscrupulous or untrained individuals from participating in teledentistry, health and safety risks to patients should be mitigated to some degree.

The proposed language does not specify the scope of training, only that the technician receive training provided by one of the entities listed above and is under the supervision of the dentist. Thus, there appears to be flexibility in designing the contents, length, and the method of training, which would ultimately determine its cost. It appears the most common form of training is by the manufacturers offered online free of charge to promote their equipment, and the Board is proposing to authorize this training and also the two additional sources noted above. There are no fees associated with this action, and no requirement for a scan technician to attend subsequent digital scan training sessions after initial training is complete. However, the Board currently does not have an estimate on what the training could cost.

Businesses and Other Entities Affected. The proposed amendments directly affect dentists who employ digital scan technicians in the practice of teledentistry, and indirectly affects the technicians themselves. The Board does not have information on the number of entities that are likely to be affected by the regulatory change. The 2020 legislation requires a Virginia license for any dentist who directs the taking of a digital scan via teledentistry, but there is no identifiable license for teledentistry. While the Board does not have specific data on dentists practicing by teledentistry, it notes that there was a substantial increase in the number of applicants for licensure from out-of-state in fiscal (FY) 2021; in FY 2020, there were 184 applicants from out-of-state and in FY 2021 there were 259 such applicants. No adverse economic impact[4] on any entities is indicated.

Small Businesses[5] Affected. Although the proposed regulation applies to any dentist employing digital scan technicians in the practice of teledentistry, the Board reports that most dentists who are affected would likely be employees of a national corporation. No adverse economic impact on small businesses is indicated.

Localities[6] Affected.[7] No effect on localities is expected.

Projected Impact on Employment. The proposed changes should deter untrained individuals from participating in teledentistry. Otherwise, no effect on total employment is expected.

Effects on the Use and Value of Private Property. The proposed changes do not appear to have an effect on the use and value of private property or the real estate development costs.

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[1] https://lis.virginia.gov/cgi-bin/legp604.exe?201+ful+CHAP0037 & https://lis.virginia.gov/cgi-bin/legp604.exe?201+ful+CHAP0220

[2] https://law.lis.virginia.gov/admincode/title18/agency60/chapter21/section250/

[3] It should be noted that the scope of the proposed changes is limited to use of digital scans in the practice of teledentistry (i.e., taking of digital dental scans

outside of a dentist's office). If the digital scans are taken at a dentist office, the Board already has authority to take action against the dentist.

[4]Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined.

[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."

[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.

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:

Pursuant to Chapters 37 and 220 of the 2020 Acts of Assembly, the proposed amendments (i) define a digital scan technician, as used in teledentistry, (ii) establish requirements for the training of technicians to practice under the direction of a dentist licensed in Virginia, and (iii) list the documentation a dentist providing direction to digital scan technician is responsible to make available to the board.

18VAC60-21-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2700 of the Code of Virginia:

"Appliance"

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"Digital scan"

"Digital scan technician"

"Digital work order"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

"Teledentistry"

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

"AAOMS" means the American Association of Oral and Maxillofacial Surgeons.

"ADA" means the American Dental Association.

"Advertising" means a representation or other notice given to the public or members thereof, directly or indirectly, by a dentist on behalf of himself, his facility, his partner or associate, or any dentist affiliated with the dentist or his facility by any means or method for the purpose of inducing purchase, sale, or use of dental methods, services, treatments, operations, procedures, or products, or to promote continued or increased use of such dental methods, treatments, operations, procedures, or products.

"CODA" means the Commission on Dental Accreditation of the American Dental Association.

"Code" means the Code of Virginia.

"Dental assistant I" means 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 chapter but shall not include an individual serving in purely an administrative, secretarial, or clerical capacity.

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered by the board to perform reversible, intraoral procedures as specified in 18VAC60-21-150 and 18VAC60-21-160.

"Mobile dental facility" means a self-contained unit in which dentistry is practiced that is not confined to a single building and can be transported from one location to another.

"Nonsurgical laser" means a laser that is not capable of cutting or removing hard tissue, soft tissue, or tooth structure.

"Portable dental operation" means a nonfacility in which dental equipment used in the practice of dentistry is transported to and utilized on a temporary basis at an out-of-office location, including patients' homes, schools, nursing homes, or other institutions.

"Radiographs" means intraoral and extraoral radiographic images of hard and soft tissues used for purposes of diagnosis.

C. The following words and terms relating to supervision as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Direct supervision" means that the dentist examines the patient and records diagnostic findings prior to delegating restorative or prosthetic treatment and related services to a dental assistant II for completion the same day or at a later date. The dentist prepares the tooth or teeth to be restored and remains immediately available in the office to the dental assistant II for guidance or assistance during the delivery of treatment and related services. The dentist examines the patient to evaluate the treatment and services before the patient is dismissed.

"Direction" means the level of supervision (i.e., immediate, direct, indirect, ~~or~~ general, or remote) that a dentist is required to exercise with a dental hygienist, a dental assistant I, a dental assistant II, or a certified registered nurse anesthetist or the level of supervision that a dental hygienist is required to exercise with a dental assistant to direct and oversee the delivery of treatment and related services. For the purpose of supervision of a digital scan technician, direction means the written or electronic instructions provided by a dentist licensed in Virginia to a digital scan technician in the form of a work order for a digital scan of a patient and the dentist's specified availability to consult with the technician while the scan is being taken.

"General supervision" means that a dentist completes a periodic comprehensive examination of the patient and issues a written order for hygiene treatment that states the specific services to be provided by a dental hygienist during one or more subsequent appointments when the dentist may or may not be present. Issuance of the order authorizes the dental hygienist to supervise a dental assistant performing duties delegable to dental assistants I.

"Immediate supervision" means the dentist is in the operatory to supervise the administration of sedation or provision of treatment.

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist , a dental assistant, or a certified registered nurse anesthetist who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, (iii) preparing the patient for dismissal following treatment, or (iv) administering topical local anesthetic, sedation, or anesthesia as authorized by law or regulation.

"Remote supervision" means that a supervising dentist is accessible and available for communication and consultation with a dental hygienist during the delivery of dental hygiene services but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided. For the purpose of practice by a public health dental hygienist, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided. For the purpose of supervision of a digital scan technician, remote supervision means that a directing dentist is accessible and available for communication and consultation in the practice of teledentistry.

D. The following words and terms relating to sedation or anesthesia as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Analgesia" means the diminution or elimination of pain.

"Continual" or "continually" means repeated regularly and frequently in a steady succession.

"Continuous" or "continuously" means prolonged without any interruption at any time.

"Deep sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

"General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"Inhalation" means a technique of administration in which a gaseous or volatile agent, including nitrous oxide, is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensation of pain with minimal alteration of consciousness.

"Local anesthesia" means the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected. Minimal sedation includes the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness and includes "inhalation analgesia" when used in combination with any such sedating agent administered prior to or during a procedure.

"Moderate sedation" means a drug-induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful

stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

"Monitoring" means to observe, interpret, assess, and record appropriate physiologic functions of the body during sedative procedures and general anesthesia appropriate to the level of sedation as provided in Part VII (18VAC60-21-260 et seq.) of this chapter.

"Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal tract (i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular).

"Provide" means, in the context of regulations for moderate sedation or deep sedation/general anesthesia, to supply, give, or issue sedating medications. A dentist who does not hold the applicable permit cannot be the provider of moderate sedation or deep sedation/general anesthesia.

"Titration" means the incremental increase in drug dosage to a level that provides the optimal therapeutic effect of sedation.

"Topical oral anesthetic" means any drug, available in creams, ointments, aerosols, sprays, lotions, or jellies, that can be used orally for the purpose of rendering the oral cavity insensitive to pain without affecting consciousness.

18VAC60-21-60. General responsibilities to patients.

A. A dentist is responsible for conducting his practice in a manner that safeguards the safety, health, and welfare of his patients and the public by:

1. Maintaining a safe and sanitary practice, including containing or isolating pets away from the treatment areas of the dental practice. An exception shall be made for a service dog trained to accompany its owner or handler for the purpose of carrying items, retrieving objects, pulling a wheelchair, alerting the owner or handler to medical conditions, or other such activities of service or support necessary to mitigate a disability.

2. Consulting with or referring patients to other practitioners with specialized knowledge, skills, and experience when needed to safeguard and advance the health of the patient.

3. Treating according to the patient's desires only to the extent that such treatment is within the bounds of accepted treatment and only after the patient has been given a treatment recommendation and an explanation of the acceptable alternatives.

4. Only delegating patient care and exposure of dental x-rays or taking of digital scans to qualified, properly trained, and supervised personnel as authorized in Part IV (18VAC60-21-110 et seq.) of this chapter.

5. Giving patients at least 30 days written notice of a decision to terminate the dentist-patient relationship.

6. Knowing the signs of abuse and neglect and reporting suspected cases to the proper authorities consistent with state law.

7. Accurately representing to a patient and the public the materials or methods and techniques to be used in treatment.

B. A dentist is responsible for conducting his financial responsibilities to patients and third party payers in an ethical and honest manner by:

1. Maintaining a listing of customary fees and representing all fees being charged clearly and accurately.

2. Making a full and fair disclosure to ~~his~~ the dentist's patient of all terms and considerations before entering into a payment agreement for services.

3. Not obtaining, attempting to obtain, or cooperating with others in obtaining payment for services by misrepresenting procedures performed, dates of service, or status of treatment.

4. Making a full and fair disclosure to ~~his~~ the dentist's patient of any financial incentives ~~he~~ the dentist received for promoting or selling products.

5. Not exploiting the dentist-patient relationship for personal gain related in nondental transactions.

18VAC60-21-165. Delegation to digital scan technicians for use in teledentistry.

A. Any digital scan technician taking intraoral digital scans for any appliance, prothesis, crown, or any other permanent or removable dental device for which a digital work order is required must complete a training program approved by the board. Training certification may be earned by verifiable participation in any course that is relevant to digital scanning that includes programs by any of the following sponsors:

1. Any sponsor listed in subsection C of 18VAC60-21-250; or

2. A training program certified by the manufacturer of the digital scanner.

B. The dentist under whom a digital scan technician is directed to take digital scans shall establish written or electronic protocols for:

1. The practice of teledentistry in compliance with subsection C of § 54.1-2711 of the Code of Virginia and any other provisions required by the board; and

2. The performance of digital scans by digital scan technicians in compliance with subsection B of § 54.1-2708.5 of the Code of Virginia.

C. The dentist under whom a digital scan technician is directed to take digital scans shall be:

1. Licensed by the board to practice dentistry in the Commonwealth;

2. Accessible and available for communication and consultation with the digital scan technician at all times during the patient interaction;

3. Responsible for ensuring that the digital scan technician has a program of training approved by the board for such purpose; and

4. Ultimately responsible for determining with the patient or the patient's representative the specific treatment the patient will receive, which aspects of treatment will be delegated to qualified personnel, and the direction required for such treatment, in accordance with this chapter and the Code of Virginia.

D. The directing dentist shall make available to the board any requested:

1. Protocols and procedures;

2. Evidence that a digital scan technician has complied with the training requirements of the board; and

3. All written or electronic work orders used for digital scans.

VA.R. Doc. No. R21-6525; Filed December 30, 2021, 2:22 p.m.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Final Regulation

Title of Regulation: **18VAC65-40. Regulations for the Funeral Service Internship Program (amending 18VAC65-40-90, 18VAC65-40-110, 18VAC65-40-130, 18VAC65-40-220, 18VAC65-40-250, 18VAC65-40-280, 18VAC65-40-320, 18VAC65-40-340, 18VAC65-40-640).**

Statutory Authority: §§ 54.1-2400 and 54.1-2817 of the Code of Virginia.

Effective Date: March 3, 2022.

Agency Contact: Corie Tillman-Wolf, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4424, FAX (804) 527-4637, or email corie.wolf@dhp.virginia.gov.

Summary:

The amendments (i) reduce the number of hours required for an internship to 2,000; (ii) require supervisors to register for supervision of each intern with an expiration for the registration of 48 months or at the completion of the intern's training, whichever occurs first, in order to allow the board to track active supervisors and make sure supervisors are in good standing; (iii) require that interns be identified to the public as interns in titles, correspondence, and communications with the public; (iv) clarify that a notice of renewal may be transmitted electronically, consistent with legislation that became effective on July 1, 2018; (v) specify that supervision must be provided under a funeral service licensee with an unrestricted license and restrict approval of supervisors with previous board action within the previous two years; (vi) remove language related to deduction of credit hours for late intern reports; (vii) clarify that an intern may not receive credit for training if the intern fails to submit a training report, rather than forfeiting partial credit for training; and (viii) clarify that disciplinary action may be imposed for failure to comply with the statutes or regulations of the Board of Funeral Directors and Embalmers.

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

18VAC65-40-90. Renewal of registration.

A. The funeral service intern registration shall expire on March 31 of each calendar year and may be renewed by submission of the renewal notice and prescribed fee.

B. A person who fails to renew a registration by the expiration date shall be deemed to have an invalid registration. No credit will be allowed for an internship period served under an expired registration.

C. The funeral service intern is responsible for notifying the board within 14 days of any changes in name, address, employment, or supervisor. Any notices shall be validly given when mailed to the address on record with the board. Renewal notices may be mailed or sent electronically.

18VAC65-40-110. ~~Reinstatement~~ Renewal or reinstatement of expired registration.

A. A funeral service intern whose registration has expired may be ~~reinstated~~ renewed within one year following expiration by payment of the current renewal fee and the late renewal fee.

B. A funeral service intern whose registration has been expired for more than one year shall apply for reinstatement by submission of an application and payment of a reinstatement fee. The board may consider reinstatement of an expired registration for up to three years following expiration.

C. When a registration is not reinstated within three years of its expiration date, a new application for registration shall be filed and a new internship begun.

18VAC65-40-130. Funeral service internship.

A. The internship shall consist of at least ~~3,000~~ 2,000 hours of training to be completed within no less than 12 months and no more than 48 months. ~~For good cause shown, the~~ The board

may grant an extension of time for completion of an internship only for extenuating circumstances.

B. The funeral service intern shall be assigned a work schedule of not less than 20 hours nor more than 60 hours per week in order to receive credit for such training. For good cause shown, the board may waive the limitation on an intern's work schedule.

C. A funeral service intern shall receive training in all areas of funeral service.

D. A funeral service intern shall be identified to the public as a funeral service intern in a title used, name tag worn, and any correspondence or communication in which the intern's name is used.

18VAC65-40-220. Qualifications of training site.

A. The board shall approve only an establishment or two combined establishments to serve as the training site or sites that:

1. Have a full and unrestricted Virginia license;

2. Have complied in all respects with the provisions of the regulations of the Board of Funeral Directors and Embalmers; and

3. Have 50 or more funerals and 50 or more bodies for embalming over a 12-month period for each person to be trained. This total must be maintained throughout the period of training. If the establishment does not meet the required number of funerals or embalmings, the funeral service intern may seek approval for an additional training site.

B. The board may grant approval for ~~a resident trainee~~ an intern to receive all or a portion of the embalming training at a facility of state or federal government or an accredited educational institution.

18VAC65-40-250. Requirements for supervision.

A. Training shall be conducted under the direct supervision of a licensee ~~or licensees~~ approved by the board. Credit shall only be allowed for training under direct supervision.

B. The board shall approve only funeral service licensees, licensed funeral directors, or licensed embalmers to give funeral training who have a full and unrestricted Virginia funeral license, have at least two consecutive years in practice as a funeral service licensee, funeral director, or embalmer and are employed full time in or under contract with the establishment, facility, or institution where training occurs. The board will not approve registration of a supervisor who has been subject to board disciplinary action within the most recent two years.

C. A supervisor licensed as an embalmer or a funeral director shall provide supervision only in the areas of funeral practice for which he is licensed. A supervisor shall ensure that [~~a funeral service~~ an] intern receives training under the direct supervision of a licensee who has a current license in good standing.

D. A supervisor shall register with the board for each [~~funeral service~~] intern for whom the supervisor is providing supervision. Such registration shall expire 48 months after registration or at the completion of the intern's training, whichever occurs first. If the intern has been granted an extension beyond 48 months for extenuating circumstances, the supervisor may continue to provide supervision for a time period specified by the board.

~~D.~~ E. Failure to register as a supervisor may subject the licensee to disciplinary action by the board.

~~E.~~ F. If a supervisor is unable or unwilling to continue providing supervision, the funeral service intern shall obtain a new supervisor. Credit for training shall resume when a new supervisor is approved by the board and the intern has paid the prescribed fee for the change of supervisor.

G. No more than two [~~funeral service~~ interns] shall be concurrently registered under any one person licensed for the practice of funeral service, funeral directing, or embalming.

18VAC65-40-280. Supervisor application package.

A. A licensee seeking approval by the board as ~~a~~ supervisor of an intern shall submit a completed application and any additional documentation as may be required to determine eligibility for each intern to be supervised.

B. The application for supervision of a funeral service intern shall be signed by the establishment manager and by the persons who will be providing supervision for embalming and for the funeral services.

18VAC65-40-320. Reports to the board.

A. The intern, the supervisor ~~or supervisors~~, and the establishment shall submit a written report to the board at the end of every 1,000 hours of training. The report shall:

1. Specify the period of time in which the 1,000 hours has been completed and verify that the intern has actually served in the required capacity during the preceding period; and

2. Be received in the board office no later than 14 days following the end of the completion of 1,000 hours. ~~Late reports may result in additional time being added to the internship.~~

B. If the internship is terminated or interrupted prior to completion of 1,000 hours or if the intern is changing supervisors or training sites, the intern and the supervisor shall submit a partial report to the board with a written explanation of the cause of program termination or interruption or of the change in training or supervision.

1. The partial report shall provide the amount of time served and the dates since the last reporting period. Credit for partial

reports shall be given for the number of hours of training completed.

2. Partial reports shall be received in the board office no later than 14 days after the interruption or termination of the internship or after the change in supervisors or training sites. ~~Credit may be deducted for late reports.~~

18VAC65-40-340. Supervisors' responsibilities.

A. The supervisor shall provide the intern with all applicable laws and regulations or sections of regulations relating to the funeral industry.

B. The supervisor shall provide the intern with copies of and instruction in the use of all forms and price lists employed by the funeral establishment.

C. The supervisor shall provide the intern with instruction in all aspects of funeral services and shall allow the intern under direct supervision to ~~conduct all necessary arrangements for~~ assist in conducting a minimum of 25 funerals.

D. The embalming supervisor shall provide instruction on all necessary precautions, embalming functions, and reporting forms and shall allow the intern under direct supervision to ~~perform~~ assist in the performance of a minimum of 25 embalmings.

E. The supervisor shall provide the intern with instruction in making preneed funeral arrangements and instruction on the laws and regulations pertaining to preneed funeral contracts and disclosures.

F. The supervisor shall provide instruction on cremation and on the laws and regulations pertaining to cremation.

G. If a training site does not offer preneed funeral planning or cremation services, the supervisor shall arrange for such training at another licensed funeral establishment that does.

18VAC65-40-640. Disciplinary action.

The board may refuse to issue or renew a license, registration, or approval to any applicant; and may suspend for a stated period of time or indefinitely, or revoke any license, registration, or approval, or reprimand any person, or place his license or registration on probation with such terms and conditions and for such time as it may designate or impose a monetary penalty for failure to comply with the laws [~~or~~ and] regulations of the Board of Funeral Directors and Embalmers.

VA.R. Doc. No. R19-6053; Filed December 29, 2021, 2:53 p.m.

BOARD FOR HEARING AID SPECIALISTS AND OPTICIANS

Proposed Regulation

Title of Regulation: **18VAC80-20. Hearing Aid Specialists Regulations (amending 18VAC80-20-70).**

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

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: April 1, 2022.

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, FAX (866) 245-9693, or email hearingaidspec@dpor.virginia.gov.

Basis: Section 54.1-113 of the Code of Virginia requires regulatory boards to periodically review and adjust fees. Section 54.1-201.4 of the Code of Virginia provides the authority to regulatory boards to levy and collect fees. Section 54.1-304.3 of the Code of Virginia describes the authority of the Department of Professional and Occupational Regulation (DPOR) to collect and account for fees. Section 54.1-308 of the Code of Virginia requires costs to be paid by regulatory boards.

Purpose: The Board for Hearing Aid Specialists and Opticians must establish fees adequate to support the costs of board operations and a proportionate share of the department's operations. Current fees do not provide adequate revenue for those costs. DPOR is funded entirely from revenue collected for license applications, renewal, examination fees, and other licensing fees and receives no general fund money. DPOR is self-supporting and must collect adequate revenue to support its mandated and approved activities and operations. Fee revenue collected on behalf of the various boards funds the department's authorized special revenue appropriation. The board's primary mission is to protect the citizens of the Commonwealth by prescribing requirements for minimal competencies, by prescribing standards of conduct and practice, and by imposing penalties for not complying with the regulations.

Substance: The board reviewed the fees and based on projected revenues and expenses developed a fee schedule that meets the requirements of the applicable statutes while being the least burdensome to the regulant population. The following is the expected range of the proposed fee increases to be made in this regulatory action.

Range of Fees:

Fee Type		Current Fee	New Fees
New Applicant	Hearing Aid Specialist	$30	$125
New Applicant Temporary Permit	Hearing Aid Specialist	$30	$125
Renewal	Hearing Aid Specialist	$20	$125
Reinstatement	Hearing Aid Specialist	$20	$125

Issues: The advantages of this change to the public is that the board will continue to be financially solvent. The advantage for the agency is that the proposed fee adjustments will ensure that the board has sufficient revenues to fund its operating expenses, allowing the department to comply with § 54.1-113 of the Code of Virginia. There are no disadvantages to the public or the Commonwealth in raising the board's fees as proposed here.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board for Hearing Aid Specialists and Opticians (Board) proposes to increase the hearing aid specialist fees it levies for initial licensure, renewal, reinstatement, and temporary permits. All fees would be increased from their current levels (which range from $20 to $50) to $125. The Board proposes to increase its fees based on a current cash deficit, which is projected to keep growing unless fees are increased.

Background. The Department of Professional and Occupational Regulation (DPOR) is funded entirely from revenue collected by the regulatory boards it supports for license applications, renewal, examination fees, and other licensing fees. Hence, DPOR must collect adequate revenue to support its mandated activities and operations. Fee revenue collected on behalf of the various Boards funds the Department's authorized special revenue appropriation. The Board determines the fees it collects based on the adequacy of the fees to provide sufficient revenue for upcoming operating cycles; it has no other source of income.

Section 54.1-201 of the Code of Virginia requires that the boards within DPOR "levy and collect fees for certification or licensure and renewal that are sufficient to cover all expenses for the administration and operation of the regulatory board and a proportionate share of the expenses' of DPOR.[1] In addition, the Callahan Act (§ 54.1-113) requires that regulatory boards adjust their fees whenever the account shows that "expenses allocated to it for the past biennium to be more than 10% greater or less than moneys collected on behalf of the board" so that "the fees are sufficient but not excessive."[2]

The board has been working to increase fees since 2014. The board's fees were last adjusted effective February 1, 2017, (FY 2017) through a regulatory action that was submitted for amendment in FY 2014.[3] However, this action did not increase the license fees, but rather removed certain fees from the regulation and replaced them with language requiring the fees to be set in accordance with the Code of Virginia §2.2-4300 (Virginia Procurement Act) and § 54.1- 201.4. Subsequently, DPOR was subject to a review by the Joint Legislative Audit and Review Commission (JLARC) in 2018. In its report, JLARC stated "DPOR should revise the fee change using more realistic expense projections." If, however, DPOR determines that the fee change is not needed in the near term, the fee change could be withdrawn."[4]

Specifically, the Board proposes the following fee increases:

Application Fee from $30 to $125 (317% increase)

Temporary Permit Fee from $30 to $125 (317% increase)

Renewal from $20 to $125 (525% increase)

Reinstatement from $50 to $125 (150% increase).

The other profession within the Board is Opticians, and the application and renewal fees for that profession are currently $100. With the effective date for new fees anticipated to be in FY2021, it will have been 18 years since fees for hearing aid specialists have been raised. This has allowed the Board to spend down an accumulated cash balance that it has retained. The Board reports that regulants have thus been anticipating a fee increase.[5] Further, the license fee and temporary permit fee appear to have been $130 in December 2002, along with a renewal fee of $175 and a reinstatement fee of $350. Hence, although the increase seems sharp on a percentage basis, the amount is comparable the fees that prevailed before the Board lowered them to decrease its cash balances.[6]

The Board reported its Callahan Act percentage (i.e., the ratio of cash balances to expenditures at the end of a biennium) to be -0.29% for the biennium ending in 2020. Unless a fee increase is implemented in the interim, the Board projects that the Callahan Act percentage would fall as low as -14.6% at the end of the 2020-2022 biennium, and -29.7% at the end of the 2022-2024 biennium.[7] Based upon these projections, it appears that the longer the Board postpones the fee increase, the higher the fee would have to be in order to close the deficit.

Estimated Benefits and Costs. The proposed fee increases would increase costs to currently licensed hearing aid specialists, and to temporary hearing aid specialist permit holders, who apply to renew their license once the increase became effective. The proposed fee increases would also affect future first-time applicants for licenses or permits, as well as those seeking to reinstate their license or permit after the fee increase became effective.

The Board estimates that biennial revenue would increase by approximately $100,600 once the fee increases go into effect.[8] Thus, the proposed fee increases would benefit the Board by eliminating the current funding deficit as well as ensuring that it has adequate revenue to pay for ongoing operational expenses. Lastly, since the Board has been trying to increase the fees since 2014, regulants have had time to anticipate and prepare for future fee increases.

DPOR considered three alternatives to the fee increases and found them to be non-viable and potentially more costly. First, a reduction in services would result in delays in issuing licenses, which would impose costs to regulants by creating barriers to their ability to work, broadly decrease the effectiveness of the Board in protecting public health, safety and welfare, and potentially decrease its revenues. Second, DPOR could obtain a Treasury loan; however, this would be a short-term solution that would require higher fee increases in the future to repay the loan. Finally, supplementing Board revenue with general funds would shift the Board's costs to

taxpayers at large, instead of regulants who more directly benefit from the activities of the Board. It would also impose significant delays and administrative costs since allocating general fund moneys to DPOR would require a change in the Code of Virginia and the Appropriations Act. Thus, although the proposed amendments increase costs to regulants, they impose a lower cost overall relative to these alternatives.

Businesses and Other Entities Affected. The Board had 814 licensed hearing aid specialists and 48 temporary hearing aid specialist permit holders as of October 1, 2020.[9] The Board estimates that there are approximately 73 first-time hearing aid specialist applicants and 53 temporary permit holder applicants annually.

Small Businesses[10] Affected. According to the Bureau of Labor Statistics, hearing aid specialists nationwide are most often employed by health and personal care stores, offices of other health practitioners, other ambulatory health care services, offices of physicians, and in general medical and surgical hospitals.[11] Thus, the proposed amendments could affect such establishments either (i) if they are businesses that are independently owned and operated by hearing aid specialists, or (ii) if they are small businesses that hire hearing aid specialists and cover the cost of maintaining their license. However, the number of such small businesses in Virginia is unknown.

Localities[12] Affected.[13] The proposed amendments would not likely disproportionately affect any particular localities, nor introduce costs for local governments.

Projected Impact on Employment. The proposed amendments could discourage some individuals pursuing licensure as hearing aid specialists due to the higher license fees, to the extent that they perceive the increase in fees to be greater than the benefits of employment in this profession. However, it is unlikely to affect the overall employment of licensed hearing aid specialists since employers would not be directly affected by the increase in license fees.

Effects on the Use and Value of Private Property. The proposed amendments moderately increase costs for hearing aid specialists. To the extent that businesses that employ hearing aid specialists pay for these fees, the proposal could decrease the value of such firms by the amount of the fees or any ancillary costs. Real estate development costs would not be affected.

[1]See https://law.lis.virginia.gov/vacode/title54.1/chapter2/section54.1-201/

[2]See https://law.lis.virginia.gov/vacode/title54.1/chapter1/section54.1-113/.

[3]See https://townhall.virginia.gov/L/ViewStage.cfm?stageid=7560.

[4]See http://jlarc.virginia.gov/pdfs/reports/Rpt509.pdf.

[5]See page 3 of https://townhall.virginia.gov/l/GetFile.cfm?File=13\5274\9051\AgencyStatement_DPOR_9051_v1.pdf.

[6]See https://townhall.virginia.gov/l/GetFile.cfm?File=13\808\2177\Text_DPOR_2177_v2.pdf. Although the action did not affect fees, the final text shows the fees that were prevalent at the time. The fees were lowered through a separate exempt action: https://townhall.virginia.gov/l/ViewStage.cfm?stageid=2407.

[7]See Addendum 4 of the August 12, 2020 Board meeting minutes: https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\13\29204\Minutes_DPOR_29204_v1.pdf.

[8]See page 6 of the ABD: https://townhall.virginia.gov/l/GetFile.cfm?File=13\5274\9051\AgencyStatement_DPOR_9051_v1.pdf.

[9]See http://www.dpor.virginia.gov/uploadedFiles/MainSite/Content/Records_and_Documents/REG_POP(1).pdf.

[10]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."

[11]See https://www.bls.gov/oes/current/oes292092.htm.

[12]"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.

[13]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

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

Summary:

The proposed amendments adjust the board's licensing fee structure to comply with § 54.1-113 of the Code of Virginia.

18VAC80-20-70. Fees.

A. All fees are nonrefundable and shall not be prorated. The date of receipt by the board or its agent is the date which will be used to determine whether or not it is on time.

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

C. In the event that a check, money draft, or similar instrument for payment of a fee required by statute or regulation is not honored by the bank or financial institution named, the applicant or regulant shall be required to remit fees sufficient to cover the original fee, plus the additional processing charge established by the department.

The following fees apply:

Application Fee	~~$30~~ $125	To be paid by all applicants for initial licensure
Temporary Permit Fee	~~$30~~ $125	
Renewal	~~$20~~ $125	
Reinstatement	~~$50~~ $125	

D. The written examination fee shall be established in compliance with the Virginia Public Procurement Act (§ 2.2-

4300 et seq. of the Code of Virginia). The practical examination fee shall be established by the department that is sufficient to cover expenses for the administration of the examination in compliance with subdivision A 4 of § 54.1-201 of the Code of Virginia.

VA.R. Doc. No. R20-5959; Filed December 29, 2021, 2:28 p.m.

BOARD OF MEDICINE

Fast-Track Regulation

Title of Regulation: **18VAC85-110. Regulations Governing the Practice of Licensed Acupuncturists (amending 18VAC85-110-10, 18VAC85-110-50, 18VAC85-110-60, 18VAC85-110-80).**

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

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: March 2, 2022.

Effective Date: March 18, 2022.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4558, 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.

Purpose: The regulatory change is necessary to maintain currency with national educational standards for the health and safety of patients who will be seeking treatment from licensed acupuncturists.

Rationale for Using Fast-Track Rulemaking Process: The impetus for this regulatory change was a recommendation from the Advisory Board on Acupuncture, which voted at its meeting on October 6, 2021, to request the amendments. The name changes are noncontroversial.

Substance: The definition for the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) is changed to the Accreditation Commission for Acupuncture and Herbal Medicine (ACAHM). The definition for the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) is changed to the Council of Colleges of Acupuncture and Herbal Medicine (CCAHM). All sections of this chapter where those acronyms are used are amended accordingly.

Issues: There is an advantage to the public if someone is looking for the updated names of accrediting bodies in Virginia regulation. There are no disadvantages. There are no advantages or disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1] Summary of the Proposed Amendments to Regulation

The Board of Medicine (Board) proposes to update the names of two organizations within 18VAC85-110 Regulations Governing the Practice of Licensed Acupuncturists (regulation).

Background. The regulation contains education requirements that must be satisfied in order to obtain acupuncture licensure in the Commonwealth. One of the requirements in the current regulation is that the candidate complete the Clean Needle Technique course as administered by the Council of Colleges of Acupuncture and Oriental Medicine. Another is that the candidate graduate from a school or college for acupuncture accredited by the Accreditation Commission for Acupuncture and Oriental Medicine or any other accrediting agency approved by the Board.

The organization formerly called the Council of Colleges of Acupuncture and Oriental Medicine has changed its name to the Council of Colleges of Acupuncture and Herbal Medicine. The organization formerly called the Accreditation Commission for Acupuncture and Oriental Medicine has changed its name to the Accreditation Commission for Acupuncture and Herbal Medicine. The Board proposes to substitute the former names of the two organizations with their new names wherever they appear in the regulation.

Estimated Benefits and Costs. The proposed amendments would have no impact on requirements in practice, but may be beneficial in that individuals seeking the names of the relevant organizations would be better informed.

Businesses and Other Entities Affected. The proposed amendments potentially affect applicants for acupuncture licensure. The Department of Health Professions reports that there are approximately 50 to 55 new licenses issued each year.

The Code of Virginia requires the Department of Planning and Budget to assess whether an adverse impact may result from the proposed regulation.[2] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. No adverse impact is indicated for this proposal.

Small Businesses[3] Affected.[4] The proposed amendments do not adversely affect small businesses.

Localities[5] Affected.[6] The proposed amendments neither disproportionately affect any particular locality, nor introduce costs for local governments.

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 amendments do not appear to substantively affect the use and value of private property. The proposed amendments do not affect real estate development costs.

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[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[3]Pursuant to § 2.2-4007.04, 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."

[4]If the proposed regulatory action may have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to Code § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[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.

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

Summary:

The amendments update the names and acronyms for accrediting organizations for acupuncturists.

18VAC85-110-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia.

Acupuncturist

Board

Licensed acupuncturist

Practice of acupuncture

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

~~"ACAOM"~~ "ACAHM" means the Accreditation Commission for Acupuncture and ~~Oriental~~ Herbal Medicine. ~~ACAOM replaces the National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine.~~

~~"CCAOM"~~ "CCAHM" means the Council of Colleges of Acupuncture and ~~Oriental~~ Herbal Medicine.

"CNT course" means a Clean Needle Technique Course as administered by the ~~CCAOM~~ CCAHM.

"NCCAOM" means the National Certification Commission for Acupuncture and Oriental Medicine.

18VAC85-110-50. Educational requirements: graduates of approved institutions or programs in the United States.

A. Requirements for acupuncture education obtained prior to July 1, 1990, shall be as provided in this subsection.

1. An applicant applying for licensure to practice as an acupuncturist on the basis of successful completion of education in a school or college of acupuncture accredited by the ~~ACAOM~~ ACAHM or other accrediting agencies approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of successful completion of an acupuncture course of study in an accredited school or college for acupuncture, providing evidence of not less than 1,000 hours of schooling in not less than a continuous 18-month period.

2. The studies shall include not less than 700 didactic hours and not less than 250 clinical hours. Additional hours may be in either didactic or clinical hours based upon the school or college curriculum.

B. Requirements for acupuncture education obtained after July 1, 1990, shall be as provided in this subsection.

An applicant applying for licensure to practice as a licensed acupuncturist on the basis of successful completion of education in a school or college for acupuncture accredited by ~~ACAOM~~ ACAHM or any other accrediting agency approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of having a minimum of three academic years in length equivalent to 90 semester credit hours or 135 quarter credit hours.

One academic year means full-time study completed in four quarters, two semesters, or three trimesters. A full-time continuous study program shall be a concentrated educational process in acupuncture that requires individual study with assigned materials in a classroom or clinical setting.

C. Requirements for acupuncture education obtained after July 1, 1999, shall be as provided in this subsection. An

applicant applying for licensure to practice as a licensed acupuncturist on the basis of successful completion of education in a school or college for acupuncture accredited by ~~ACAOM~~ ACAHM or any other accrediting agency approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of having a minimum of 1,725 hours of entry-level acupuncture education to include at least 1,000 didactic hours and 500 clinical hours. Clinical hours may include observation, as well as internship or treatment hours; the remaining 225 hours may be earned as either didactic or clinical. Correspondence programs or courses in acupuncture are excluded and may not be used to meet the requirements for acupuncture education.

D. Requirements for acupuncture education obtained after February 1, 2011, shall be as provided in this subsection. An applicant applying for licensure to practice as a licensed acupuncturist on the basis of successful completion of education in a school or college for acupuncture accredited by ~~ACAOM~~ ACAHM or any other accrediting agency approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of having a minimum of 1,905 hours of entry-level acupuncture education to include at least 1,155 didactic hours and 660 clinical hours. Clinical hours may include observation, as well as internship or treatment hours; the remaining 90 hours may be earned as either didactic or clinical hours. Correspondence programs or courses in acupuncture are excluded and may not be used to meet the requirements for acupuncture education.

E. An applicant from an acupuncture program in a school or college that has achieved candidacy status for accreditation by ~~ACAOM~~ ACAHM shall be eligible for licensure provided the program meets the applicable requirements of subsection A, B, C, or D of this section, with the exception of full ~~ACAOM~~ ACAHM accreditation.

18VAC85-110-60. Requirements of foreign graduates of nonaccredited educational programs in acupuncture.

A. An applicant who has completed an educational course of study in a school or college outside the United States or Canada that is not accredited by ~~ACAOM~~ ACAHM or any other board-approved accrediting agency shall:

1. Submit a transcript from his educational course of study in acupuncture to a credential evaluation service approved by the board to determine equivalency in education and training to that required in 18VAC85-110-50.

2. Meet the examination requirements as prescribed in 18VAC85-110-80 and 18VAC85-110-90.

B. All documents submitted to the board which are not in English must be translated into English and certified by the embassy of the issuing government or by a translating service.

18VAC85-110-80. Examination requirements for licensure.

The examination requirements for licensure shall consist of:

1. Passing the NCCAOM comprehensive written examination, resulting in current, active certification by the NCCAOM at the time the application is filed with the board;

2. Passing the Point Location Examination; and

3. Completing the CNT course as administered by the ~~CCAOM~~ CCAHM.

VA.R. Doc. No. R22-6955; Filed December 29, 2021, 2:53 p.m.

Proposed Regulation

Title of Regulation: **18VAC85-160. Regulations Governing the Licensure of Surgical Assistants and Certification of Surgical Technologists (amending 18VAC85-160-40, 18VAC85-160-60; adding 18VAC85-160-65 through 18VAC85-160-130).**

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

Public Hearing Information:

February 7, 2022 - noon - Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Training Room 2, Richmond, VA 23233-1463

Public Comment Deadline: April 1, 2022.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4558, 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. Regulations on surgical assistants and surgical technologists are promulgated in accordance with § 54.1-2956.12 of the Code of Virginia.

Purpose: Currently, the regulation for surgical assistants and surgical technologists does not provide standards of practice relating to confidentiality and responsibilities of practitioners to their patients. Amendments are necessary to ensure there are standards for confidentiality, patient records, dual relationships, and informed consent to protect public health and safety. Additionally, there are currently no requirements for maintaining competency or continuing education for surgical assistants or surgical technologists. To protect patients who receive services during surgical procedures, it is essential for these practitioners to stay abreast of new techniques and information.

Substance: In 2020, the level of regulation for surgical assistants was elevated by action of the General Assembly from voluntary registration to licensure. Amendments to regulation were adopted under an exemption to conform to statute, and a NOIRA was also published to announce the intent to adopt additional amendments to make regulations

consistent with other licensed professions under the Board of Medicine.

The proposed amendments will (i) add definitions as necessary; (ii) conform fees for licensure to other professions under the board; (iii) add requirements for continuing competency for surgical assistants licensed under a grandfathering provision; (iv) provide for an inactive license and for reactivation or reinstatement of a license; (v) provide for a restricted volunteer license or voluntary practice by out-of-state practitioners; and (vi) provide for renewal of certification of surgical technologists, including requirements for continuing education. Finally, the board will adopt standards of practice similar to those for other licensed professions under its jurisdiction and will also consider the code of ethics specific to surgical assistants.

Issues: The primary advantages to the public are the addition of continuing education requirements for all surgical assistants and surgical technologists to ensure competency for continuation in practice and the standards of conduct by which licensees or certificate holders could be held accountable for unprofessional acts. There are no disadvantages.

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. In response to recent legislation, this action changes the means by which surgical assistants and surgical technologists are regulated. This action expands upon changes already made by the Board of Medicine (Board) in two exempt actions that are already in effect.

Chapter 1222 of the 2020 Acts of Assembly[1] changed the regulation of surgical assistants[2] from registration to licensure. In an exempt action,[3] the Board amended the Regulations Governing the Licensure of Surgical Assistants and Registration of Surgical Technologists (regulation) to conform to the 2020 legislation. In the current action, the Board proposes to: 1) raise the initial, renewal, and late renewal licensure fees for surgical assistants, 2) establish an inactive license with an accompanying fee and rules on reactivation, 3) establish reinstatement with an accompanying fee for when the license has been lapsed for two years or more, 4) establish reinstatement with an accompanying fee for when the license was revoked, 5) establish a fee for a letter of good standing or verification to another jurisdiction, and 6) require all licensees complete 38 hours of continuing education (CE) for license renewal.

Chapter 230 of the 2021 Special Session 1 Acts of Assembly[4] changed the regulation of surgical technologists[5] from registration to certification. In another exempt action,[6] the Board amended the regulation to conform to the 2021 legislation. In the current action, the Board proposes to require all certificate holders to complete 30 hours of CE every two years for certification renewal. The proposed 18VAC85-160-40 Fees section includes fees for inactive certification and also for reinstatement of certification that has been lapsed for two years or more. However, unlike the changes proposed for surgical assistant licensure, the proposed regulation does not include text on the process for obtaining inactive certification and any associated rules, how to reactivate certification, or how to reinstate certification.

Additionally, pertaining to both surgical assistants and surgical technologists, the Board proposes to add six new sections to the regulation, all of which contain text that is essentially identical to text in the Board's other regulations for other health care professionals. The proposed six new sections are: 18VAC85-160-80 Confidentiality, 18VAC85-160-90 Patient records, 18VAC85-160-100 Communication with patients; termination of relationship, 18VAC85-160-110 Practitioner responsibility, 18VAC85-160-120 Sexual contact, and 18VAC85-160-130 Refusal to provide information.

Background.

Fees, The table below compares current surgical assistant licensure fees with the proposed fees:

	Current	Proposed
Initial licensure	$75	$130
Renewal	$70	$135
Additional fee to process a late renewal application within one renewal cycle	$25	$50

The Board does not propose to change the initial certification, certification renewal, and the late renewal application within one renewal cycle fees for surgical technologists.

The following table displays the proposed new fees for surgical assistants and surgical technologists:

	Surgical Assistants	Surgical Technologists
Renewal of inactive license or inactive certification	$70	$35
Reinstatement of license or certification that has been lapsed for two years or more	$180	$90
Fee for when the license was revoked	$2,000	Not applicable
Fee for a letter of good standing or verification to another jurisdiction for a license	$10	Not applicable

Continuing Education for Surgical Assistants. In order to qualify for initial licensure as a surgical assistant, the candidate must provide evidence of:

"1. A current credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting or the National Commission for Certification of Surgical Assistants or their successors;

2. Successful completion of a surgical assistant training program during the applicant's service as a member of any branch of the armed forces of the United States; or

3. Practice as a surgical assistant in the Commonwealth at any time in the six months immediately prior to July 1, 2020."

Under the current regulation, in order for a surgical assistant who was initially licensed based on a credential (described in number one above) to renew his license, he must attest that the credential is current at the time of renewal (the renewal fee must also be paid). Both the National Board of Surgical Technology and Surgical Assisting, and the National Commission for Certification of Surgical Assistants, require 38 hours of CE every two years for the credential to remain current.

In contrast, besides paying the renewal fee, the current regulation does not specify any requirements for licensure renewal for surgical assistants who were initially licensed based on the second or third category above. The Board now proposes to add the following:

A surgical assistant who was licensed based on successful completion of a surgical assistant training program during the person's service as a member of any branch of the armed forces of the United States or based on practice as a surgical assistant in the Commonwealth at any time in the six months immediately prior to July 1, 2020, shall attest to completion of 38 hours of continuing education recognized by the National Surgical Assistant Association at the time of biennial renewal.

Continuing Education for Surgical Technologists. In order to qualify for initial certification as a surgical technologist, the candidate must provide evidence of:

"1. Successful completion of an accredited surgical technologist training program and a current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor; or

2. Successful completion of a training program for surgical technology during the applicant's service as a member of any branch of the armed forces of the United States."

The current regulation lists a biennial fee for surgical technologist certification renewal, but does not state any other certification renewal requirements. The Board proposes to add the following:

"A. A surgical technologist who was certified based on certification as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor shall attest that the credential is current at the time of renewal.

B. A surgical technologist who was certified based on successful completion of a training program for surgical technology during the person's service as a member of any branch of the armed forces of the United States, or based on practice as a surgical technologist at any time in the six months prior to July 1, 2021 shall attest to completion of 30 hours of continuing education recognized by the Association of Surgical Technologists at the time of biennial renewal."

The National Board of Surgical Technology and Surgical Assisting certification renewal requires 30 hours of CE recognized by the Association of Surgical Technologists (AST) every two years. Thus, the proposed requirements equate to all surgical technologists needing 30 hours of CE for Virginia certification renewal.

Standard New Sections. The proposed 18VAC85-160-80 Confidentiality in its entirety states that "A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. 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."

The proposed 18VAC85-160-90 Patient records: 1) provides reminders to comply with a specified section of the Code of Virginia § 32.1-127.1:03, 2) states that "Practitioners who are employed by a health care institution or other entity in which the individual practitioner does not own or maintain his own records shall maintain patient records in accordance with the policies and procedures of the employing entity," and 3) states that "Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall "Maintain a patient record for a minimum of six years following the last patient encounter" with some exceptions specified.

The proposed 18VAC85-160-100 Communication with patients; termination of relationship, states that the practitioner: shall not deliberately make false or misleading statements, should follow specified sections of the Code of Virginia, and shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

The proposed 18VAC85-160-110 Practitioner responsibility states that the practitioner shall not: perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent, knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice, engage in an egregious pattern of disruptive behavior or

interaction in a health care setting, or exploit the practitioner/patient relationship for personal gain.

Section 54.1-2915 of the Code of Virginia. Unprofessional conduct; grounds for refusal or disciplinary action[7] lists grounds for disciplinary action for which the Board may act, including sexual contact with a patient. The proposed 18VAC85-160-120 Sexual contact provides greater detail on what constitutes unprofessional conduct and grounds for discipline through sexual contact.

The proposed 18VAC85-160-130 Refusal to provide information in its entirety states that "A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation."

Estimated Benefits and Costs.

Fee Increases. The fees in the current regulation for initial licensure, license renewal, and processing a late renewal application within one renewal cycle are all the same as they were when surgical assistants were registered rather than licensed prior to 2020. As a registered profession, surgical assistants were not subject to disciplinary action under § 54.1-2915. The existing regulation also does not specify disciplinary action. According to the Department of Health Professions (DHP), a large percentage of the revenue collected by the agency is used to cover the costs of investigations and disciplinary proceedings. Thus, as a licensed profession which is subject to disciplinary action under § 54.1-2915, the cost of regulating surgical assistants has become substantially higher.

Prior to Chapter 1222 of the 2020 Acts of Assembly, § 54.1-2956.13 A stated that "No person shall use or assume the title "registered surgical assistant" unless such person is registered with the Board." In other words, people who were not registered with the Board could do the work of surgical assistants; they just could not use the title "registered surgical assistant." Chapter 1222 amended § 54.1-2956.13 A to "No person shall engage in the practice of surgical assisting or use or assume the title "surgical assistant" unless such person holds a license as a surgical assistant issued by the Board." As a result, it is now against the law to do the work of surgical assistants in the Commonwealth without being licensed by the Board. To the extent that no longer allowing individuals who have not met all of the requirements necessary to earn surgical assistant licensure to practice surgical assisting may reduce the likelihood of adverse surgical outcomes, switching from registration to licensure for surgical assistants may be beneficial. Additionally, it is potentially beneficial for those individuals who do meet the licensure requirements in that there is likely reduced competition for jobs. Thus, for at least some if not most licensed surgical assistants, if the higher fees are necessary for licensure rather than registration, then the benefits of licensure outweigh the additional cost.

Continuing Education. Under both the current and proposed regulations, surgical assistants who were initially licensed based on a current credential as either a surgical assistant or surgical first assistant (issued by the National Board of Surgical Technology and Surgical Assisting, or the National Commission for Certification of Surgical Assistants or their successors) may renew their license by paying the renewal fee and attesting that the credential is current at the time of renewal. In order to keep the credential current, 38 hours of CE have to be completed biennially. Thus, other than paying a higher renewal fee, there is no change for license renewal for these surgical assistants.

For surgical assistants who were initially licensed based on a different method, the proposed regulation introduces a new requirement of 38 CE hours every two years. The National Surgical Assistant Association lists the following as methods to earn CE credits:[8]

- Health care facility mandatory education
- Health care facility sponsored in-services
- Attending professional physician organization programs
- Writing for health-related publications
- Instruction of health professionals
- College credit
- Lecture
- Clinical demonstration
- Completion of enduring material activities.[9]

One CE credit equals 50 to 60 minutes of activity when attending a program or viewing a recorded CE lectures and completing the post-lecture CE exam. All CE activities must be relevant to the practice of surgical assisting to qualify for CE credit. Since most surgical assistants work for hospital systems, some of the required CE hours would likely be covered by health care facility mandatory education and/or health care facility sponsored in-services for at least some surgical assistants.

For those surgical assistants who have not been participating in activities that would qualify for 38 CE hours every two years, the proposed requirement may make it more likely that they remain up-to-date in advances and current skills in their profession, which could have a positive impact on public health. On the other hand, there may be individuals who remain up-to-date in their skills without participating in activities that meet the 38-hour requirement. These individuals would be required to spend time and potentially dollars differently than they otherwise would have chosen.

The current regulation lists a biennial fee for surgical technologist certification renewal, but does not state any other certification renewal requirements. The proposed regulation effectively newly requires 30 hours of CE every two years for Virginia surgical technologist certification renewal. Surgical technologists who have chosen to keep current National Board of Surgical Technology and Surgical Assisting certification would not be practically affected, since such certification also requires 30 hours of CE every two years.

According to AST, the vast majority of all surgical technologist CE credits are earned through one or more of the ways listed below:[10]

- AST distance CE (journal tests or CE packages);
- Hospital internal training;
- Live lectures at AST state assemblies, national conference and others, such as ACS Congress;
- College courses; and
- Healthcare manufacturers" live events. In order for the CE credits to be accepted by AST, the live program must be approved by AST and the program must be relevant to the practice of surgical technology or surgical first assisting. Live events are stand-alone events, such as forums or hands-on workshops.

The AST website lists CE packages for members.[11] Annual membership is $80 and 30 hours of CE credits through CE packages costs about $50, in addition to the time it takes to complete. Since most surgical technologists work for hospital systems,[12] some of the required CE hours may be covered by hospital internal training for at least some surgical technologists.

Similar to surgical assistants, for those surgical technologists who have not been participating in activities that would qualify for 30 CE hours every two years, the proposed requirement may make it more likely that they remain up-to-date in advances and current skills in their profession, which could have a positive impact on public health. On the other hand, there may be individuals who remain up-to-date in their skills without participating in activities that meet the 30-hour requirement. These individuals would be required to spend time and potentially dollars differently than they otherwise would have chosen.

Inactive Licensure, Reactivation, and Reinstatement. The current regulation does not address reinstatement of lapsed or revoked licenses or certification or inactive licenses or certification. The proposed regulation includes text on obtaining inactive certification and associated rules, how to reactivate certification, and how to reinstate certification. Having this information spelled out in the regulation is beneficial for the public and regulated entities.

Standard New Sections. The proposed new Confidentiality section does not appear to add requirements beyond what already exists in the Code of Virginia.[13] Thus adding it would not likely have impact beyond improving clarity for someone who reads the regulation, but not the relevant part of the Code of Virginia.

The reminders in the proposed Patient records section to comply with Code of Virginia requirements on confidentiality and patient records do not produce any new requirements, but may be beneficial for readers of the regulation who are unfamiliar with these Code requirements. The proposed statement that "Practitioners who are employed by a health care institution or other entity in which the individual practitioner does not own or maintain his own records shall maintain patient records in accordance with the policies and procedures of the employing entity" would not likely have a substantive impact since the employers would presumably already require this. There are not likely many, if any, surgical assistants and surgical technologists who are self-employed or own patient records. If there are any, and they do not currently keep records for a minimum of six years following the last patient encounter, the proposed statement that "Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall "Maintain a patient record for a minimum of six years following the last patient encounter may have some impact.

The language in the proposed Communication with patients; termination of relationship section indicating that the practitioner shall not deliberately make false or misleading statements and should follow specified sections of the Code of Virginia does not produce any new requirements, but may be beneficial for readers of the regulation who are unfamiliar with these Code requirements. Stating that the practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner would probably not have a substantial impact since surgical assistants and surgical technologists work under the supervision of a licensed doctor of medicine, osteopathy, or podiatry and not typically directly with patients.

The statement in the proposed Practitioner responsibility section that the practitioner shall not perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent does not produce any new requirements, but may be beneficial for readers of the regulation who are unfamiliar with these Code requirements. The proposed language on the practitioner not knowingly allowing subordinates to jeopardize patient safety or providing patient care outside of the subordinate's scope of practice, engaging in an egregious pattern of disruptive behavior or interaction in a health care setting, or exploiting the practitioner/patient relationship for personal gain might help reduce the likelihood of these activities from occurring.

The proposed Sexual contact section may be beneficial in that by providing greater detail on what constitutes unprofessional conduct and grounds for discipline through sexual contact, there may be greater clarity on what behavior is grounds for Board disciplinary action.

The proposed Refusal to provide information section may help encourage practitioners to cooperate with the Board. Businesses and Other Entities Affected. The proposed amendments affect surgical assistants, surgical technologists, and providers of continuing education. According to DHP, surgical assistants and surgical technologists typically practice in large hospital systems. As of June 30, 2021, there were 368 surgical assistants licensed and 242 surgical technologists

registered with the Commonwealth.[14] The switch from registration to certification for surgical technologists took place on July 1, 2021.

The proposed fee increases for the initial, renewal, and late renewal of surgical assistant licenses would increase costs for all surgical assistants. The proposed minimum of 38 hours of CE for surgical assistant license renewal and 30 hours of CE for surgical technologist certification renewal every two years increases costs (whether in time or dollars) for those practitioners that would not have otherwise participated in activities that would meet those number of CE hours. An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. Thus, an adverse impact is indicated.

Small Businesses[15] Affected. The proposed amendments do not appear to adversely affect small businesses.

Localities[16] Affected.[17] The proposed amendments neither disproportionately affect any particular locality nor introduce costs for local governments.

Projected Impact on Employment. There may be a small increase in employment at providers of CE. Given the nature of the activities that qualify for CE, any such increase would likely be modest.

Effects on the Use and Value of Private Property. The proposed CE requirements would likely prompt an increase in demand for CE activities. Given the nature of the activities that qualify for CE, any increase in demand for private outside provision of CE and an associated increase in business value would likely be modest. The proposed amendments do not affect real estate development costs.

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[1]See https://lis.virginia.gov/cgi-bin/legp604.exe?201+ful+CHAP1222

[2]Section 54.1-2900 of the Code of Virginia defines "surgical assistant" as "an individual who has met the requirements of the Board for licensure as a surgical assistant and who works under the direct supervision of a licensed doctor of medicine, osteopathy, or podiatry." That section also defines the "practice of surgical assisting" as "the performance of significant surgical tasks, including manipulation of organs, suturing of tissue, placement of hemostatic agents, injection of local anesthetic, harvesting of veins, implementation of devices, and other duties as directed by a licensed doctor of medicine, osteopathy, or podiatry under the direct supervision of a licensed doctor of medicine, osteopathy, or podiatry."

[3]See https://townhall.virginia.gov/L/ViewStage.cfm?stageid=9039

[4]See https://lis.virginia.gov/cgi-bin/legp604.exe?212+ful+CHAP0230

[5]According to the Department of Health Professions, a surgical technologist is usually responsible for ensuring the sterility of the room, the equipment, the surgical instruments, the surgical towels, etc. and making sure everything needed is present and arranged for maximum efficiency prior to the procedure.

[6]See https://townhall.virginia.gov/L/ViewStage.cfm?stageid=9312

[7]See https://law.lis.virginia.gov/vacode/54.1-2915/

[8]See http://www.nsaa.net/wp-content/uploads/2019/12/Continuing-Education-Policy-Rev.-2019.pdf

[9]Enduring material is defined as a non-live offering, including but not limited to, CE articles delivered hard-copy or electronically that have a post-article CE exam; health care facility mandatory education tests online; viewing a recorded CE lecture on-line, CD, or other electronic means that has a post-article CE exam.

[10]See https://www.ast.org/Members/Submit_Credits/

[11]See https://www.ast.org/Members/CE_Credit_Packages/

[12]Source: Department of Health Professions

[13]See https://law.lis.virginia.gov/vacode/32.1-127.1:03/

[14]Source: Department of Health Professions.

[15]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.'

[16]"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.

[17]§ 2.2-4007.04 defines 'particularly affected" as bearing disproportionate material impact.

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

Summary:

The proposed amendments (i) add definitions; (ii) conform fees for licensure to other professions under the board; (iii) add requirements for continuing competency for surgical assistants licensed under a grandfathering provision; (iv) provide for an inactive license and for reactivation or reinstatement of a license; (v) provide for a restricted volunteer license or voluntary practice by out-of-state practitioners; and (vi) provide for renewal of certification of surgical technologists, including requirements for continuing education. Finally, the board proposes standards of practice similar to those for other licensed professions under its jurisdiction and a code of ethics specific to surgical assistants.

Part I
General provisions

18VAC85-160-40. Fees.

A. The following fees have been established by the board:

1. The fee for licensure as a surgical assistant shall be $130 or certification as a surgical technologist shall be $75.

2. The fee for renewal of licensure ~~or certification~~ as a surgical assistant shall be ~~$70~~ $135 and for certification as a surgical technologist, it shall be $70. Renewals shall be due in the birth month of the licensee or certificate holder 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~~ $50 for a surgical assistant and $25 for a surgical technologist.

4. The handling fee for a returned check or a dishonored credit card or debit card shall be $50.

5. The fees for inactive license renewal shall be $70 for a surgical assistant and $35 for inactive certification renewal for a surgical technologist.

6. The fee for reinstatement of a surgical assistant license that has been lapsed for two years or more shall be $180; for a surgical technologist certification, it shall be $90.

7. The fee for a letter of good standing or verification to another jurisdiction for a license shall be $10.

8. The fee for reinstatement of licensure as a surgical assistant pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

B. Unless otherwise provided, fees established by the board are not refundable.

Part II
Requirements for licensure or certification

18VAC85-160-60. Renewal of licensure for a surgical assistant.

A. A surgical assistant who was licensed based on a credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting or the National Commission for the Certification of Surgical Assistants or their successors shall attest that the credential is current at the time of renewal.

B. A surgical assistant who was licensed based on successful completion of a surgical assistant training program during the person's service as a member of any branch of the armed forces of the United States or based on practice as a surgical assistant in the Commonwealth at any time in the six months immediately prior to July 1, 2020, shall attest to completion of 38 hours of continuing education recognized by the National Surgical Assistant Association at the time of biennial renewal.

18VAC85-160-65. Renewal of certification for a surgical technologist.

A. A surgical technologist who was certified based on certification as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor shall attest that the credential is current at the time of renewal.

B. A surgical technologist who was certified based on successful completion of a training program for surgical technology during the person's service as a member of any branch of the armed forces of the United States, or based on practice as a surgical technologist at any time in the six months prior to July 1, 2021, shall attest to completion of 30 hours of continuing education recognized by the Association of Surgical Technologists at the time of biennial renewal.

18VAC85-160-70. Reinstatement or reactivation of surgical assistant licensure.

A. A licensed surgical assistant who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be required to maintain hours of active practice or meet the continued competency requirements of 18VAC85-160-60 and shall not be entitled to perform any act requiring a license to practice surgical assisting in Virginia.

B. An inactive licensee may reactivate his license upon submission of the following:

1. An application as required by the board;

2. A payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure; and

3. Documentation of completed continued competency hours as required by 18VAC85-160-60.

C. A surgical assistant who allows his license to lapse for a period of two years or more and chooses to resume his practice shall submit a reinstatement application to the board and information on any practice and licensure or certification in other jurisdictions during the period in which the license was lapsed and shall pay the fee for reinstatement of licensure as prescribed in 18VAC85-160-40.

D. The board reserves the right to deny a request for reactivation or reinstatement to any licensee who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provisions of this chapter.

E. A surgical assistant whose license has been revoked by the board and who wishes to be reinstated shall make a new application to the board and payment of the fee for reinstatement of his license as prescribed in 18VAC85-160-40 pursuant to § 54.1-2408.2 of the Code of Virginia.

Part III
Standards of conduct

18VAC85-160-80. Confidentiality.

A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. 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.

18VAC85-160-90. Patient records.

A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.

B. Practitioners shall provide patient records to another practitioner or to the patient or the patient's personal representative in a timely manner and in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage and keep timely, accurate, legible, and complete patient records.

D. Practitioners who are employed by a health care institution or other entity in which the individual practitioner does not own or maintain the practitioner's own records shall maintain

patient records in accordance with the policies and procedures of the employing entity.

E. Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall:

1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

a. Records of a minor child shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;

b. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or the patient's personal representative; or

c. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

2. Post information or in some manner inform all patients concerning the timeframe for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

F. When a practitioner is closing, selling, or relocating his practice, the practitioner shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

18VAC85-160-100. Communication with patients; termination of relationship.

A. Communication with patients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or the patient's legally authorized representative in understandable terms and encourage participation in decisions regarding the patient's care.

2. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a treatment or procedure provided or directed by the practitioner in the treatment of any disease or condition.

3. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research with the exception of retrospective chart reviews.

B. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make the patient record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make the practitioner's services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

18VAC85-160-110. Practitioner responsibility.

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which the practitioner is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or the subordinate's area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 3 of this section.

18VAC85-160-120. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2915 A 19 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does

not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct 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 patient care. For purposes of this section, key third party of a patient means spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct 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 patient care.

18VAC85-160-130. Refusal to provide information.

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

VA.R. Doc. No. R21-6696; Filed December 30, 2021, 2:33 p.m.

BOARD OF LONG-TERM CARE ADMINISTRATORS

Proposed Regulation

Titles of Regulations: **18VAC95-20. Regulations Governing the Practice of Nursing Home Administrators (amending 18VAC95-20-175, 18VAC95-20-310, 18VAC95-20-340, 18VAC95-20-390, 18VAC95-20-400).**

18VAC95-30. Regulations Governing the Practice of Assisted Living Facility Administrators (amending 18VAC95-30-70, 18VAC95-30-100, 18VAC95-30-160, 18VAC95-30-170, 18VAC95-30-180, 18VAC95-30-190).

Statutory Authority: §§ 54.1-2400 and 54.1-3102 of the Code of Virginia.

Public Hearing Information:

March 4, 2022 - noon - Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Suite 201, Board Room 4, Henrico, Virginia

Public Comment Deadline: April 2, 2022.

Agency Contact: Corie Tillman Wolf, Executive Director, Board of Long-Term Care Administrators, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4595, FAX (804) 527-4413, or email corie.wolf@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 Long-Term Care Administrators the authority to promulgate regulations to administer the regulatory system. The specific mandate for the Board of Long-Term Care Administrators to license nursing home and assisted living facility administrators is found in § 54.1-3102 of the Code of Virginia.

Purpose: The purpose of this regulatory action is to strengthen current training and supervision requirements for prospective administrator licensees in the nursing home and assisted living settings. Training is essential for prospective administrators not only as preparation for examination and licensure, but also as a means of ensuring safety and competency for practice within the long-term care setting, which in turn enhances public health and safety. The board has also strengthened training for current and prospective administrators in the area of mental impairments, including dementia and Alzheimer's, to ensure that administrators are adequately equipped to handle the needs of residents in their care who are facing these challenges.

Substance: The board has amended its regulations to (i) clarify and enhance training and supervision requirements for prospective nursing home and assisted living facility administrators receiving pre-licensure training in an administrator-in-training (AIT) program; (ii) establish an additional pathway for individuals to qualify for AIT training in the assisted living setting and strengthen the current requirement for college or university coursework to include coursework in business or human services; (iii) offer continuing education credit for preceptors who supervise AITs and to enhance the training and continuing education received by both AITs and administrators related to mental impairments, including dementia and Alzheimer's; and (iv) specify limitations on the assisted living facilities that qualify for an AIT program.

Issues: The primary advantages are more opportunity for persons to become administrators of assisted living facilities to alleviate shortages, incentive for administrators to serve as preceptors for persons in training, and more emphasis on training and education in mental or cognitive impairment to better serve an affected population. There are no disadvantages to the public. There are no advantages or disadvantages to the board or the department.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. The Board of Long-Term Care Administrators (Board) proposes to:

1) establish an additional pathway for individuals to qualify for Administrator-in-Training (AIT) program in the Assisted-Living Facility (ALF) setting and strengthen the current requirement for college or university coursework to include coursework in business and/or human services, 2) enhance training and supervision requirements for prospective nursing home and ALF administrators receiving pre-licensure training in an AIT program, 3) offer continuing education credit for preceptors[2] who supervise AITs, 4) enhance the training and continuing education received by both AITs and administrators related to mental impairments, and 5) specify limitations on the assisted living facilities that qualify for an AIT program.

Background. The Board issues licenses to nursing facility administrators as well as ALF administrators. Both administrator types have an AIT program. This regulatory action stems from a set of recommendations from a regulatory advisory panel on both types of AITs which was convened by the Board.

Estimated Benefits and Costs. One of the pathways to become an ALF administrator is through the completion of an AIT program. Requirements for entry into the AIT program vary. One of the proposed changes would allow individuals who lack the currently required 30 hours of postsecondary education or a degree as a nurse, but who have at least three years of health care experience, to include at least one consecutive year in a managerial or supervisory role in a health care setting within the five years prior to application to join an AIT program. In essence, this amendment would allow a person who has been performed certain roles in a health care setting, such as the food services manager, activities director, or human resources manager, to qualify for entry into an ALF AIT program to become an ALF administrator.

According to the Department of Health Professions (DHP), with an increasingly aging population, there is an ongoing need for more administrators in the field. Also, workforce surveys conducted in 2021 show that the median age for nursing home and ALF administrators is 50 and 52, respectively.[3] Thirty-eight percent of nursing home administrators are 55 years or older, while 43% of ALF administrators are 55 years or older.[4] DHP believes these facilities will face a wave of retirements of administrators in the next few years and the ALF community believes this change is urgently needed to fill currently open positions and those that would be needed to meet future needs in long term care.

The proposed additional pathway would open up opportunity for some individuals to climb the career ladder into the administrator role. This change would likely expand the pool of potential administrators and benefit those who currently lack 30 hours of postsecondary education or a degree as a nurse to get into an ALF AIT program. The impact on residents would depend on whether basic, managerial, or supervisory experience in health care setting is a good substitute for postsecondary education or a degree as a nurse.

At the same time, the Board proposes to strengthen AIT program educational requirements by targeting coursework subject matter areas that are more relevant to an ALF administrator. According to DHP, "Thirty hours at a community college without some specified coursework (plus the existing requirement of 640 hours in an AIT program) may not prepare an individual to handle the complexity of managing the health care needs, the financial and regulatory responsibilities, and the human resource issues of a facility." While the total number of hours (30 semester hours) would not change, the Board proposes to require at least 15 of the 30 hours in business or human services or a combination thereof. Those who are at the beginning of their coursework may meet this requirement by carefully choosing their coursework. However, this change may disqualify those who completed 30 hours of coursework but currently lack at least 15 of the 30 hours in business or human services or a combination and may shrink the pool of potential administrators or force them to take more courses. The impact on residents would depend on whether targeted coursework would help improve their care.

The Board also proposes to incentivize becoming a preceptor for AIT programs through continuing education requirements. Serving as a preceptor is a time-consuming responsibility and a learning experience for the preceptor as well as the trainee. Additional preceptors would be needed if there is an enrollment increase in AIT programs due to additional pathway proposed. A nursing facility or ALF administrator who serves as a registered preceptor in an approved AIT program would be allowed to receive one hour of continuing education credit for each week of training up to a maximum of ten hours (half of the total required hours). This change would not affect the required continuing education hours but only how credits could be earned by the administrators who are preceptors. The intent is to encourage and reward preceptors for AIT programs especially given the potential increase in enrollment in training programs.

The Board proposes to strengthen training for current and prospective nursing home and ALF administrators in the area of mental impairments, including dementia and Alzheimer's disease, to ensure that administrators are adequately equipped to handle the needs of residents in their care who are facing these challenges. There is a strong correlation between aging and developing dementia, and according to demographers at the University of Virginia, one in five Virginians will be over 65 years by 2030.[5] Additionally, DHP notes that many residents of long term care facilities are affected by mental impairment and that continuous education is essential to appropriately plan for and execute their care. There are new and developing techniques and treatments that require administrators to stay current and knowledgeable. Therefore, the Board proposes that current administrators (both nursing home and ALF) complete at least two hours of continuing education for each renewal year shall relate to the care of residents with mental or cognitive impairments, including Alzheimer's disease and dementia and that AIT programs (both

nursing home and ALF) provide training on the care of residents with cognitive or mental impairments, including Alzheimer's disease and dementia.

New continuing education and training requirements can be fulfilled by choosing such courses or training as part of existing hourly requirements. This change would likely help residents with cognitive or mental impairments. However, the impact on other residents would depend on the type of training or education that would have been taken instead, if any.

Finally, the Board proposes to specify limitations on the assisted living facilities that qualify for an AIT program. Currently, the regulation states that an ALF AIT program cannot be conducted in an ALF with a provisional license, as determined by the Department of Social Services (DSS). The advisory panel recommended three additional limitations based on the need to train administrators with the competencies to safely run an ALF. Under the proposed changes, an AIT program cannot be operated in an ALF with a conditional license in which the AIT applicant is the owner of the facility; in a facility that is only licensed for residential care (not assisted living); and in a facility with resident capacity of less than 20 residents.

If the person who wants to operate an ALF AIT is the owner of the facility and it has been given a conditional license by DSS, there are concerns that the owner would be serving as the acting AIT of their own new facility, thereby resulting in inadequate AIT training and/or supervision. If a facility is only licensed for residential care, a licensed administrator is not required and there would be insufficient oversight and training opportunities for an ALF AIT. For example, residents handle their own medications, rather than employing medication aides or nurses for that task.

The panel used data estimates from DSS to make its recommendation about the bed capacity of an ALF facility in which an AIT program could be operated. It concluded that a facility with fewer than 20 beds did not have the breadth and depth of staff and experience to adequately prepare a person in training to safely and effectively operate an assisted living facility.

According to data from DSS, of the 571 facilities licensed to provide assisted living care, there were approximately 100 that are in the range of three to 10 beds (73 of those are located in Fairfax and Central Virginia; none were located in the Western district of the state). Therefore the Board agreed with the recommendation of the panel that there was ample opportunity in all parts of the state for AIT programs in facilities with adequate bed capacity needed for training of competent administrators.

Businesses and Other Entities Affected. According to data from DSS, there are 571 facilities licensed as ALFs; approximately 67 of those facilities are residential only (i.e., do not require a licensed administrator). The total licensed resident capacity across all ALFs is approximately 36,121. For nursing homes, there are nearly 300 licensed nursing homes containing over 32,000 beds.

The proposed regulatory changes would primarily affect persons in AIT programs (nursing home and assisted living) and licensees who are registered as preceptors. There are six acting administrators in ALF AIT programs, 86 persons undergoing an ALF administrator-in-training program, 188 ALF preceptors, 72 persons undergoing a nursing home administrator-in-training program, and 209 nursing home preceptors.

No affected entity appears to be disproportionately affected.

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[6] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. As noted above, the proposal that at least 15 of the 30 hours required for entry into an ALF AIT program be in business or human services or a combination thereof may disqualify some individuals from enrollment in an AIT program or may force them to acquire more hours than other individuals who already completed 30 hours of coursework in other areas. Although there is no information on whether any such AIT candidates exist, an adverse impact on them would be indicated.

Small Businesses[7] Affected.[8]

Types and Estimated Number of Small Businesses Affected. According to DHP, most of the nursing home AIT programs are operated in large facilities that are part of a regional or national group. Many of the ALF AIT programs are in facilities that would be considered small businesses.

Costs and Other Effects. As discussed, the new rules may disqualify some assisted living facilities from operating an AIT program even if they wanted to. Although there is no information on whether there exists any such assisted living facility, an adverse impact on them would be indicated.

Alternative Method that Minimizes Adverse Impact. There are no clear alternative methods that both reduce adverse impact and meet the intended policy goals.

Localities[9] Affected.[10] The proposed amendments do not appear to disproportionately affect any particular localities or affect costs for local governments.

Projected Impact on Employment. One of the proposed amendments would provide an additional pathway to become an administrator to existing assisted living facility employees. While that change may provide a new career opportunity for certain individuals, it does not appear to directly affect total employment.

Effects on the Use and Value of Private Property. No significant effect on the use and value of private property or real estate development costs is expected.

[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed

amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]A preceptor is an experienced practitioner who provides supervision during clinical practice.

[3]https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/ltc/1706ALFA2021.pdf and https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/ltc/1701NHA2021.pdf

[4]https://statchatva.org/2017/07/05/1-in-5-virginians-will-be-over-65-years-by-2030/

[5]Ibid.

[6]Pursuant to Code § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[7]Pursuant to § 2.2-4007.04, 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."

[8]If the proposed regulatory action may have an adverse effect on small businesses, Code § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to § 2.2-4007.1 of the Code of Virginia, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[9]"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.

[10]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

Agency's Response to Economic Impact Analysis: The Board of Long-Term Care Administrators concurs with the economic impact analysis of the Department of Planning and Budget.

Summary:

The proposed amendments (i) clarify and enhance training and supervision requirements for prospective nursing home and assisted living facility administrators receiving pre-licensure training in an administrator-in-training (AIT) program; (ii) establish an additional pathway for individuals to qualify for AIT training in the assisted living setting and strengthen the current requirement for college or university coursework to include coursework in business or human services; (iii) offer continuing education credit for preceptors who supervise AITs and to enhance the training and continuing education received by both AITs and administrators related to mental impairments, including dementia and Alzheimer's; and (iv) specify limitations on the assisted living facilities that qualify for an AIT program.

18VAC95-20-175. Continuing education requirements.

A. In order to renew a nursing home administrator license, an applicant shall attest on his renewal application to completion of 20 hours of approved continuing education for each renewal year.

1. Up to 10 of the 20 hours may be obtained through Internet or self-study courses and up to 10 continuing education hours in excess of the number required may be transferred or credited to the next renewal year.

2. Up to two hours of the 20 hours required for annual renewal may be satisfied through delivery of 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.

3. At least two hours of continuing education for each renewal year shall relate to the care of residents with mental or cognitive impairments, including Alzheimer's disease and dementia.

4. A licensee who serves as the registered preceptor in an approved AIT or Assisted Living Facility AIT program may receive one hour of continuing education credit for each week of training up to a maximum of 10 hours of self-study course credit for each renewal year.

5. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following initial licensure.

B. In order for continuing education to be approved by the board, it shall (i) be related to health care administration and shall be approved or offered by NAB, an accredited institution, or a government agency or (ii) as provided in subdivision A 2 of this section.

C. Documentation of continuing education.

1. The licensee shall retain in ~~his~~ the licensee's personal files for a period of three renewal years complete documentation of continuing education including evidence of attendance or participation as provided by the approved sponsor for each course taken.

2. Evidence of attendance shall be an original document provided by the approved sponsor and shall include:

a. Date the course was taken;

b. Hours of attendance or participation;

c. Participant's name; and

d. Signature of an authorized representative of the approved sponsor.

3. If contacted for an audit, the licensee shall forward to the board by the date requested a signed affidavit of completion on forms provided by the board and evidence of attendance or participation as provided by the approved sponsor.

D. The board may grant an extension of up to one year or an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the administrator, such as a certified illness, a temporary disability, mandatory military service, or officially declared disasters. The request for an extension shall be received in writing and granted by the board prior to the renewal date.

18VAC95-20-310. Required hours of training.

A. The AIT program shall consist of 2,000 hours of continuous training in a facility as prescribed in 18VAC95-20-330 to be completed within 24 months. An extension may be granted by the board on an individual case basis. The board may reduce the required hours for applicants with certain qualifications as prescribed in ~~subsection~~ subsections B and C of this section.

B. An AIT applicant with prior health care work experience may request approval to receive a maximum 1,000 hours of credit toward the total 2,000 hours as follows:

1. The applicant shall have been employed full time for four of the past five consecutive years immediately prior to application as an assistant administrator or director of nursing in a training facility as prescribed in 18VAC95-20-330, or as the licensed administrator of an assisted living facility;

2. The applicant with experience as a hospital administrator shall have been employed full time for three of the past five years immediately prior to application as a hospital administrator-of-record or an assistant hospital administrator in a hospital setting having responsibilities in all of the following areas:

a. Regulatory;

b. Fiscal;

c. Supervisory;

d. Personnel; and

e. Management; or

3. The applicant who holds a license as a registered nurse shall have held an administrative level supervisory position for at least four of the past five consecutive years, in a training facility as prescribed in 18VAC95-20-330.

C. An AIT applicant with the following educational qualifications shall meet these requirements:

1. An applicant with a master's or a baccalaureate degree in a health care-related field that meets the requirements of 18VAC95-20-221 with no internship shall complete 320 hours in an AIT program;

2. An applicant with a master's degree in a field other than health care shall complete 1,000 hours in an AIT program;

3. An applicant with a baccalaureate degree in a field other than health care shall complete 1,500 hours in an AIT program; or

4. An applicant with 60 semester hours of education in an accredited college or university shall complete 2,000 hours in an AIT program.

D. An AIT shall be required to serve weekday, evening, night and weekend shifts and to receive training in all areas of nursing home operation. An AIT shall receive credit for no more than 40 hours of training per week.

E. An AIT shall complete training on the care of residents with cognitive or mental impairments, including Alzheimer's disease and dementia.

18VAC95-20-340. Supervision of trainees.

A. Training shall be under the supervision of a preceptor who is registered or recognized by a licensing board.

B. A preceptor may supervise no more than two AIT's at any one time.

C. A preceptor shall:

1. Provide direct instruction, planning, and evaluation in the training facility;

2. Shall be routinely present with the trainee for on-site supervision in the training facility as appropriate to the experience and training of the AIT and the needs of the residents in the facility; and

3. Shall continually evaluate the development and experience of the AIT to determine specific areas in the Domains of Practice that need to be addressed.

18VAC95-20-390. Training plan.

Prior to the beginning of the AIT program, the preceptor shall develop and submit for board approval a training plan that shall include and be designed around the specific training needs of the administrator-in-training. The training plan shall address the Domains of Practice approved by NAB that is in effect at the time the training program is submitted for approval. An AIT program shall include training in each of the learning areas ~~in the Domains of Practice~~ as outlined in the NAB AIT Manual.

18VAC95-20-400. Reporting requirements.

A. The preceptor shall maintain progress reports on forms prescribed by the board for each month of training. The preceptor shall document in the progress report evidence of on-site supervision of the AIT training.

B. The AIT's ~~certificate~~ final report of completion ~~plus~~ with the accumulated original monthly reports shall be submitted by the preceptor to the board within 30 days following the completion of the AIT program.

18VAC95-30-70. Continuing education requirements.

A. In order to renew an assisted living administrator license, an applicant shall attest on ~~his~~ the applicant's renewal application to completion of 20 hours of approved continuing education for each renewal year.

1. Up to 10 of the 20 hours may be obtained through Internet or self-study courses and up to 10 continuing education hours in excess of the number required may be transferred or credited to the next renewal year.

2. Up to two hours of the 20 hours required for annual renewal may be satisfied through delivery of 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.

3. At least two hours of continuing education for each renewal year shall relate to the care of residents with mental or cognitive impairments, including Alzheimer's disease and dementia.

4. A licensee who serves as the registered preceptor in an approved ALF AIT program may receive one hour of continuing education credit for each week of training up to a maximum of 10 hours of self-study course credit for each renewal year.

5. A licensee is exempt from completing continuing education requirements for the first renewal following initial licensure in Virginia.

B. In order for continuing education to be approved by the board, it shall (i) be related to the Domains of Practice for residential care/assisted living and approved or offered by NAB, an accredited educational institution, or a governmental agency or (ii) be as provided in subdivision A 2 of this section.

C. Documentation of continuing education.

1. The licensee shall retain in his personal files for a period of three renewal years complete documentation of continuing education including evidence of attendance or participation as provided by the approved sponsor for each course taken.

2. Evidence of attendance shall be an original document provided by the approved sponsor and shall include:

a. Date the course was taken;

b. Hours of attendance or participation;

c. Participant's name; and

d. Signature of an authorized representative of the approved sponsor.

3. If contacted for an audit, the licensee shall forward to the board by the date requested a signed affidavit of completion on forms provided by the board and evidence of attendance or participation as provided by the approved sponsor.

D. The board may grant an extension of up to one year or an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the administrator, such as a certified illness, a temporary disability, mandatory military service, or officially declared disasters. The request for an extension shall be submitted in writing and granted by the board prior to the renewal date.

18VAC95-30-100. Educational and training requirements for initial licensure.

A. To be qualified for initial licensure as an assisted living facility administrator, an applicant shall hold a high school diploma or general education diploma (GED) and hold one of the following qualifications:

1. Administrator-in-training program.

a. Complete at least 30 semester hours of postsecondary education in an accredited college or university ~~in any subject~~ with at least 15 of the 30 semester hours in business or human services or a combination thereof and 640 hours in an ALF AIT program as specified in 18VAC95-30-150;

b. Complete an educational program as a licensed practical nurse and hold a current, unrestricted license or multistate licensure privilege and 640 hours in an ALF AIT program;

c. Complete an educational program as a registered nurse and hold a current, unrestricted license or multistate licensure privilege and 480 hours in an ALF AIT program;

d. Complete at least 30 semester hours in an accredited college or university with courses in the content areas of (i) ~~client/resident~~ client or resident care, (ii) human resources management, (iii) financial management, (iv) physical environment, and (v) leadership and governance, and 480 hours in an ALF AIT program;

e. Hold a master's or a baccalaureate degree in health care-related field or a comparable field that meets the requirements of subsection B of this section with no internship or practicum and 320 hours in an ALF AIT program; ~~or~~

f. Hold a master's or baccalaureate degree in an unrelated field and 480 hours in an ALF AIT program; or

g. Have at least three years of health care experience, to include at least one consecutive year in a managerial or supervisory role, in a health care setting within the five years prior to application and 640 hours in an ALF AIT program. For purposes of this qualification, these definitions shall apply: (i) "health care experience" means

full-time equivalency experience in providing care to residents or patients in a health care setting; (ii) "health care setting" means a licensed home health organization, licensed hospice program, licensed hospital or nursing home, licensed assisted living facility, licensed adult day program, or licensed mental health or developmental services facility; and (iii) "managerial or supervisory role" means an employment role that includes management responsibility and supervision of two or more staff.

2. Certificate program.

Hold a baccalaureate or higher degree in a field unrelated to health care from an accredited college or university and successfully complete a certificate program with a minimum of 21 semester hours study in a health care-related field that meets course content requirements of subsection B of this section from an accredited college or university and successfully complete not less than a 320-hour internship or practicum that addresses the Domains of Practice as specified in 18VAC95-30-160 in a licensed assisted living facility as part of the certificate program under the supervision of a preceptor; or

3. Degree and practical experience.

Hold a baccalaureate or higher degree in a health care-related field that meets the course content requirements of subsection B of this section from an accredited college or university and have completed not less than a 320-hour internship or practicum that addresses the Domains of Practice as specified in 18VAC95-30-160 in a licensed assisted living facility as part of the degree program under the supervision of a preceptor.

B. To meet the educational requirements for a degree in a health care-related field, an applicant must provide an official transcript from an accredited college or university that documents successful completion of a minimum of 21 semester hours of coursework concentrated on the administration and management of health care services to include a minimum of six semester hours in the content area set out in subdivision 1 of this subsection, three semester hours in each of the content areas in subdivisions 2 through 5 of this subsection, and three semester hours for an internship or practicum.

1. Customer care, supports, and services;

2. Human resources;

3. Finance;

4. Environment;

5. Leadership and management.

18VAC95-30-160. Required content of an ALF administrator-in-training program.

A. Prior to the beginning of the training program, the preceptor shall develop and submit for board approval a training plan that shall include and be designed around the specific training needs of the administrator-in-training. The training plan shall include the tasks and the knowledge and skills required to complete those tasks as approved by NAB as the domains of practice for residential care/assisted living in effect at the time the training is being provided. An ALF AIT program shall include training in each of the learning areas ~~in the domains of practice~~ as outlined in the NAB AIT Manual.

B. An ALF AIT shall be required to serve weekday, evening, night, and weekend shifts and to receive training in all areas of an assisted living facility operation.

C. An AIT shall receive credit for no more than 40 hours of training per week.

D. An ALF AIT shall complete training on the care of residents with cognitive or mental impairments, including Alzheimer's disease and dementia.

18VAC95-30-170. Training facilities.

A. Training in an ALF AIT program or for an internship shall be conducted only in:

1. An assisted living facility or unit licensed by the Virginia Board of Social Services or by a similar licensing body in another jurisdiction;

2. An assisted living facility owned or operated by an agency of any city, county, or the Commonwealth or of the United States government; or

3. An assisted living unit located in and operated by a licensed hospital as defined in § 32.1-123 of the Code of Virginia, a state-operated hospital, or a hospital licensed in another jurisdiction.

B. ~~A new ALF AIT program or internship shall not be conducted in a~~ Training in an ALF AIT program or for an internship shall not be conducted in:

1. An assisted living facility with a provisional license as determined by the Department of Social Services in which the AIT program is a new ALF AIT program;

2. An assisted living facility with a conditional license as determined by the Department of Social Services in which the AIT applicant is the owner of the facility;

3. A facility that is licensed as residential only and does not require an administrator licensed by the Board of Long-Term Care Administrators; or

4. An assisted living facility with a licensed resident capacity of fewer than 20 residents.

18VAC95-30-180. Preceptors.

A. Training in an ALF AIT program shall be under the supervision of a preceptor who is registered or recognized by Virginia or a similar licensing board in another jurisdiction.

B. To be registered by the board as a preceptor, a person shall:

1. Hold a current, unrestricted Virginia assisted living facility administrator or nursing home administrator license;

2. Be employed full time as an administrator in a training facility for a minimum of two of the past four years immediately prior to registration or be a regional administrator with on-site supervisory responsibilities for a training facility;

3. Provide evidence that he has completed the online preceptor training course offered by NAB; and

4. Submit an application and fee as prescribed in 18VAC95-30-40. The board may waive such application and fee for a person who is already approved as a preceptor for nursing home licensure.

C. A preceptor shall:

1. Provide direct instruction, planning, and evaluation;

2. Be routinely present ~~with~~ for on-site supervision of the trainee in the training facility as appropriate to the experience and training of the ALF AIT and the needs of the residents in the facility; and

3. Continually evaluate the development and experience of the trainee to determine specific areas needed for concentration.

D. A preceptor may supervise no more than two trainees at any one time.

E. A preceptor for a person who is serving as an acting administrator while in an ALF AIT program shall be present in the training facility for face-to-face instruction and review of the trainee's performance for a minimum of four hours per week.

F. To renew registration as a preceptor, a person shall:

1. Hold a current, unrestricted Virginia assisted living facility or nursing home license and be employed by or have ~~an~~ a written agreement with a training facility for a preceptorship; and

2. Meet the renewal requirements of 18VAC95-30-60.

18VAC95-30-190. Reporting requirements.

A. The preceptor shall maintain progress reports on forms prescribed by the board for each month of training. The preceptor shall document in the progress report evidence of on-site supervision of the AIT training. For a person who is serving as an acting administrator while in an ALF AIT program, the preceptor shall include in the progress report evidence of face-to-face instruction and review for a minimum of ~~two~~ four hours per week.

B. The trainee's ~~certificate~~ final report of completion ~~plus~~ with the accumulated original monthly reports shall be submitted by the preceptor to the board within 30 days following the completion of the program.

VA.R. Doc. No. R21-6286; Filed December 29, 2021, 4:51 p.m.

BOARD OF PHARMACY

Final Regulation

Title of Regulation: **18VAC110-30. Regulations for Practitioners of the Healing Arts to Sell Controlled Substances (amending 18VAC110-30-10, 18VAC110-30-20, 18VAC110-30-21, 18VAC110-30-40, 18VAC110-30-270).**

Statutory Authority: §§ 54.1-2400 and 54.1-3307 of the Code of Virginia.

Effective Date: March 3, 2022.

Agency Contact: Caroline Juran, RPh, Executive Director, Board of Pharmacy, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 527-4456, FAX (804) 527-4472, or email caroline.juran@dhp.virginia.gov.

Summary:

Pursuant to Chapters 609 and 610 of the 2020 Acts of Assembly, the amendments (i) define the term "practitioner" to include nurse practitioners or physician assistants for the purpose of issuance of a limited-use license and (ii) include the allowance for issuance of a limited-use permit for nonprofit facilities for the sale of Schedule VI drugs and devices used in administration of such drugs.

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

18VAC110-30-10. Definitions.

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

"Board" means the Virginia Board of Pharmacy.

"Controlled substance" means a drug, substance or immediate precursor in Schedules I through VI of the Drug Control Act.

"Licensee" means a practitioner who is licensed by the Board of Pharmacy to sell controlled substances.

"Personal supervision" means the licensee must be physically present and render direct, personal control over the entire service being rendered or acts being performed. Neither prior nor future instructions shall be sufficient nor shall supervision be rendered by telephone, written instructions, or by any mechanical or electronic methods.

"Practitioner" or "practitioner of the healing arts" means a doctor of medicine, osteopathic medicine or podiatry who possesses a current active license issued by the Board of Medicine. For the purpose of a limited-use permit for a nonprofit facility, a "practitioner" or "practitioner of the

healing arts" may also mean a physician assistant with a current active license issued by the Board of Medicine or a nurse practitioner with a current active license issued by the Joint Boards of Nursing and Medicine.

"Sale" means barter, exchange, or gift, or offer thereof, and each such transaction made by any person, whether as an individual, proprietor, agent, servant or employee. It does not include the gift of manufacturer's samples to a patient.

"Special packaging" means packaging that is designed or constructed to be significantly difficult for children under five years of age to open or obtain a toxic or harmful amount of the controlled substance contained therein within a reasonable time and not difficult for normal adults to use properly, but does not mean packaging which all such children cannot open or obtain a toxic or harmful amount within a reasonable time.

"U.S.P.-N.F." means the United States Pharmacopeia-National Formulary.

18VAC110-30-20. Application for licensure.

A. Prior to engaging in the sale of controlled substances, a practitioner shall make application on a form provided by the board and be issued a license. After June 7, 2016, the practitioner shall engage in such sale from a location that has been issued a facility permit.

B. ~~In order to be eligible for a license to sell controlled substances, a practitioner shall possess a current, active license to practice medicine, osteopathic medicine, or podiatry issued by the Virginia Board of Medicine. Any disciplinary action taken by the Board of Medicine against the practitioner's license to practice shall constitute grounds for the board to deny, restrict, or place terms on the license to sell.~~ Prior to engaging in the sale of Schedule VI controlled substances, excluding the combination of misoprostol and methotrexate, and hypodermic syringes and needles for the administration of prescribed controlled substances from a nonprofit facility, a doctor of medicine, osteopathic medicine, or podiatry, a nurse practitioner, or a physician assistant shall make application on a form provided by the board and be issued a limited-use license.

C. Any disciplinary action taken by the Board of Medicine, or in the case of a nurse practitioner, by the Joint Boards of Nursing and Medicine, against the practitioner's license to practice shall constitute grounds for the board to deny, restrict, or place terms on the license to sell.

18VAC110-30-21. Application for facility permit.

A. After June 7, 2016, any location at which practitioners of the healing arts sell controlled substances shall have a permit issued by the board in accordance with § 54.1-3304.1 of the Code of Virginia. A licensed practitioner of the healing arts shall apply for the facility permit on a form provided by the board.

B. For good cause shown, the board may issue a limited-use facility permit when the scope, degree, or type of services provided to the patient is of a limited nature. The permit to be issued shall be based on conditions of use requested by the applicant or imposed by the board in cases where certain requirements of this chapter may be waived.

1. The limited-use facility permit application shall list the regulatory requirements for which a waiver is requested, if any, and a brief explanation as to why each requirement should not apply to that practice.

2. A policy and procedure manual detailing the type and volume of controlled substances to be sold and safeguards against diversion shall accompany the application.

3. The issuance and continuation of a limited-use facility permit shall be subject to continuing compliance with the conditions set forth by the board.

4. A limited-use facility permit may be issued to a nonprofit facility for the purpose of dispensing Schedule VI controlled substances, excluding the combination of misoprostol and methotrexate, and hypodermic syringes and needles for the administration of prescribed controlled substances.

C. The executive director may grant a waiver of the security system when storing and selling multiple strengths and formulations of no more than five different topical Schedule VI drugs intended for cosmetic use.

18VAC110-30-40. Acts to be performed by the licensee.

A. The selection of the controlled substance from the stock, any preparation or packaging of a controlled substance or the preparation of a label for a controlled substance to be transferred to a patient shall be the personal responsibility of the licensee.

1. Any compounding of a controlled substance shall be personally performed by the licensee or a registered pharmacy technician under the supervision of the licensee.

2. A licensee may supervise one person who may be present in the storage and selling area to assist in performance of pharmacy technician tasks, as set forth in § 54.1-3321 of the Code of Virginia, provided such person is not licensed to sell controlled substances and is either:

a. A pharmacy technician registered with the board; or

b. A licensed nurse or physician assistant who has received training in technician tasks consistent with training required for pharmacy technicians.

3. Unless using one of the board-approved training courses for pharmacy technicians, a licensee who uses a nurse or physician assistant to perform pharmacy technician tasks shall develop and maintain a training manual and shall document that such licensee has successfully completed general training in the following areas:

a. The entry of prescription information and drug history into a data system or other recordkeeping system;

b. The preparation of prescription labels or patient information;

c. The removal of the drug to be dispensed from inventory;

d. The counting or measuring of the drug to be dispensed to include pharmacy calculations;

e. The packaging and labeling of the drug to be dispensed and the repackaging thereof;

f. The stocking or loading of automated dispensing devices or other devices used in the dispensing process, if applicable; and

g. Applicable laws and regulations related to dispensing.

4. A licensee who employs or uses pharmacy technicians, licensed nurses or physician assistants to assist in the storage and selling area shall develop and maintain a site-specific training program and manual for training to work in that practice. The program shall include training consistent with that specific practice to include~~, but not be limited to,~~ training in proper use of site-specific computer programs and equipment, proper use of other equipment used in the practice in performing technician duties, and pharmacy calculations consistent with the duties in that practice.

5. A licensee shall maintain documentation of successful completion of the site-specific training program for each pharmacy technician, nurse or physician assistant for the duration of the employment and for a period of two years from date of termination of employment. Documentation for currently employed persons shall be maintained on site or at another location where the records are readily retrievable upon request for inspection. After employment is terminated, such documentation may be maintained at an off-site location where it is retrievable upon request.

B. Prior to the dispensing, the licensee shall:

1. Conduct a prospective drug review and offer to counsel a patient in accordance with provisions of § 54.1-3319 of the Code of Virginia; and

2. Inspect the prescription product to verify its accuracy in all respects, and place his initials on the record of sale as certification of the accuracy of, and the responsibility for, the entire transaction.

C. If the record of sale is maintained in an automated data processing system as provided in 18VAC110-30-200, the licensee shall personally place his initials with each entry of a sale as a certification of the accuracy of, and the responsibility for, the entire transaction.

18VAC110-30-270. Grounds for disciplinary action.

In addition to those grounds listed in § 54.1-3316 of the Code of Virginia, the board may revoke, suspend, refuse to issue or renew a license to sell controlled substances or may deny any application if it finds that the licensee or applicant has had his license to practice medicine, osteopathic medicine, or podiatry or license as a physician assistant or nurse practitioner suspended or revoked in Virginia or in any other state or no longer holds a current active license to practice in the Commonwealth of Virginia.

VA.R. Doc. No. R21-6380; Filed January 12, 2022, 11:35 a.m.

BOARD OF COUNSELING

Proposed Regulation

Titles of Regulations: **18VAC115-20. Regulations Governing the Practice of Professional Counseling (amending 18VAC115-20-10, 18VAC115-20-40, 18VAC115-20-45, 18VAC115-20-51, 18VAC115-20-52, 18VAC115-20-106 through 18VAC115-20-140).**

18VAC115-50. Regulations Governing the Practice of Marriage and Family Therapy (amending 18VAC115-50-10, 18VAC115-50-20, 18VAC115-50-40, 18VAC115-50-55, 18VAC115-50-60, 18VAC115-50-70, 18VAC115-50-96 through 18VAC115-50-120).

18VAC115-60. Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners (amending 18VAC115-60-10, 18VAC115-60-20, 18VAC115-60-40 through 18VAC115-60-90, 18VAC115-60-116 through 18VAC115-60-140).

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

Public Hearing Information:

February 18, 2022 - noon - Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room 4, Richmond, VA 23233

Public Comment Deadline: April 1, 2022.

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.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Counseling the authority to promulgate regulations to administer the regulatory system. Specific authority for regulation of the profession of counseling is found in §§ 54.1-3503 and 54.1-3506 of the Code of Virginia.

Purpose: The board has added more pathways to licensure by endorsement to encourage portability for licensees from other states. By doing so, Virginia citizens with mental health needs may have greater access to care. Additional standards of conduct and causes for disciplinary action will provide further guidance to licensees on the expectations for ethical practice and give the board more explicit grounds on which to discipline practitioners for the purpose of protecting the health, safety, and welfare of the public they serve.

Substance: The intent of the amendments resulting from the periodic review is to update regulations, clarify language, achieve consistency among requirements for licensees, and facilitate obtaining license by endorsement. Additional standards of practice and ground for disciplinary action are included to address issues that have arisen or for consistency with other behavioral health professional regulations. Amendments for residents and residencies that are currently in effect through emergency action are incorporated into this periodic review to avoid confusion and conflict. Similar changes are recommended in all three chapters, with some specific amendments to 18VAC115-50 and 18VAC115-60, including elimination of the waiver of a licensing examination in marriage and family therapy or substance abuse treatment for counselors who want to obtain those specialized licenses.

Issues: The advantages to the public include more accountability and transparency for residencies and additional standards of practice to facilitate ethical practice and professional conduct; there are no disadvantages for the public. Amendments to licensure by endorsement may benefit a small number of applicants who are now unable to be initially licensed in Virginia. There are no advantages or disadvantages to the agency or the Commonwealth, other than amendments are intended to clarify regulatory requirements.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to a periodic review,[1] the Board of Counseling (Board) proposes to: 1) expand pathways to licensure by endorsement, depending in part on whether the applicant's degree was from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), 2) deem a degree from a CACREP-accredited program to meet the current coursework requirements, 3) remove a waiver of examination requirements from licensed professional counselors who wish to obtain specialty licenses, 4) add a $75 fee for reinstating a resident license, 5) require maintenance of records relating to supervision for a period of five years, 6) amend the definition of "face-to-face" to include communications through visual, interactive, real-time technology, 7) add an allowance for up to two hours of continuing education credits, and 8) introduce additional standards of practice and grounds for disciplinary action.

Background. The Board issues three types of licenses relevant to this action: general counseling, marriage and family therapy, and substance abuse treatment. A general counseling licensee can offer marriage and family therapy or substance abuse treatment, but not vice versa. In that sense, marriage and family therapy or substance abuse treatment licenses are specialty licenses. Also, an individual may have a specialty license, but may lack the general counseling license (i.e., cannot practice outside the specialty area).

Estimated Benefits and Costs.

Pathways to licensure by endorsement. The Board proposes to expand pathways to licensure by endorsement in several ways. In simple terms, licensure by endorsement allows a licensed professional in one state to obtain licensure in another state. Currently, licensure by endorsement in all three license categories requires evidence of either (i) the education and experience required for licensure by examination or (ii) post-licensure clinical practice in 24 of the last 60 months immediately preceding licensure application in Virginia. However, the proposed changes for the three license categories differ slightly.

For both general counselors and marriage and family therapists who lack the required evidence of post-licensure clinical practice,[2] the Board would now accept applicants if they have either (a) three years of active licensure along with a National Certified Counselor (NCC) credential issued by the National Board for Certified Counselors (NBCC), or (b) a graduate-level degree from a CACREP-accredited program. If the individual lacks an NCC credential or the degree from a CACREP-accredited program, he or she must then have ten years of active licensure. Although these are presently distinct options, after January 2022 only one option will effectively exist. At that point, the NBCC states that only those students graduating from a CACREP-accredited program will be eligible to apply for the NCC credential.[3]

According to the Department of Health Professions (DHP), the Board included these two options to follow the October 2019 recommendations of the National Portability Taskforce, comprised of the American Association of State Counseling Board, the Association for Counselor Education and Supervision, the American Mental Health Counselors Association, and the NBCC. The taskforce recommended several pathways, including that the applicant meet the current standards for endorsement set by the licensing board. Otherwise, the taskforce provided other options that it recommended for applicants who also have been actively licensed as a counselor for at least three years.[4]

For the general counselors only, the Board proposes to accept verification of the Certified Clinical Mental Health Counselor (CCMHC) credential from the NBCC (this option replaces the credential registry of the American Association of State Counseling Boards because that registry no longer exists). After January of 2022, this option will also effectively require the applicant to have graduated from a CACREP-accredited program because the NCC credential is a prerequisite for the CCMHC.

For the substance abuse practitioners, the Board would start accepting a mental health license in good standing from any other United States jurisdiction in addition to a Virginia mental health license, and a licensing examination deemed to be substantially equivalent by the Board if the applicant is licensed in another jurisdiction.

The Board also proposes to count teaching graduate-level courses in counseling or marriage and family therapy toward

the required post-licensure clinical practice for the two relevant license types.

The proposed additional pathways to licensure by endorsement would benefit a number of applicants who are now unable to be initially licensed in Virginia. Also, counting teaching graduate courses as active practice would make more individuals eligible. In 2019, DHP issued 201, 48, and 35 licenses by endorsement respectively for general counseling, marriage and family therapy, and substance abuse treatment. The proposed amendments to licensure by endorsement would add to the supply of these services, improve accessibility, and be beneficial for the Commonwealth.

Notwithstanding the clearly beneficial aspects of expanding pathways to licensure compared to the status quo, the differential treatment of graduate programs based upon their accreditation would likely directly affect the number of counselors who are eligible for licensure by endorsement, and indirectly affect the relative values of counseling degrees. Under the proposed regulations, a similarly situated counselor with a degree from a non-CACREP accredited institution would have to wait an additional seven years to access Virginia's mental health services market. This delay would likely decrease the number of persons who would otherwise be eligible to practice as counselors in Virginia, and diminish the relative value of degrees from non-CACREP accredited programs compared to those with CACREP accreditation. To the extent a benefit results from this differential treatment, this decrease in the number of eligible counselors and relative value may be offset, but the Board did not provide any information to indicate the basis for the differential treatment or the nature and extent of the benefits that would result. An assessment of the impact of this differential treatment, both benefits and costs, would also require information on the accreditation status of programs for applicants seeking licensure by endorsement, but the Board reports these data are not maintained.

Although the Board reports that it is generally following the recommendations of the taskforce, it appears that the Board's proposal differs in certain aspects that limit the number of counselors who would have been eligible for licensure by endorsement under the taskforce's full recommendations. First, the taskforce recommended acceptance of degrees from a CACREP-accredited program as one pathway, but that this apply only to degrees awarded after January 1, 2025. In contrast, the Board proposes to implement this requirement when this regulation becomes effective. The Board's proposal would therefore appear to further decrease the number of non-CACREP graduates who are eligible for licensure by endorsement, and reduce the time available to a potential counseling student to adjust his or her choices regarding graduate counseling programs in light of this change. Second, the taskforce recommended acceptance of degrees awarded by a regionally accredited program before January 1, 2025. Many counseling programs may not have a program specific accreditation, but rather rely on regional accreditation for the entire institution. Because this option is not included in the proposed regulation, there may be an additional reduction in the number of counselors who would have qualified for licensure by endorsement under the taskforce's recommendations. Third, the taskforce recommends that degrees from programs that lack either CACREP or regional accreditation be accepted, if the degree was awarded prior to December 1, 2014, and the applicant has three years of active licensure. Although this option is not included in the proposed regulation, the Board's proposal to require ten years of active licensure for any applicant from a non CACREP-accredited program would also appear to decrease the number of persons who would have been eligible for licensure by endorsement under the taskforce's recommendations. To the extent a benefit results from the Board's decision to not adopt all of the taskforce's recommendations, the likely decrease in the number of eligible counselors may be offset, but the Board did not provide any information to indicate the basis for their decision or the nature and extent of the benefits that would result.

Qualifying coursework. The Board proposes to add language that would essentially deem that all applicants with degrees from CACREP-accredited programs meet the current coursework requirements.[5] In contrast, current language contains specific coursework requirements for licensure for each of the three practice areas. For example, the coursework requirements for professional counseling are a minimum of 60 semester hours or 90 quarter hours of graduate study with a minimum of three semester hours or 4.0 quarter hours in 12 specific areas. The specific areas are: 1) professional counseling identity, function, and ethics, 2) theories of counseling and psychotherapy, 3) counseling and psychotherapy techniques, 4) human growth and development, 5) group counseling and psychotherapy theories and techniques, 6) career counseling and development theories and techniques, 7) appraisal, evaluation, and diagnostic procedures, 8) abnormal behavior and psychopathology, 9) multicultural counseling theories and techniques, 10) research, 11) diagnosis and treatment of addictive disorders, 12) marriage and family systems theory. In addition, 600 hours of supervised internship with 240 hours of face-to-face client contact is required. Similarly, the coursework requirements for licensed marriage and family therapy and substance abuse treatment are specifically listed in the regulation.

Currently the Board reviews the applicant's transcript "course by course" often with a request for a syllabus to determine its concentration in counseling. According to DHP, the proposed change simply acknowledges that the Board has reviewed the requirements for a degree in clinical mental health counseling from a CACREP-accredited program and knows that it has met all such requirements. Thus, instead of a course-by-course review of a transcript, the proposal would allow the Board only to look at whether the degree is from a CACREP-accredited program. The coursework submitted from a non-CACREP-accredited program would still need to be reviewed to ensure that it meets the specific coursework requirements. DHP states

that the proposal essentially reflects the current practice the Board follows in evaluating coursework submitted and therefore does not expect any significant economic impact from this change.

However, as in the licensure by endorsement, this proposal too would likely decrease the relative value of degrees from non-CACREP accredited institutions. Although this change would ensure that a coursework from a CACREP-accredited institution would always meet the Board's standards, coursework from a non-CACREP institution would continue to be reviewed on a case-by-case basis. The added certainty stemming from this change would likely make degrees from a CACREP-accredited institution relatively more valuable.

Additionally, the Board proposes to allow an option to approve the completion of up to 100 of the 600 hours and up to 40 of the 240 hours of face-to-face client contact to be added to the hours required for residency if the academic course was less than 600 hours. The new language would facilitate licensure for some applicants from non-accredited programs. Currently, some applicants have to find an educational program that will allow them to enroll in an academic course that is comprised of internship hours. The amended language would permit graduates to obtain a resident license and complete the required internship hours in the residency. Since there is faculty oversight of an internship in an academic program, the Board believes it is still necessary for the vast majority of the internship to be completed as part of a student's educational program.

Specialty license examination. Historically, the specialty license examination has been waived for general counseling licensees if they wished to obtain a specialty license. The Board proposes to remove that waiver so that a general counseling licensee would be required to pass the specialty examination for the area if they wished to obtain a specialty license. That does not mean that a general counseling licensee can no longer practice a specialty area, but rather it means that if they wish to get a specialty license issued (e.g. for marketing purposes), now they have to pass the specialty examination. Accordingly, this particular change would introduce additional burdens on general counselors who may wish to obtain a specialty license in terms of the time required to prepare for, take the specialty exam, and the exam fees. According to DHP, the cost for the marriage and family therapy specialty exam is $355 and the cost for the substance abuse treatment specialty exam is $150.

Other changes.[6] The Board proposes to add a $75 fee for reinstatement of a resident license. This fee is added to cover the administrative costs of reinstatement of resident licenses. A resident who fails to renew after one year would be able to reinstate within the six-year window allowed for completion of a residency. The requirements for reinstatement of a resident license are similar to the reinstatement of a full license. An applicant for reinstatement would have to submit a current report from a national practitioner databank at a cost of $4 per report to ensure the Board has more complete information about disciplinary actions in other states or malpractice judgements. The main intent of the amendment is to provide an allowance for a person who needs or wants a break in a residency (illness, family responsibility, etc.) to let the license lapse, but reinstate at a later time to complete the hours. Residency hours (3,400) can be completed in less than two years, so a person could have a lapse of some months and still complete the required hours within a six-year timeframe. The Board does not propose to allow reinstatement indefinitely, because there needs to be some continuity in the supervised experience of a residency and there is concern about "permanent" residents who would continuously lapse and reinstate.

A proposed new provision specifies the maintenance of records relating to supervision for a period of five years after termination or completion of supervision. According to DHP, the five-year retention is necessary to ensure records are available to residents and to the Board within the timeframe in which the resident may be applying for licensure. The requirement for retention of records by a supervisor relating to a residency should not impose costs (other than retention of a file); a licensee typically only supervises a handful of residents.

The definition for "face-to-face" is amended to include use of visual, interactive, real-time technology in the in-person delivery of clinical services. The amendment may enhance the ability to provide counseling services by telehealth and facilitate supervision of residents.

The Board proposes to add an allowance for up to two hours of continuing education credits per renewal period for attendance at board meetings/hearings. Attendance at Board meetings or hearings may increase practitioner's knowledge concerning issues affecting their profession.

Additional standards of practice and grounds for disciplinary action are proposed to be included to address issues that have arisen or for consistency with other behavioral health professional regulations. These amendments would provide further guidance to licensees on the expectations for ethical practice and give the Board more explicit grounds on which to discipline practitioners for the purpose of protecting the health, safety and welfare of the public they serve.

Businesses and Other Entities Affected. Persons likely to be affected by the proposed changes are residents in counseling and licensees. According to DHP, there are 9,156 residents in professional counseling, 352 residents in marriage and family therapy, and eight residents in substance abuse practice. There are 6,004 licensed professional counselors, 894 licensed marriage and family therapists, and 265 licensed substance abuse practitioners.

The proposed changes remove the waiver for the specialty examination for those general counselors who wish to obtain a specialty license. However, it is not clear whether the costs associated with that change clearly outweigh the benefits from

other changes for the same individuals. Thus, no adverse economic impact[7] is indicated on general counselors.

However, the counselors who hold degrees from non-CACREP accredited institutions would be negatively affected in terms of the lower relative value of their degrees compared to the value of degrees from CACREP-accredited institutions. Since there is no offsetting benefits, an adverse impact on counselors or students in non-CACREP accredited programs is indicated.

Small Businesses[8] Affected. The Board reports that some persons licensed for independent practice own or are employed by small professional practices.

Types and Estimated Number of Small Businesses Affected. The Board does not maintain data on the number of applicants or licensees that meet the definition of a small business.

Costs and Other Effects. Most of the proposed amendments are expected to be beneficial as discussed above, with the exception of those that provide differential treatment regarding portability and eligible coursework requirements for programs with CACREP accreditation. To the extent counselors with non-CACREP accredited degrees seek to, operate as, or work for small businesses, an adverse impact on them would be indicated.

Alternative Method that Minimizes Adverse Impact. The adverse impact on counselors or students with non-CACREP accredited degrees could be mitigated by adopting the additional pathways recommended by the taskforce. Specifically, the taskforce also recommended acceptance of (a) degrees from regionally-accredited programs, awarded before January 1, 2025, if the applicant also has three years of active licensure, and (b) degrees from programs without CACREP or regional accreditation if the degree was awarded prior to December 1, 2014, and the applicant has three years of active licensure.

Localities[9] Affected.[10] The proposed amendments do not introduce costs for local governments. Accordingly, no additional funds would be required.

Projected Impact on Employment. The proposed amendments would make it easier to obtain licensure by endorsement and may add to the supply of licensed counselors in Virginia compared to the status quo. As mentioned above, the proposed changes would likely have a negative impact on employment prospects of counselors and students with degrees in non-CACREP accredited programs while improving the prospects of CACREP accredited program graduates.

Effects on the Use and Value of Private Property. The proposed amendments would negatively affect the relative value of non-CACREP degrees while enhancing the value of CACREP accredited degrees.

[1]https://townhall.virginia.gov/L/ViewPReview.cfm?PRid=1673

[2]According to DHP, there is no known NCC credential or CACREP accredited programs for substance abuse counseling specialty.

[3]See https://www.nbcc.org/Assets/EducationalStandards.pdf

[4]The taskforce's full recommendation can be found at https://www.amhca.org/advocacy/portability/portability2019

[5]More precisely, for professional counseling, the applicant shall have successfully completed the requirements for a degree in a program accredited by CACREP in clinical mental health counseling or any other specialty approved by the Board; for marriage and family therapy the applicant shall have successfully completed the requirements for a marriage and family therapy program accredited by CACREP; for substance abuse treatment the applicant shall have successfully completed the requirements for a degree in a program accredited by CACREP in addiction counseling or any other specialty approved by the Board.

[6]The proposed amendments for residents and residencies that are currently in effect through emergency action are incorporated into this periodic review to avoid confusion and conflict. The economic effects of those changes are discussed in the relevant action and are not repeated here. See the Economic Impact of https://townhall.virginia.gov/l/viewstage.cfm?stageid=8897

[7]Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined.

[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."

[9]"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.

[10]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

Agency's Response to Economic Impact Analysis:

The Board of Counseling would like to address some misinterpretations or mischaracterizations of the board's proposed endorsement provisions and coursework review.

Page 1: The goal of the periodic review is to expand pathways to licensure by endorsement significantly beyond what the regulations currently allow. That is all. The board has expanded the options for all types of applicants and the board's actions have not limited any applicant's options. An applicant's own choices may limit the availability of options, but the board attempted to allow multiple scenarios for obtaining a license by endorsement.

Page 2: Licensure by endorsement allows a licensed professional in one state to obtain a comparable license in another state potentially without having to retake the exam or meet all of Virginia's requirements for initial licensure in Virginia. Currently there are only two pathways to licensure by endorsement: (i) have clinically practiced for 24 out of the past 60 months prior to submitting an application; or (ii) submit evidence of meeting the education and experience Virginia requires for licensure by examination. Now, the board proposes to significantly expand on those two pathways to licensure by endorsement in the following ways: If an applicant has not clinically practiced for 24 out of the past 60 months prior to submitting an application (in which case the applicant would not have to meet Virginia's education or experience requirements), then the applicant now can obtain licensure by endorsement if by meeting one of the following options: (i) three years of active licensure (which does not mean active

practice) along with a National Certified Counselor (NCC) credential issued by the National Board for Certified Counselors (NBCC); (ii) hold a graduate degree from a CACREP-accredited program; or (iii) have 10 years of active licensure (which again does not mean active practice). The applicant just has to maintain a license in an active status. Even if after January 2022, NBCC requires graduation from a Council for Accreditation of Counseling and Related Educational Programs (CACREP) program, the board still has expanded the pathways for endorsement, which is a positive step forward in this environment. Additionally, the board considered these options at the behest of the national organizations and considered public comment.

Pages 3 and 4: An individual who did not graduate from a CACREP program would still have the same options as are currently available; that is, an applicant could obtain licensure in another state, practice for two years, and then apply by endorsement in Virginia. If the board did not expand the options for licensure then these individuals would still have the same opportunities for licensure in Virginia as they do now. At this point, all of Virginia's universities are either CACREP accredited or seeking accreditation. The board wants to encourage applicants to attend accredited programs, as all other health professions require graduation from accredited programs. Because CACREP is currently the only accreditation program, the board has left it open to allow acceptance of other programs. The board, unlike other health programs, has not required graduation from an accredited program. All graduates still have an opportunity to obtain licensure in Virginia. It helps applicants to know that graduation from a CACREP program will help ensure an easier path to licensure so the applicants do not find themselves spending money on a program that does nothing to further their pursuit of licensure.

Page 6: Graduates from non-CACREP programs would still have their transcripts reviewed by staff, but having a degree from an accredited program ensures staff can trust the program has already required all of the coursework that the board requires in regulation. It does benefit the applicant to graduate from an accredited program for the same reasons it benefits all other professions to graduate from an accredited program. It protects the applicant from any uncertainty within the process.

Summary:

The proposed amendments (i) expand pathways to licensure by endorsement; (ii) provide that a degree from a Council for Accreditation of Counseling and Related Educational Programs-accredited program meets the current coursework requirements; (iii) remove a waiver of examination requirements from licensed professional counselors who wish to obtain specialty licenses; (iv) add a $75 fee for reinstating a resident license; (v) require maintenance of records relating to supervision for a period of five years; (vi) amend the definition of "face-to-face" to include communications through visual, interactive, real-time technology; (vii) add an allowance for up to two hours of continuing education credits; and (viii) introduce additional standards of practice and grounds for disciplinary action.

18VAC115-20-10. 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"

"Counseling"

"Professional counselor"

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

"Ancillary counseling services" means activities such as case management, recordkeeping, referral, and coordination of services.

"Applicant" means any individual who has submitted an official application and paid the application fee for licensure as a professional counselor.

"CACREP" means the Council for Accreditation of Counseling and Related Educational Programs.

"Candidate for licensure" means a person who has satisfactorily completed all educational and experience requirements for licensure and has been deemed eligible by the board to sit for its examinations.

"Clinical counseling services" means activities such as assessment, diagnosis, treatment planning, and treatment implementation.

"Competency area" means an area in which a person possesses knowledge and skill and the ability to apply them in the clinical setting.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"CORE" means Council on Rehabilitation Education.

"Exempt setting" means an agency or institution in which licensure is not required to engage in the practice of counseling according to the conditions set forth in § 54.1-3501 of the Code of Virginia.

"Face-to-face" means the in-person delivery of clinical counseling services for a client or the use of visual, real-time, interactive, secured technology for delivery of such services.

"Group supervision" means the process of clinical supervision of no more than six persons in a group setting provided by a qualified supervisor.

"Internship" means a formal academic course from a regionally accredited college or university in which supervised, practical experience is obtained in a clinical setting in the application of counseling principles, methods, and techniques.

"Jurisdiction" means a state, territory, district, province, or country that has granted a professional certificate or license to practice a profession, use a professional title, or hold oneself out as a practitioner of that profession.

"Nonexempt setting" means a setting that does not meet the conditions of exemption from the requirements of licensure to engage in the practice of counseling as set forth in § 54.1-3501 of the Code of Virginia.

"Regional accrediting agency" means one of the regional accreditation agencies recognized by the U.S. Secretary of Education responsible for accrediting senior postsecondary institutions.

"Residency" means a postgraduate, supervised, clinical experience.

"Resident" means an individual who has a supervisory contract and has been issued a temporary license by the board to provide clinical services in professional counseling under supervision.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual or group consultation, guidance, and instruction that is specific to the clinical counseling services being performed with respect to the clinical skills and competencies of the person supervised.

"Supervisory contract" means an agreement that outlines the expectations and responsibilities of the supervisor and resident in accordance with regulations of the board.

18VAC115-20-40. Prerequisites for licensure by examination.

Every applicant for licensure examination by the board shall:

1. Meet the degree program requirements prescribed in 18VAC115-20-49, the coursework requirements prescribed in 18VAC115-20-51, and the experience requirements prescribed in 18VAC115-20-52;

2. Pass the licensure examination specified by the board;

3. Submit the following to the board:

a. A completed application;

b. Official transcripts documenting the applicant's completion of the degree program and coursework requirements prescribed in 18VAC115-20-49 and 18VAC115-20-51. Transcripts previously submitted for board approval of a resident license do not have to be resubmitted unless additional coursework was subsequently obtained;

c. Verification of supervision forms documenting fulfillment of the residency requirements of 18VAC115-20-52 and copies of all required evaluation forms, including verification of current licensure of the supervisor if any portion of the residency occurred in another jurisdiction;

d. Verification of any other mental health or health professional license or certificate ever held in another jurisdiction;

e. The application processing and initial licensure fee as prescribed in 18VAC115-20-20; and

f. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank ~~(NPDB)~~; and

4. Have no unresolved disciplinary action against a mental health or health professional license ~~or~~, certificate, or registration held in Virginia or in another jurisdiction. The board will consider history of disciplinary action on a case-by-case basis.

18VAC115-20-45. Prerequisites for licensure by endorsement.

A. Every applicant for licensure by endorsement shall hold or have held a professional counselor license for independent clinical practice in another jurisdiction of the United States and shall submit the following:

1. A completed application;

2. The application processing fee and initial licensure fee as prescribed in 18VAC115-20-20;

3. Verification of all mental health or health professional licenses ~~or~~, certificates, or registrations the applicant holds or has ever held 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;

4. Documentation of having completed education and experience requirements as specified in subsection B of this section;

5. Verification of a passing score on an examination required for counseling licensure in the jurisdiction in which licensure was obtained;

6. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank ~~(NPDB)~~; and

7. An ~~affidavit~~ attestation of having read and understood the regulations and laws governing the practice of professional counseling in Virginia.

B. Every applicant for licensure by endorsement shall meet one of the following:

1. Educational requirements consistent with those specified in 18VAC115-20-49 and 18VAC115-20-51 and experience requirements consistent with those specified in 18VAC115-20-52; or

2. ~~If an applicant does not have~~ In lieu of documentation of educational and experience credentials consistent with those required by this chapter, ~~he shall~~ the applicant may provide:

~~a. Documentation of education and supervised experience that met the requirements of the jurisdiction in which he was initially licensed as verified by an official transcript and a certified copy of the original application materials; and~~

~~b.~~ a. Evidence of post-licensure clinical practice in counseling, as defined in § 54.1-3500 of the Code of Virginia, at the highest level for independent practice for 24 of the last 60 months immediately preceding his licensure application in Virginia. Clinical practice shall mean the rendering of direct clinical counseling services ~~or,~~ clinical supervision of counseling services, or teaching graduate-level courses in counseling; ~~or~~

~~3. In lieu of transcripts verifying education and documentation verifying supervised experience, the board may accept verification from the credentials registry of the American Association of State Counseling Boards or any other board-recognized entity.~~

b. Verification of the Certified Clinical Mental Health Counselor credential from the National Board of Certified Counselors (NBCC) or any other board-recognized entity;

c. Evidence of an active license at the highest level of counselor licensure for independent practice for at least 10 years prior to the date of application; or

d. Evidence of an active license at the highest level of counselor licensure for independent practice for at least three years prior to the date of application and one of the following:

(1) The National Certified Counselor credential, in good standing, as issued by the NBCC; or

(2) A graduate-level degree from a program accredited in clinical mental health counseling by CACREP.

18VAC115-20-51. Coursework requirements.

A. The applicant shall have successfully completed ~~60~~:

1. The requirements for a degree in a program accredited by CACREP in clinical mental health counseling or any other specialty approved by the board; or

2. Sixty semester hours or 90 quarter hours of graduate study in the following core coursework with a minimum of three semester hours or 4.0 quarter hours in each of subdivisions ~~1 through 12~~ 2 a through 2 l of this subsection:

~~1.~~ a. Professional counseling identity, function, and ethics;

~~2.~~ b. Theories of counseling and psychotherapy;

~~3.~~ c. Counseling and psychotherapy techniques;

~~4.~~ d. Human growth and development;

~~5.~~ e. Group counseling and psychotherapy theories and techniques;

~~6.~~ f. Career counseling and development theories and techniques;

~~7.~~ g. Appraisal, evaluation, and diagnostic procedures;

~~8.~~ h. Abnormal behavior and psychopathology;

~~9.~~ i. Multicultural counseling theories and techniques;

~~10.~~ j. Research;

~~11.~~ k. Diagnosis and treatment of addictive disorders;

~~12.~~ l. Marriage and family systems theory; and

~~13.~~ 3. Supervised internship as a formal academic course of at least 600 hours to include 240 hours of face-to-face client contact. Only internship hours earned after completion of 30 graduate semester hours may be counted ~~towards~~ toward residency hours. If the academic course was less than 600 hours, the board may approve the completion of up to 100 of the 600 hours and up to 40 of the 240 hours of face-to-face client contact to be added to the hours required for residency.

B. If 60 graduate hours in counseling were completed prior to April 12, 2000, the board may accept those hours if they meet the regulations in effect at the time the 60 hours were completed.

18VAC115-20-52. Resident license and requirements for a residency.

A. Resident license. Applicants for temporary licensure as a resident in counseling shall:

1. Apply for licensure on a form provided by the board to include the following: (i) verification of a supervisory contract, (ii) the name and licensure number of the clinical supervisor and location for the supervised practice, and (iii) an attestation that the applicant will be providing clinical counseling services;

2. Have submitted an official transcript documenting a graduate degree that meets the requirements specified in 18VAC115-20-49 to include completion of the coursework and internship requirement specified in 18VAC115-20-51;

3. Pay the ~~registration~~ resident licensure fee;

4. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank ~~(NPDB)~~; and

5. Have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration in Virginia or in another jurisdiction. The board will consider the history of disciplinary action on a case-by-case basis.

B. Residency requirements.

1. The applicant for licensure as a professional counselor shall have completed a 3,400-hour supervised residency in the role of a professional counselor working with various populations, clinical problems, and theoretical approaches in the following areas:

a. Assessment and diagnosis using psychotherapy techniques;

b. Appraisal, evaluation, and diagnostic procedures;

c. Treatment planning and implementation;

d. Case management and recordkeeping;

e. Professional counselor identity and function; and

f. Professional ethics and standards of practice.

2. The 3,400-hour residency shall include a minimum of 200 hours of in-person supervision between supervisor and resident in the consultation and review of clinical counseling services provided by the resident. Supervision shall occur at a minimum of one hour and a maximum of four hours per 40 hours of work experience during the period of the residency. For the purpose of meeting the 200-hour supervision requirement, in-person may include the use of secured technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident. Up to 20 hours of the supervision received during the supervised internship may be counted toward the 200 hours of in-person supervision if the supervision was provided by a licensed professional counselor.

3. No more than half of the 200 hours may be satisfied with group supervision. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

4. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of approved supervision.

5. The residency shall include at least 2,000 hours of face-to-face client contact in providing clinical counseling services. The remaining hours may be spent in the performance of ancillary counseling services.

6. A graduate-level internship in excess of 600 hours, which was completed in a program that meets the requirements set forth in 18VAC115-20-49, may count for up to an additional 300 hours toward the requirements of a residency.

7. Supervised practicum and internship hours in a CACREP-accredited doctoral counseling program may be accepted for up to 900 hours of the residency requirement and up to 100 of the required hours of supervision provided the supervisor holds a current, unrestricted license as a professional counselor.

8. The residency shall be completed in not less than 21 months or more than ~~four~~ six years. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, ~~2020~~ 2022. ~~An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue.~~ A resident shall meet the renewal requirements of subsection C of 18VAC115-20-100 in order to maintain a license in current, active status.

9. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

10. Residents may not call themselves professional counselors, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners or professional counselors. During the residency, residents shall use their names and the initials of their degree, their resident license number, and the title "Resident in Counseling" in all written communications. Clients shall be informed in writing that the resident does not have authority for independent practice and is under supervision and shall provide the supervisor's name, professional address, and phone number.

11. Residents shall not engage in practice under supervision in any areas for which they have not had appropriate education.

12. Residency hours shall be accepted if they were approved by the licensing board in another United States jurisdiction ~~that meet~~ and completed in that jurisdiction, and if those hours are consistent with the requirements of this ~~section shall be accepted~~ subsection.

C. Supervisory qualifications. A person who provides supervision for a resident in professional counseling shall:

1. Document two years of post-licensure clinical experience;

2. Have received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-20-106; and

3. Hold an active, unrestricted license as a professional counselor or a marriage and family therapist in the jurisdiction where the supervision is being provided. At least 100 hours of the supervision shall be rendered by a licensed professional counselor. ~~Supervisors who are substance abuse treatment practitioners, school psychologists, clinical psychologists, clinical social workers, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.~~

D. Supervisory responsibilities.

1. Supervision by any individual whose relationship to the resident compromises the objectivity of the supervisor is prohibited.

2. The supervisor of a resident shall assume full responsibility for the clinical activities of that resident specified within the supervisory contract for the duration of the residency, regardless of whether the supervisor is onsite or offsite at the location where services are provided by the resident.

3. The supervisor is accountable for the resident's compliance with residency requirements of this section.

4. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period.

~~4.~~ 5. The supervisor shall report the total hours of residency and shall evaluate the applicant's competency in the six areas stated in subdivision B 1 of this section.

~~5.~~ 6. The supervisor shall provide supervision as defined in 18VAC115-20-10.

7. The supervisor shall maintain copies of supervisory contracts, quarterly reports, and the verification of supervision forms evaluating the applicant's competency for five years after termination or completion of supervision.

E. Applicants shall document successful completion of their residency on the Verification of Supervision Form at the time of application. Applicants must receive a satisfactory competency evaluation on each item on the evaluation sheet. Supervised experience obtained prior to April 12, 2000, may be accepted toward licensure if this supervised experience met the board's requirements that were in effect at the time the supervision was rendered.

18VAC115-20-106. Continuing competency activity criteria.

A. Continuing competency activities must focus on increasing knowledge or skills in one or more of the following areas:

1. Ethics, standards of practice, or laws governing behavioral science professions;

2. Counseling theory;

3. Human growth and development;

4. Social and cultural foundations;

5. The helping relationship;

6. Group dynamics, processing, and counseling;

7. Lifestyle and career development;

8. Appraisal of individuals;

9. Research and evaluation;

10. Professional orientation;

11. Clinical supervision;

12. Marriage and family therapy; or

13. Addictions.

B. Approved hours of continuing competency activity shall be one of the following types:

1. Formally organized learning activities or home study. Activities may be counted at their full hour value. Hours shall be obtained from one or a combination of the following board-approved, mental health-related activities:

a. Regionally accredited university or college level academic courses in a behavioral health discipline.

b. Continuing education programs offered by universities or colleges.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state, or local governmental agencies or licensed health facilities and licensed hospitals.

d. Workshops, seminars, conferences, or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The International Association of Marriage and Family Counselors and its state affiliates.

(2) The American Association for Marriage and Family Therapy 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.

(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.

(12) The American Association of Pastoral Counselors.

2. Individual professional activities.

a. ~~Publication/presentation/new~~ Publication, presentation, or new program development.

(1) Publication of articles. Activity will count for a maximum of eight hours. Publication activities are limited to articles in refereed journals or a chapter in an edited book.

(2) Publication of books. Activity will count for a maximum of 18 hours.

(3) Presentations. Activity will count for a maximum of eight hours. The same presentations may be used only once in a two-year period. Only actual presentation time may be counted.

(4) New program development. Activity will count for a maximum of eight hours. New program development includes a new course, seminar, or workshop. New courses shall be graduate or undergraduate level college or university courses.

(5) Attendance at board meetings or disciplinary proceedings. Activity shall count for actual time of meeting or proceeding for a maximum of two hours during one renewal period.

b. Dissertation. Activity will count for a maximum of 18 hours. Dissertation credit may only be counted once.

c. Clinical supervision/consultation. Activity will count for a maximum of ~~10~~ six hours. Continuing competency can only be granted for clinical supervision/consultation received on a regular basis with a set agenda. Continuing competency cannot be granted for supervision provided to others.

d. Leadership. Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officer of state or national counseling organization; editor ~~and/or~~ or reviewer of professional counseling journals; member of state counseling ~~licensure/certification~~ licensure or certification board; member of a national counselor certification board; member of a national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; or other leadership positions with justifiable professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

e. Practice related programs. Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the regulant submits proof of attendance plus a written justification of how the activity assists ~~him~~ the regulant in ~~his~~ the direct service of ~~his~~ the regulant's clients. Examples include language courses, software training, and medical topics, etc.

18VAC115-20-107. Documenting compliance with continuing competency requirements.

A. All licensees are required to maintain original documentation for a period of two years following renewal.

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 as follows:

1. To document completion of formal organized learning activities, the licensee shall provide:

a. Official transcripts showing credit hours earned; or

b. Certificates of participation.

2. Documentation of home study shall be made by identification of the source material studied, summary of content, and a signed affidavit attesting to completion of the home study.

3. Documentation of individual professional activities shall be by one of the following:

a. Certificates of participation;

b. Proof of presentations made;

c. Reprints of publications;

d. Letters from educational institutions or agencies approving continuing education programs;

e. Official notification from the association that sponsored the item writing workshop or continuing education program; or

f. Documentation of attendance at formal staffing or participation in clinical supervision/consultation by a signed ~~affidavit~~ attestation on a form provided by the board.

D. Continuing competency hours required by a disciplinary order shall not be used to satisfy renewal requirements.

18VAC115-20-110. Late renewal; reinstatement.

A. A person whose license has expired may renew it within one year after its expiration date by paying the late fee prescribed in 18VAC115-20-20 as well as the license renewal fee prescribed for the year the license was not renewed and providing evidence of having met all applicable continuing competency requirements.

B. A person who fails to renew a professional counselor license after one year or more and wishes to resume practice shall (i) apply for reinstatement~~,~~; (ii) pay the reinstatement fee for a lapsed license~~,~~; (iii) submit verification of any mental health license ~~he~~ the person holds or has held in another jurisdiction, if applicable~~,~~; (iv) provide a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank; and (v) provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

C. A person wishing to reactivate an inactive professional counselor license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal; (ii) documentation of continued competency hours equal to the number of years the license has been inactive not to exceed a maximum of 80 hours; and (iii) verification of any mental health license he holds or has held in another jurisdiction, if applicable. The board may require the applicant for reactivation to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

D. A person who fails to renew a resident license after one year or more and wishes to resume his residency within the six-year limitation from the date of initial issuance of a resident license shall (i) apply for reinstatement; (ii) pay the initial licensure fee for a resident in counseling; and (iii) provide evidence of having met continuing competency requirements not to exceed a maximum of 12 hours. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the resident license.

18VAC115-20-130. 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. Regardless of the delivery method, whether in person, by phone, or electronically, these standards shall apply to the practice of counseling.

B. Persons licensed or registered 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. Practice only within the boundaries of their competence, based on their education, training, supervised experience, and appropriate professional experience and represent their education, training, and experience accurately to clients;

3. Stay abreast of new counseling information, concepts, applications, and practices that are necessary to providing appropriate, effective professional services;

4. Be able to justify all services rendered to clients as necessary and appropriate for diagnostic or therapeutic purposes;

5. 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 appropriate arrangements for the continuation of treatment for clients, when necessary, following termination of a counseling relationship;

6. Make appropriate arrangements for continuation of services, when necessary, during interruptions such as vacations, unavailability, relocation, illness, and disability;

7. Disclose to clients all experimental methods of treatment and inform clients of the risks and benefits of any such treatment. Ensure that the welfare of the clients is in no way compromised in any experimentation or research involving those clients;

8. Neither accept nor give commissions, rebates, or other forms of remuneration for referral of clients for professional services;

9. Inform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed; the limitations of confidentiality; and other pertinent information when counseling is initiated and throughout the counseling process as necessary. Provide clients with accurate information regarding the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements;

10. Select tests for use with clients that are valid, reliable, and appropriate and carefully interpret the performance of individuals not represented in standardized norms;

11. Determine whether a client is receiving services from another mental health service ~~provider~~ professional, and if so, ~~refrain from providing services to the client without having an informed consent discussion with the client and having been granted communication privileges with the other professional~~ document efforts to coordinate care;

12. Use only in connection with one's practice as a mental health professional those educational and professional degrees or titles that have been earned at a college or university accredited by an accrediting agency recognized by the U.S. Department of Education, or credentials granted by a national certifying agency, and that are counseling in nature;

13. Advertise professional services fairly and accurately in a manner that is not false, misleading, or deceptive, including compliance with 18VAC115-20-52 regarding the requirements for representation to the public by residents in counseling; ~~and~~

14. Not engage in conversion therapy with any person younger than 18 years of age;

15. Make appropriate referrals based on the interests of the client; and

16. 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 is beyond the control of the practitioner shall not be considered negligent or willful.

C. In regard to patient records, persons licensed or registered by the board shall:

1. Maintain written or electronic clinical records for each client to include treatment dates and identifying information to substantiate diagnosis and treatment plan, client progress, and termination;

2. Maintain timely, accurate, legible, and complete 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. Disclose or release records to others only with the client's expressed written consent or that of the client's legally authorized representative in accordance with § 32.1-127.1:03 of the Code of Virginia;

4. 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; and

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) or 10 years following termination, whichever comes later;

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 his legally authorized representative.

D. In regard to dual or multiple relationships, persons licensed or registered by the board shall:

1. Avoid dual or multiple relationships with clients that could impair professional judgment or increase the risk of harm to clients. Examples of such relationships include familial, social, financial, business, bartering, or close personal relationships with clients. Counselors shall take appropriate professional precautions when a dual relationship cannot be avoided, such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation or neglect occurs;

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and not counsel persons with whom they have had a romantic relationship or sexual intimacy. Counselors shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Counselors who engage in such relationship or intimacy after five years following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of, or participation in sexual behavior or involvement with a counselor does not change the nature of the conduct nor lift the regulatory prohibition;

3. Not engage in any romantic relationship or sexual intimacy or establish a counseling or psychotherapeutic relationship with a ~~supervisee~~ person under supervision or student. Counselors shall avoid any nonsexual dual relationship with a ~~supervisee~~ person under supervision or student in which there is a risk of exploitation or potential harm to the ~~supervisee~~ person under supervision or student or the potential for interference with the supervisor's professional judgment; and

4. Recognize conflicts of interest and inform all parties of the nature and directions of loyalties and responsibilities involved.

E. Persons licensed or registered by this board shall report to the board known or suspected violations of the laws and regulations governing the practice of professional counseling.

F. Persons licensed or registered by the board shall advise their clients of their right to report to the Department of Health Professions any information of which the licensee may become aware in his professional capacity indicating that there is a reasonable probability that a person licensed or certified as a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, may have engaged in unethical, fraudulent, or unprofessional conduct as defined by the pertinent licensing statutes and regulations.

18VAC115-20-140. Grounds for revocation, suspension, probation, reprimand, censure, or denial of renewal of license or registration.

A. Action by the board to revoke, suspend, deny issuance or renewal of a license, or take disciplinary action may be taken in accordance with the following:

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 professional counseling, or any provision of this chapter;

2. ~~Procurement of~~ Procuring, attempting to procure, or maintaining a license~~, including submission of an~~

~~application or supervisory forms,~~ or registration by fraud or misrepresentation;

3. Conducting one's practice in such a manner 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 counseling with reasonable skill and safety to clients by reason of illness, abusive use of alcohol, drugs, narcotics, chemicals, or other type of material or result of any mental or physical condition~~;

4. Demonstrating an inability to practice counseling with reasonable skill and safety to clients by reason of illness or substance misuse or as a result of any mental, emotional, or physical condition;

5. Intentional or negligent conduct that causes or is likely to cause injury to a client ~~or clients~~;

~~5.~~ 6. Performance of functions outside the demonstrable areas of competency;

~~6.~~ 7. Failure to comply with the continued competency requirements set forth in this chapter;

~~7.~~ 8. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of counseling, or any part or portion of this chapter; ~~or~~

~~8.~~ 9. Performance of an act likely to deceive, defraud, or harm the public~~.~~;

10. Knowingly allowing persons under supervision to jeopardize client safety or provide care to clients outside of such person's scope of practice or area of responsibility;

11. Having an action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

12. Failing to cooperate with an employee of the Department of Health Professions in the conduct of an investigation; or

13. Failing to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia or abuse of aged or incapacitated adults as required in § 63.2-1606 of the Code of Virginia.

B. Following the revocation or suspension of a license, the licensee may petition the board for reinstatement upon good cause shown or as a result of substantial new evidence having been obtained that would alter the determination reached.

18VAC115-50-10. 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: (i) "board," (ii) "marriage and family therapy," (iii) "marriage and family therapist," and (iv) "practice of marriage and family therapy."

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

"Ancillary counseling services" means activities such as case management, recordkeeping, referral, and coordination of services.

"CACREP" means the Council for Accreditation of Counseling and Related Educational Programs.

"COAMFTE" means the Commission on Accreditation for Marriage and Family Therapy Education.

"Clinical marriage and family services" means activities such as assessment, diagnosis, and treatment planning and treatment implementation for couples and families.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"Face-to-face" means the in-person delivery of clinical marriage and family services for a client or the use of visual, real-time, interactive, secured technology for delivery of such services.

"Internship" means a formal academic course from a regionally accredited university in which supervised practical experience is obtained in a clinical setting in the application of counseling principles, methods, and techniques.

"Regional accrediting agency" means one of the regional accreditation agencies recognized by the U.S. Secretary of Education as responsible for accrediting senior post-secondary institutions and training programs.

"Residency" means a postgraduate, supervised clinical experience.

"Resident" means an individual who has a supervisory contract and has been issued a temporary license by the board approval to provide clinical services in marriage and family therapy under supervision.

"Supervision" means an ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented, individual or group consultation, guidance, and instruction with respect to the clinical skills and competencies of the person or persons being supervised.

"Supervisory contract" means an agreement that outlines the expectations and responsibilities of the supervisor and resident in accordance with regulations of the board.

18VAC115-50-20. Fees.

A. The board has established fees for the following:

Application and initial licensure as a resident	$65
Pre-review of education only	$75

Initial licensure by examination: Processing and initial licensure as a marriage and family therapist	$175
Initial licensure by endorsement: Processing and initial licensure as a marriage and family therapist	$175
Active annual license renewal for a marriage and family therapist	$130
Inactive annual license renewal for a marriage and family therapist	$65
Annual renewal for a resident in marriage and family therapy	$30
~~Penalty for late~~ Late renewal for a marriage and family therapist	$45
Late renewal for resident in marriage and family therapy	$10
Reinstatement of a lapsed license for a marriage and family therapist	$200
Reinstatement of lapsed resident license	$75
Verification of license to another jurisdiction	$30
Additional or replacement licenses	$10
Additional or replacement wall certificates	$25
Returned check or dishonored credit or debit card	$50
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

C. Examination fees shall be determined and made payable as determined by the board.

18VAC115-50-40. Application for licensure by endorsement.

A. Every applicant for licensure by endorsement shall hold or have held a license for the independent clinical practice of marriage and family ~~license~~ therapy in another jurisdiction in the United States and shall submit:

1. A completed application;

2. The application processing and initial licensure fee prescribed in 18VAC115-50-20;

3. Documentation of licensure as follows:

a. Verification of all mental health or health professional licenses ~~or,~~ certificates, or registrations the applicant holds or has ever held 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; and

b. Documentation of a marriage and family therapy license obtained by standards specified in subsection B of this section;

4. Verification of a passing score on a marriage and family therapy licensure examination in the jurisdiction in which licensure was obtained;

5. An ~~affidavit~~ attestation of having read and understood the regulations and laws governing the practice of marriage and family therapy in Virginia; and

6. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank ~~(NPDB)~~.

B. Every applicant for licensure by endorsement shall meet one of the following:

1. Educational requirements consistent with those specified in 18VAC115-50-50 and 18VAC115-50-55 and experience requirements consistent with those specified in 18VAC115-50-60;

2. ~~If an applicant does not have~~ In lieu of documentation of educational and experience credentials consistent with those required by this chapter, ~~he shall~~ the applicant may provide:

~~a. Documentation of education and supervised experience that met the requirements of the jurisdiction in which he was initially licensed as verified by an official transcript and a certified copy of the original application materials; and~~

~~b.~~ a. Evidence of post-licensure clinical practice as a marriage and family therapist for 24 of the last 60 months immediately preceding his licensure application in Virginia. Clinical practice shall mean the rendering of direct clinical services in marriage and family therapy ~~or,~~ clinical supervision of marriage and family services, or teaching graduate level courses in marriage and family therapy; ~~or~~

~~3. In lieu of transcripts verifying education and documentation verifying supervised experience, the board may accept verification from the credentials registry of the American Association of State Counseling Boards or any other board recognized entity.~~

b. Evidence of an active license at the highest level of licensure for independent practice of marriage and family therapy for at least 10 years prior to the date of application; or

c. Evidence of an active license at the highest level of licensure for independent practice of marriage and family therapy for at least three years prior to the date of application and a graduate-level degree from a program accredited in marriage and family therapy by COAMFTE or CACREP.

18VAC115-50-55. Coursework requirements.

A. The applicant shall have successfully completed:

1. The requirements for a marriage and family therapy program accredited by CACREP; or

2. The applicant shall have successfully completed 60 semester hours or 90 quarter hours of graduate coursework with ~~a minimum of six semester hours or nine quarter hours completed in each of the core areas identified in subdivisions 1 and 2 of this subsection, and three semester hours or 4.0 quarter hours in each of the core areas identified in subdivisions 3 through 9 of this subsection~~:

~~1. Marriage and family studies (marital and family development; family systems theory);~~

~~2. Marriage and family therapy (systemic therapeutic interventions and application of major theoretical approaches);~~

~~3.~~ a. A minimum of 12 semester hours or 18 quarter hours completed in marriage and family studies (marital and family development, family systems, systemic therapeutic interventions, and application of major theoretical approaches).

b. Three semester hours or four quarter hours in each of the following core areas:

(1) Human growth and development across the lifespan;

~~4.~~ (2) Abnormal behaviors;

~~5.~~ (3) Diagnosis and treatment of addictive behaviors;

~~6.~~ (4) Multicultural counseling;

~~7.~~ (5) Professional identity and ethics;

~~8.~~ (6) Research (research methods; quantitative methods; statistics); or

~~9.~~ (7) Assessment and treatment (appraisal, assessment and diagnostic procedures); and

~~10. Supervised~~ c. A supervised internship as a formal academic course of at least 600 hours to include 240 hours of direct client contact, of which 200 hours shall be with couples and families. Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours. If the academic course was less than 600 hours, the board may approve the completion of up to 100 of the 600 hours and up to 40 of the 240 hours of direct client contact to be added to the hours required for residency.

B. If the applicant holds a current, unrestricted license as a professional counselor, clinical psychologist, or clinical social worker, the board may accept evidence of successful completion of 60 semester hours or 90 quarter hours of graduate study~~, including~~. However, the applicant must provide evidence of a minimum of ~~six~~ 12 semester hours or ~~nine~~ 18 quarter hours completed in marriage and family ~~studies (marital and family development; family systems theory) and six semester hours or nine quarter hours completed in marriage and family therapy (systemic therapeutic interventions and application of major theoretical approaches)~~ therapy (marital and family development, family systems, systemic therapeutic interventions, and application of major theoretical approaches).

18VAC115-50-60. Resident license and requirements for a residency.

A. Resident license. Applicants for temporary licensure as a resident in marriage and family therapy shall:

1. Apply for licensure on a form provided by the board to include the following: (i) verification of a supervisory contract, (ii) the name and licensure number of the supervisor and location for the supervised practice, and (iii) an attestation that the applicant will be providing marriage and family services.

2. Have submitted an official transcript documenting a graduate degree as that meets the requirements specified in 18VAC115-50-50 to include completion of the coursework and internship requirement specified in 18VAC115-50-55;

3. Pay the ~~registration~~ resident license fee;

4. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank ~~(NPDB)~~; and

5. Have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration in Virginia or in another jurisdiction. The board will consider the history of disciplinary action on a case-by-case basis.

B. Residency requirements.

1. The applicant for licensure as a marriage and family therapist shall have completed no fewer than 3,400 hours of supervised residency in the role of a marriage and family therapist, to include 200 hours of in-person supervision with the supervisor in the consultation and review of marriage and family services provided by the resident. For the purpose of meeting the 200 hours of supervision required for a residency, in-person may also include the use of technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident. At least one-half of the 200 hours of supervision shall be rendered by a licensed marriage and family therapist.

a. Residents shall receive a minimum of one hour and a maximum of four hours of supervision for every 40 hours of supervised work experience.

b. No more than 100 hours of the supervision may be acquired through group supervision, with the group consisting of no more than six residents. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

c. Up to 20 hours of the supervision received during the supervised internship may be counted towards the 200 hours of in-person supervision if the supervision was provided by a licensed marriage and family therapist or a licensed professional counselor.

2. The 3,400-hour residency shall include documentation of at least 2,000 hours in face-to-face clinical marriage and family services of which 1,000 hours shall be face-to-face client contact with couples or families or both. The remaining hours of the 3,400-hour residency may be spent in the performance of ancillary counseling services. For applicants who hold current, unrestricted licensure as a professional counselor, clinical psychologist, or clinical social worker, the remaining hours may be waived.

3. The ~~residency shall consist of practice in the core areas set forth in 18VAC115-50-55.~~ applicant for licensure shall have completed a 3,400-hour supervised residency in the role of a marriage and family therapist working with various populations, clinical problems, and theoretical approaches in the following areas:

a. Assessment and diagnosis using psychotherapy techniques;

b. Appraisal, evaluation, and diagnostic procedures;

c. Treatment planning and implementation;

d. Case management and recordkeeping;

e. Marriage and family therapy identity and function; and

f. Professional ethics and standards of practice.

4. The residency shall begin after the completion of a master's degree in marriage and family therapy or a related discipline as set forth in 18VAC115-50-50.

5. A graduate-level internship in excess of 600 hours, which was completed in a program that meets the requirements set forth in 18VAC115-50-50, may count for up to an additional 300 hours towards the requirements of a residency.

6. Supervised practicum and internship hours in a COAMFTE-accredited or a CACREP-accredited doctoral program in marriage and family therapy or counseling may be accepted for up to 900 hours of the residency requirement and up to 100 of the required hours of supervision provided the supervisor holds a current, unrestricted license as a marriage and family therapist or professional counselor.

7. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

8. Residents shall not call themselves marriage and family therapists, directly bill for services rendered, or in any way represent themselves as marriage and family therapists. During the residency, residents may use their names, the initials of their degree, their resident license number, and the title "Resident in Marriage and Family Therapy." Clients shall be informed in writing that the resident does not have authority for independent practice and is under supervision, along with the name, address, and telephone number of the resident's board-approved supervisor.

9. Residents shall not engage in practice under supervision in any areas for which they do not have appropriate education.

10. The residency shall be completed in not less than 21 months or more than ~~four~~ six years from the start of residency. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, ~~2020~~ 2022. ~~An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue.~~ A resident shall meet the renewal requirements of subsection C of 18VAC115-50-90 in order to maintain a resident license in current, active status.

11. Residency hours ~~that are~~ shall be accepted if they were approved by the licensing board in another United States jurisdiction and ~~that meet~~ completed in that jurisdiction and if those hours are consistent with the requirements of subsection B of this section ~~shall be accepted~~.

12. Supervision that is not concurrent with a residency will not be accepted, nor can residency hours be accrued in the absence of approved supervision.

C. Supervisory qualifications. A person who provides supervision for a resident in marriage and family therapy shall:

1. Hold an active, unrestricted license as a marriage and family therapist or professional counselor in the jurisdiction where the supervision is being provided;

2. Document two years post-licensure marriage and family therapy experience; and

3. Have received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-50-96. At least one-half of the 200 hours of supervision shall be rendered by a licensed marriage and family therapist. ~~Supervisors who are clinical psychologists, clinical social workers, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.~~

D. Supervisory responsibilities.

1. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period. The supervisor shall report the total hours of residency and evaluate the applicant's competency to the board. The supervisor shall maintain copies of supervisory contracts, quarterly reports, and verification of supervision forms

evaluating an applicant's competency for five years after termination or completion of supervision.

2. Supervision by an individual whose relationship to the resident is deemed by the board to compromise the objectivity of the supervisor is prohibited.

3. The supervisor shall provide supervision as defined in 18VAC115-50-10 and shall assume full responsibility for the clinical activities of residents as specified within the supervisory contract ~~for the duration~~ until completion or termination of the residency, regardless of whether the supervisor is onsite or offsite at the location where services are provided by the resident.

4. The supervisor is accountable for the resident's compliance with residency requirements of this section.

18VAC115-50-70. General examination requirements.

A. All applicants for initial licensure shall pass an examination, as prescribed by the board, with a passing score as determined by the board. ~~The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor issued by the board.~~

B. An applicant is required to pass the prescribed examination within six years from the date of initial issuance of a resident license by the board.

C. A resident shall remain in a residency practicing under supervision until the resident has passed the licensure examination and been granted a license as a marriage and family therapist.

18VAC115-50-96. Continuing competency activity criteria.

A. Continuing competency activities must focus on increasing knowledge or skills in one or more of the following areas:

1. Ethics, standards of practice or laws governing behavioral science professions;

2. Counseling theory;

3. Human growth and development;

4. Social and cultural foundations;

5. The helping relationship;

6. Group dynamics, processing and counseling;

7. Lifestyle and career development;

8. Appraisal of individuals;

9. Research and evaluation;

10. Professional orientation;

11. Clinical supervision;

12. Marriage and family therapy; or

13. Addictions.

B. Approved hours of continuing competency activity shall be one of the following types:

1. Formally organized learning activities or home study. Activities may be counted at their full hour value. Hours shall be obtained from one or a combination of the following board-approved, mental health-related activities:

a. Regionally accredited university or college level academic courses in a behavioral health discipline.

b. Continuing education programs offered by universities or colleges.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state, or local governmental agencies or licensed health facilities and licensed hospitals.

d. Workshops, seminars, conferences, or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The International Association of Marriage and Family Counselors and its state affiliates.

(2) The American Association for Marriage and Family Therapy 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.

(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.

(12) The American Association of Pastoral Counselors.

2. Individual professional activities.

a. ~~Publication/presentation/new~~ Publication, presentation, or new program development.

(1) Publication of articles. Activity will count for a maximum of eight hours. Publication activities are limited to articles in refereed journals or a chapter in an edited book.

(2) Publication of books. Activity will count for a maximum of 18 hours.

(3) Presentations. Activity will count for a maximum of eight hours. The same presentations may be used only once in a two-year period. Only actual presentation time may be counted.

(4) New program development activity will count for a maximum of eight hours. New program development includes a new course, seminar, or workshop. New courses shall be graduate or undergraduate level college or university courses.

(5) Attendance at board meetings or disciplinary proceedings. Activity shall count for actual time of meeting or proceeding for a maximum of two hours during one renewal period.

b. Dissertation. Activity will count for a maximum of 18 hours. Dissertation credit may only be counted once.

c. Clinical supervision/consultation. Activity will count for a maximum of ~~10~~ six hours. Continuing competency can only be granted for clinical supervision/consultation received on a regular basis with a set agenda. Continuing competency cannot be granted for supervision that you provide to others.

d. Leadership. Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officers of state or national counseling organization; editor or reviewer of professional counseling journals; member of state counseling ~~licensure/certification~~ licensure or certification board; member of a national counselor certification board; member of a national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; other leadership positions with justifiable professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

e. Practice related programs. Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the regulant submits proof of attendance plus a written justification of how the activity assists ~~him~~ the regulant in ~~his~~ the direct service of ~~his~~ the regulant's clients. Examples include language courses, software training, medical topics, etc.

18VAC115-50-97. Documenting compliance with continuing competency requirements.

A. All licensees are required to maintain original documentation for a period of two years following renewal.

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 as follows:

1. To document completion of formal organized learning activities, licensee shall provide:

a. Official transcripts showing credit hours earned; or

b. Certificates of participation.

2. Documentation of home study shall be made by identification of the source material studied, summary of content, and a signed affidavit attesting to completion of the home study.

3. Documentation of individual professional activities shall be by one of the following:

a. Certificates of participation;

b. Proof of presentations made;

c. Reprints of publications;

d. Letters from educational institutions or agencies approving continuing education programs;

e. Official notification from the association that sponsored the item writing workshop or continuing education program; or

f. Documentation of attendance at formal staffing ~~shall be~~ or participation in clinical supervision/consultation by signed ~~affidavit~~ attestation on a form provided by the board.

D. Continuing competency hours required by a disciplinary order shall not be used to satisfy renewal requirements.

18VAC115-50-100. Late renewal, reinstatement.

A. A person whose license has expired may renew it within one year after its expiration date by paying the late fee prescribed in 18VAC115-50-20 as well as the license fee prescribed for the period the license was not renewed and providing evidence of having met all applicable continuing competency requirements.

B. A person seeking reinstatement of a marriage and family therapy license one year or more after its expiration date must:

1. Apply for reinstatement and pay the reinstatement fee;

2. Submit ~~documentation~~ verification of any mental health license he holds or has held in another jurisdiction, if applicable;

3. Submit evidence regarding the continued ability to perform the functions within the scope of practice of the license if required by the board to demonstrate competency; ~~and~~

4. Provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours obtained within the four years immediately preceding application for reinstatement; and

5. Provide a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank.

C. A person wishing to reactivate an inactive marriage and family license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal and (ii) documentation of continued competency hours equal to the number of years the license has been inactive, not to exceed a maximum of 80 hours, obtained within the four years immediately preceding application for reinstatement. The board may require additional evidence regarding the person's continued ability to perform the functions within the scope of practice of the license.

D. A person who fails to renew a resident license after one year or more and wishes to resume his residency within the six-year limitation from the date of initial issuance of a resident license shall (i) apply for reinstatement; (ii) pay the initial licensure fee for a resident in counseling; and (iii) provide evidence of having met continuing competency requirements not to exceed a maximum of 12 hours. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the resident license.

18VAC115-50-110. Standards of practice.

A. The protection of the public's 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. Regardless of the delivery method, whether in person, by phone or electronically, these standards shall apply to the practice of marriage and family therapy.

B. Persons licensed or registered 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. Practice only within the boundaries of their competence, based on their education, training, supervised experience, and appropriate professional experience and represent their education, training, and experience accurately to clients;

3. Stay abreast of new marriage and family therapy information, concepts, applications, and practices that are necessary to providing appropriate, effective professional services;

4. Be able to justify all services rendered to clients as necessary and appropriate for diagnostic or therapeutic purposes;

5. 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 appropriate arrangements for the continuation of treatment for clients, when necessary, following termination of a counseling relationship;

6. Make appropriate arrangements for continuation of services, when necessary, during interruptions such as vacations, unavailability, relocation, illness, and disability;

7. Disclose to clients all experimental methods of treatment and inform client of the risks and benefits of any such treatment. Ensure that the welfare of the client is not compromised in any experimentation or research involving those clients;

8. Neither accept nor give commissions, rebates or other forms of remuneration for referral of clients for professional services;

9. Inform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed; the limitations of confidentiality; and other pertinent information when counseling is initiated and throughout the counseling process as necessary. Provide clients with accurate information regarding the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements;

10. Select tests for use with clients that are valid, reliable, and appropriate and carefully interpret the performance of individuals not represented in standardized norms;

11. Determine whether a client is receiving services from another mental health service ~~provider~~ professional, and if so, ~~refrain from providing services to the client without having an informed consent discussion with the client and having been granted communication privileges with the other professional~~ document efforts to coordinate care;

12. Use only in connection with one's practice as a mental health professional those educational and professional degrees or titles that have been earned at a college or university accredited by an accrediting agency recognized by the U.S. Department of Education, or credentials granted by a national certifying agency, and that are counseling in nature;

13. Advertise professional services fairly and accurately in a manner that is not false, misleading or deceptive, including compliance with 18VAC115-50-60 regarding requirements for representation to the public by residents in marriage and family therapy; ~~and~~

14. Not engage in conversion therapy with any person younger than 18 years of age;

15. Make appropriate referrals based on the interests of the client; and

16. 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 is beyond the control of the practitioner shall not be considered negligent or willful.

C. In regard to patient records, persons licensed or registered by the board shall:

1. Maintain timely, accurate, legible, and complete written or electronic clinical records for each client to include treatment dates and identifying information to substantiate diagnosis and treatment plan, client progress, and termination;

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. Disclose or release client records to others only with clients' expressed written consent or that of their legally authorized representative in accordance with § 32.1-127.1:03 of the Code of Virginia;

4. Ensure confidentiality in the usage of client records and clinical materials by obtaining informed consent from clients or their 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; and

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) or 10 years following termination, whichever comes later;

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 transferred to another mental health service provider or given to the client or his legally authorized representative.

D. In regard to dual or multiple relationships, persons licensed or registered by the board shall:

1. Avoid dual or multiple relationships with clients that could impair professional judgment or increase the risk of harm to clients. Examples of such relationships include familial, social, financial, business, bartering, or close personal relationships with clients. Marriage and family therapists shall take appropriate professional precautions when a dual or multiple relationship cannot be avoided, such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs;

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and also not counsel persons with whom they have had a sexual intimacy or romantic relationship. Marriage and family therapists shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Marriage and family therapists who engage in such relationship or intimacy after five years following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of or participation in sexual behavior or involvement with a marriage and family therapist does not change the nature of the conduct nor lift the regulatory prohibition;

3. Not engage in any romantic relationships or sexual relationship or establish a counseling or psychotherapeutic relationship with a ~~supervisee~~ person under supervision or student. Marriage and family therapists shall avoid any nonsexual dual relationship with a ~~supervisee~~ person under supervision or student in which there is a risk of exploitation or potential harm to the ~~supervisee~~ person under supervision or student or the potential for interference with the supervisor's professional judgment; and

4. Recognize conflicts of interest and inform all parties of the nature and directions of loyalties and responsibilities involved.

E. Persons licensed or registered by this board shall report to the board known or suspected violations of the laws and regulations governing the practice of marriage and family therapy.

F. Persons licensed or registered by the board shall advise their clients of their right to report to the Department of Health Professions any information of which the licensee may become aware in his professional capacity indicating that there is a reasonable probability that a person licensed or certified as a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, may have engaged in unethical, fraudulent or unprofessional conduct as defined by the pertinent licensing statutes and regulations.

18VAC115-50-120. Disciplinary action.

A. Action by the board to revoke, suspend, deny issuance or removal of a license~~,~~ or registration or take other disciplinary action may be taken in accordance with the following:

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 marriage and family therapy, or any provision of this chapter;

2. ~~Procurement of~~ Procuring, attempting to procure, or maintaining a license~~, including submission of an application or supervisory forms,~~ or registration by fraud or misrepresentation;

3. Conducting one's practice in such a manner as to make it a danger to the health and welfare of one's clients or the general public ~~or if one is unable to practice marriage and family therapy with reasonable skill and safety to clients by reason of illness, abusive use of alcohol, drugs, narcotics, chemicals, or other type of material or result of any mental or physical condition~~;

4. Demonstrating an inability to practice marriage and family therapy with reasonable skill and safety to clients by reason of illness or substance misuse or as a result of any mental, emotional, or physical condition;

5. Intentional or negligent conduct that causes or is likely to cause injury to a client ~~or clients~~;

~~5.~~ 6. Performance of functions outside the demonstrable areas of competency;

~~6.~~ 7. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of marriage and family therapy, or any part or portion of this chapter;

~~7.~~ 8. Failure to comply with the continued competency requirements set forth in this chapter; ~~or~~

~~8.~~ 9. Performance of an act likely to deceive, defraud, or harm the public;

10. Knowingly allowing persons under supervision to jeopardize client safety or provide care to clients outside of such person's scope of practice or area of responsibility;

11. Having an action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

12. Failing to cooperate with an employee of the Department of Health Professions in the conduct of an investigation; or

13. Failing to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia, or abuse of aged or incapacitated adults as required in § 63.2-1606 of the Code of Virginia.

B. Following the revocation or suspension of a license, the licensee may petition the board for reinstatement upon good cause shown or as a result of substantial new evidence having been obtained that would alter the determination reached.

18VAC115-60-10. 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"

"Licensed substance abuse treatment practitioner"

"Substance abuse"

"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:

"Ancillary services" means activities such as case management, recordkeeping, referral, and coordination of services.

"Applicant" means any individual who has submitted an official application and paid the application fee for licensure as a substance abuse treatment practitioner.

"CACREP" means the Council for Accreditation of Counseling and Related Educational Programs.

"Candidate for licensure" means a person who has satisfactorily completed all educational and experience requirements for licensure and has been deemed eligible by the board to sit for its examinations.

"Clinical substance abuse treatment services" means activities such as assessment, diagnosis, treatment planning, and treatment implementation.

"COAMFTE" means the Commission on Accreditation for Marriage and Family Therapy Education.

"Competency area" means an area in which a person possesses knowledge and skill and the ability to apply them in the clinical setting.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"Exempt setting" means an agency or institution in which licensure is not required to engage in the practice of substance abuse treatment according to the conditions set forth in § 54.1-3501 of the Code of Virginia.

"Face-to-face" means the in-person delivery of clinical substance abuse treatment services for a client or the use of visual, real-time, interactive, secured technology for delivery of such services.

"Group supervision" means the process of clinical supervision of no more than six persons in a group setting provided by a qualified supervisor.

"Internship" means a formal academic course from a regionally accredited university in which supervised, practical

experience is obtained in a clinical setting in the application of counseling principles, methods and techniques.

"Jurisdiction" means a state, territory, district, province, or country that has granted a professional certificate or license to practice a profession, use a professional title, or hold oneself out as a practitioner of that profession.

"Nonexempt setting" means a setting that does not meet the conditions of exemption from the requirements of licensure to engage in the practice of substance abuse treatment as set forth in § 54.1-3501 of the Code of Virginia.

"Regional accrediting agency" means one of the regional accreditation agencies recognized by the U.S. Secretary of Education responsible for accrediting senior postsecondary institutions.

"Residency" means a postgraduate, supervised, clinical experience.

"Resident" means an individual who has a supervisory contract and has been issued a temporary license by the board to provide clinical services in substance abuse treatment under supervision.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual or group consultation, guidance, and instruction with respect to the clinical skills and competencies of the person supervised.

"Supervisory contract" means an agreement that outlines the expectations and responsibilities of the supervisor and resident in accordance with regulations of the board.

18VAC115-60-20. Fees required by the board.

A. The board has established the following fees applicable to licensure as a substance abuse treatment practitioner or resident in substance abuse treatment:

Application and initial licensure as a resident in substance abuse treatment	$65
Pre-review of education only	$75
Initial licensure by examination: Processing and initial licensure as a substance abuse treatment practitioner	$175
Initial licensure by endorsement: Processing and initial licensure as a substance abuse treatment practitioner	$175
Active annual license renewal for a substance abuse treatment practitioner	$130
Inactive annual license renewal for a substance abuse treatment practitioner	$65
Annual renewal for a resident in substance abuse treatment	$30
Duplicate license	$10
Verification of license to another jurisdiction	$30
Late renewal for a substance abuse treatment practitioner	$45
Late renewal for a resident in substance abuse treatment	$10
Reinstatement of a lapsed license of a substance abuse treatment practitioner	$200
Reinstatement of a lapsed resident license	$75
Replacement of or additional wall certificate	$25
Returned check or dishonored credit or debit card	$50
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

C. Examination fees shall be determined and made payable as determined by the board.

18VAC115-60-40. Application for licensure by examination.

Every applicant for licensure by examination by the board shall:

1. Meet the degree program, coursework, and experience requirements prescribed in 18VAC115-60-60, 18VAC115-60-70, and 18VAC115-60-80;

2. Pass the examination required for initial licensure as prescribed in 18VAC115-60-90;

3. Submit the following items to the board:

a. A completed application;

b. Official transcripts documenting the applicant's completion of the degree program and coursework requirements prescribed in 18VAC115-60-60 and 18VAC115-60-70. Transcripts previously submitted for board approval of a resident license do not have to be resubmitted unless additional coursework was subsequently obtained;

c. Verification of supervision forms documenting fulfillment of the residency requirements of 18VAC115-60-80 and copies of all required evaluation forms, including verification of current licensure of the supervisor of any portion of the residency occurred in another jurisdiction;

d. ~~Documentation~~ Verification of any other mental health or health professional license or certificate ever held in another jurisdiction;

e. The application processing and initial licensure fee as prescribed in 18VAC115-60-20; and

f. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank ~~(NPDB)~~; and

4. Have no unresolved disciplinary action against a mental health or health professional license ~~or,~~ certificate, or registration held in Virginia or in another jurisdiction. The board will consider history of disciplinary action on a case-by-case basis.

18VAC115-60-50. Prerequisites for licensure by endorsement.

Every applicant for licensure by endorsement shall submit:

1. A completed application;

2. The application processing and initial licensure fee as prescribed in 18VAC115-60-20;

3. Verification of all mental health or health professional licenses ~~or,~~ certificates, or registrations ever held in any other jurisdiction. In order to qualify for endorsement, the applicant shall have no unresolved disciplinary action against a license ~~or,~~ certificate, or registration. The board will consider history of disciplinary action on a case-by-case basis;

4. Further documentation of one of the following:

a. A current license for the independent practice of substance abuse treatment ~~license~~ or addiction counseling in good standing in another jurisdiction ~~obtained by meeting requirements substantially equivalent to those set forth in this chapter~~; or

b. A mental health license in good standing from Virginia or another United States jurisdiction in a category acceptable to the board that required completion of a master's degree in mental health to include 60 graduate semester hours in mental health as documented by an official transcript; and

(1) Board-recognized national certification in substance abuse treatment or addiction counseling;

(2) If the master's degree was in substance abuse treatment, ~~two years of~~ the applicant shall have post-licensure experience in providing substance abuse treatment or addiction counseling in 24 out of the past 60 months immediately preceding the submission of the application to the board;

(3) If the master's degree was not in substance abuse treatment or addiction counseling, ~~five~~ two years of post-licensure experience in substance abuse treatment or addiction counseling plus 12 credit hours of didactic training in the substance abuse treatment competencies set forth in 18VAC115-60-70 C as documented by an official transcript; or

(4) Current substance abuse counselor certification in Virginia in good standing ~~or a Virginia substance abuse treatment specialty licensure designation~~ with two years of post-licensure or certification substance abuse treatment or addiction counseling experience; ~~or~~

~~c. Documentation of education and supervised experience that met the requirements of the jurisdiction in which he was initially licensed as verified by an official transcript and a certified copy of the original application materials and evidence of post licensure clinical practice for 24 of the last 60 months immediately preceding his licensure application in Virginia. Clinical practice shall mean the rendering of direct clinical substance abuse treatment services or clinical supervision of such services;~~

5. Verification of a passing score on ~~a substance abuse~~ the licensure examination ~~as established by the jurisdiction in which licensure was obtained. The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor within the Commonwealth of Virginia~~ prescribed in 18VAC115-60-90, or if the applicant is licensed in another jurisdiction, a licensing examination deemed to be substantially equivalent by the board;

6. An ~~affidavit~~ attestation of having read and understood the regulations and laws governing the practice of substance abuse treatment in Virginia; and

7. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank ~~(NPDB)~~.

18VAC115-60-60. Degree program requirements.

A. The applicant shall have completed a graduate degree from a program that prepares individuals to practice substance abuse treatment, addiction counseling, or a related counseling discipline as defined in § 54.1-3500 of the Code of Virginia from a college or university accredited by a regional accrediting agency that meets the following criteria:

1. There must be a sequence of academic study with the expressed intent to prepare counselors as documented by the institution;

2. There must be an identifiable counselor training faculty and an identifiable body of students who complete that sequence of academic study; and

3. The academic unit must have clear authority and primary responsibility for the core and specialty areas.

B. Programs that are approved by CACREP as programs in addictions counseling are recognized as meeting the requirements of subsection A of this section.

C. Graduates of programs that are not within the United States or Canada shall provide documentation from an acceptable credential evaluation service that provides information that allows the board to determine if the program meets the requirements set forth in this chapter.

18VAC115-60-70. Coursework requirements.

A. The applicant shall have successfully completed ~~60 semester hours or 90 quarter hours of graduate study.~~

~~B. The applicant shall have completed~~:

1. The requirements for a degree in a program accredited by CACREP in addiction counseling or any other specialty approved by the board; or

2. The applicant shall have successfully completed 60 semester hours or 90 quarter hours of graduate study in a general core curriculum containing a minimum of three semester hours or 4.0 quarter hours in each of the areas identified in this section:

~~1.~~ a. Professional identity, function and ethics;

~~2.~~ b. Theories of counseling and psychotherapy;

~~3.~~ c. Counseling and psychotherapy techniques;

~~4.~~ d. Group counseling and psychotherapy, theories and techniques;

~~5.~~ e. Appraisal, evaluation and diagnostic procedures;

~~6.~~ f. Abnormal behavior and psychopathology;

~~7.~~ g. Multicultural counseling, theories and techniques;

~~8.~~ h. Research; and

~~9.~~ i. Marriage and family systems theory.

~~C.~~ B. The applicant shall also have completed 12 graduate semester credit hours or 18 graduate quarter hours in the following substance abuse treatment competencies. Evidence of current certification as a master addictions counselor may be used to verify completion of the required graduate hours specified in this subsection.

1. Assessment, appraisal, evaluation and diagnosis specific to substance ~~abuse~~ use disorder;

2. Treatment planning models, client case management, interventions and treatments to include relapse prevention, referral process, step models and documentation process;

3. Understanding addictions: The biochemical, sociocultural, and psychological factors of substance use and abuse;

4. Addictions and special populations including~~, but not limited to,~~ adolescents, women, ethnic groups and the elderly; and

5. Client and community education.

~~D.~~ C. The applicant shall have completed a supervised internship of 600 hours as a formal academic course to include 240 hours of ~~direct~~ face-to-face client contact, of which 200 hours shall be in addiction counseling or treating substance ~~abuse specific treatment problems~~ use disorder. Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours. If the academic course was less than 600 hours, the board may approve completion of up to 100 of the 600 hours and up to 40 of the 240 hours of face-to-face client contact to be added to the hours required for residency.

~~E. One course may satisfy study in more than one content area set forth in subsections B and C of this section.~~

~~F. If the applicant holds a current, unrestricted license as a professional counselor, clinical psychologist, or clinical social worker, the board may accept evidence of successful completion of 60 semester hours or 90 quarter hours of graduate study, including the hours specified in subsection C of this section.~~

18VAC115-60-80. Resident license and requirements for a residency.

A. Licensure. Applicants for a temporary resident license in substance abuse treatment shall:

1. Apply for licensure on a form provided by the board to include the following: (i) verification of a supervisory contract, (ii) the name and licensure number of the supervisor and location for the supervised practice, and (iii) an attestation that the applicant will be providing substance abuse treatment services;

2. Have submitted an official transcript documenting a graduate degree that meets the requirements specified in 18VAC115-60-60 to include completion of the coursework and internship requirement specified in 18VAC115-60-70;

3. Pay the registration fee;

4. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank ~~(NPDB)~~; and

5. Have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration in Virginia or in another jurisdiction. The board will consider the history of disciplinary action on a case-by-case basis.

B. Applicants who are beginning their residencies in exempt settings shall register supervision with the board to assure acceptability at the time of application.

C. Residency requirements.

1. The applicant for licensure as a substance abuse treatment practitioner shall have completed no fewer than 3,400 hours in a supervised residency in substance abuse treatment with various populations, clinical problems and theoretical approaches in the following areas:

a. Clinical evaluation;

b. Treatment planning, documentation, and implementation;

c. Referral and service coordination;

d. Individual and group counseling and case management;

e. Client family and community education; and

f. Professional and ethical responsibility.

2. The residency shall include a minimum of 200 hours of in-person supervision between supervisor and resident occurring at a minimum of one hour and a maximum of four hours per 40 hours of work experience during the period of the residency.

a. No more than half of these hours may be satisfied with group supervision.

b. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

c. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of approved supervision.

d. For the purpose of meeting the 200-hour supervision requirement, in-person supervision may include the use of technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident.

e. Up to 20 hours of the supervision received during the supervised internship may be counted towards the 200 hours of in-person supervision if the supervision was provided by a licensed professional counselor.

3. The residency shall include at least 2,000 hours of face-to-face client contact in providing clinical services with at least 1,000 of those hours providing substance abuse treatment ~~services~~ or addiction counseling with individuals, families, or groups of ~~individuals suffering from the effects of substance abuse or dependence~~ people with substance use disorder. The remaining hours (1,400 of the 3,400) may be spent in the performance of ancillary services.

4. A graduate level degree internship in excess of 600 hours, which is completed in a program that meets the requirements set forth in 18VAC115-60-70, may count for up to an additional 300 hours towards the requirements of a residency.

5. The residency shall be completed in not less than 21 months or more than ~~four~~ six years from the start of the residency. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, ~~2020~~ 2022. ~~An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue.~~ A resident shall meet the renewal requirements of subsection C of 18VAC115-60-110 in order to maintain a license in current, active status.

6. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

7. Residents may not call themselves substance abuse treatment practitioners, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners or substance abuse treatment practitioners. During the residency, residents shall use their names and the initials of their degree, their resident license number, and the title "Resident in Substance Abuse Treatment" in all written communications. Clients shall be informed in writing that the resident does not have authority for independent practice and is under supervision and shall provide the board-approved supervisor's name, professional address, and telephone number.

8. Residents shall not engage in practice under supervision in any areas for which they have not had appropriate education.

9. Residency hours that are approved by the licensing board in another United States jurisdiction and ~~that meet~~ are completed in that jurisdiction shall be accepted if those hours are consistent with the requirements of this ~~section shall be accepted~~ subsection.

D. Supervisory qualifications.

1. A person who provides supervision for a resident in substance abuse treatment shall hold an active, unrestricted license as a professional counselor or substance abuse treatment practitioner in the jurisdiction where the supervision is being provided. ~~Supervisors who are marriage and family therapists, school psychologists, clinical psychologists, clinical social workers, clinical nurse specialists, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.~~

2. All supervisors shall document two years post-licensure substance abuse treatment experience and at least 100 hours of didactic instruction in substance abuse treatment. Supervisors must document a three-credit-hour course in supervision, a 4.0-quarter-hour course in supervision, or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-60-116.

E. Supervisory responsibilities.

1. Supervision by any individual whose relationship to the resident compromises the objectivity of the supervisor is prohibited.

2. The supervisor of a resident shall assume full responsibility for the clinical activities of that resident specified within the supervisory contract ~~for the duration~~ until completion or termination of the residency, regardless of whether the supervisor is onsite or offsite at the location where services are provided by the resident.

3. The supervisor is accountable for the resident's compliance with residency requirements of this section.

4. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period. The supervisor shall maintain copies of supervisory contracts, quarterly reports, and the verification of supervision forms evaluating an applicant's competency for five years after termination or completion of supervision.

~~4.~~ 5. The supervisor shall report the total hours of residency to the board and shall evaluate the applicant's competency in the six areas stated in subdivision C 1 of this section.

~~F. Documentation of supervision. Applicants shall document successful completion of their residency on the Verification of Supervision form at the time of application. Applicants must receive a satisfactory competency evaluation on each item on the evaluation sheet.~~

18VAC115-60-90. General examination requirements; time limits.

A. Every applicant for licensure as a substance abuse treatment practitioner by examination shall pass a written examination as prescribed by the board. Such applicant is required to pass the prescribed examination within six years from the date of initial issuance of a resident license by the board.

B. Every applicant for licensure as a substance abuse treatment practitioner by endorsement shall have passed a substance abuse examination deemed by the board to be substantially equivalent to the Virginia examination.

C. ~~The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor issued by the board.~~

~~D.~~ The board shall establish a passing score on the written examination.

~~E.~~ D. A resident shall remain in a residency practicing under supervision until the resident has passed the licensure examination and been granted a license as a substance abuse treatment practitioner.

18VAC115-60-116. Continuing competency activity criteria.

A. Continuing competency activities must focus on increasing knowledge or skills in one or more of the following areas:

1. Ethics, standards of practice or laws governing behavioral science professions;

2. Counseling theory;

3. Human growth and development;

4. Social and cultural foundations;

5. The helping relationship;

6. Group dynamics, processing and counseling;

7. Lifestyle and career development;

8. Appraisal of individuals;

9. Research and evaluation;

10. Professional orientation;

11. Clinical supervision;

12. Marriage and family therapy; or

13. Addictions.

B. Approved hours of continuing competency activity shall be one of the following types:

1. Formally organized learning activities or home study. Activities may be counted at their full hour value. Hours shall be obtained from one or a combination of the following board-approved, mental health-related activities:

a. Regionally accredited university-or college-level academic courses in a behavioral health discipline.

b. Continuing education programs offered by universities or colleges.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state, or local governmental agencies or licensed health facilities and licensed hospitals.

d. Workshops, seminars, conferences, or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The International Association of Marriage and Family Counselors and its state affiliates.

(2) The American Association for Marriage and Family Therapy 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) The National Board for Certified Counselors.

(10) A national behavioral health organization or certification body.

(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.

2. Individual professional activities.

a. ~~Publication/presentation/new~~ Publication, presentation, or new program development.

(1) Publication of articles. Activity will count for a maximum of eight hours. Publication activities are limited to articles in refereed journals or a chapter in an edited book.

(2) Publication of books. Activity will count for a maximum of 18 hours.

(3) Presentations. Activity will count for a maximum of eight hours. The same presentations may be used only once in a two-year period. Only actual presentation time may be counted.

(4) New program development. Activity will count for a maximum of eight hours. New program development includes a new course, seminar, or workshop. New courses shall be graduate or undergraduate level college or university courses.

(5) Attendance at board meetings or disciplinary proceedings. Activity shall count for actual time of meeting or proceeding for a maximum of two hours during one renewal period.

b. Dissertation. Activity will count for a maximum of 18 hours. Dissertation credit may only be counted once.

c. Clinical supervision/consultation. Activity will count for a maximum of ~~10~~ six hours. Continuing competency can only be granted for clinical supervision/consultation received on a regular basis with a set agenda. Continuing competency cannot be granted for supervision that you provide to others.

d. Leadership. Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officers of state or national counseling organization; editor or reviewer of professional counseling journals; member of state counseling ~~licensure/certification~~ licensure or certification board; member of a national counselor certification board; member of a national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; other leadership positions with justifiable professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

e. Practice related programs. Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the regulant submits proof of attendance plus a written justification of how the activity assists ~~him~~ the regulant in ~~his~~ the direct service of ~~his~~ the regulant's clients. Examples include language courses, software training, medical topics, etc.

18VAC115-60-117. Documenting compliance with continuing competency requirements.

A. All licensees are required to maintain original documentation for a period of two years following renewal.

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 as follows:

1. To document completion of formal organized learning activities, licensee shall provide:

a. Official transcripts showing credit hours earned; or

b. Certificates of participation.

2. Documentation of home study shall be made by identification of the source material studied, summary of content, and a signed affidavit attesting to completion of the home study.

3. Documentation of individual professional activities shall be by one of the following:

a. Certificates of participation;

b. Proof of presentations made;

c. Reprints of publications;

d. Letters from educational institutions or agencies approving continuing education programs;

e. Official notification from the association that sponsored the item writing workshop or continuing education program; or

f. Documentation of attendance at formal staffing or participation in clinical supervision/consultation shall be by signed ~~affidavit~~ attestation on a form provided by the board.

D. Continuing competency hours required by a disciplinary order shall not be used to satisfy renewal requirements.

18VAC115-60-120. Late renewal; reinstatement.

A. A person whose license has expired may renew it within one year after its expiration date by paying the late renewal fee prescribed in 18VAC115-60-20, as well as the license fee prescribed for the year the license was not renewed and providing evidence of having met all applicable continuing competency requirements.

B. A person who fails to renew a substance abuse treatment practitioner license after one year or more and wishes to resume practice shall (i) apply for reinstatement~~,~~; (ii) pay the reinstatement fee for a lapsed license~~,~~; (iii) submit verification of any mental health license ~~he~~ the person holds or has held in another jurisdiction, if applicable~~,~~; (iv) provide a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank; and (v) provide evidence of

having met all applicable continuing competency requirements not to exceed a maximum of 80 hours obtained within the four years immediately preceding application for reinstatement. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

C. A person wishing to reactivate an inactive substance abuse treatment practitioner license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal; (ii) documentation of continued competency hours equal to the number of years the license has been inactive not to exceed a maximum of 80 hours obtained within the four years immediately preceding application for reactivation; and (iii) verification of any mental health license he holds or has held in another jurisdiction, if applicable. The board may require the applicant for reactivation to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

D. A person who fails to renew a resident license after one year or more and wishes to resume his residency within the six-year limitation from the date of initial issuance of a resident license shall (i) apply for reinstatement; (ii) pay the initial licensure fee for a resident in substance abuse treatment; and (iii) provide evidence of having met continuing competency requirements not to exceed a maximum of 12 hours. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the resident license.

18VAC115-60-130. 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. Regardless of the delivery method, whether in person, by phone or electronically, these standards shall apply to the practice of substance abuse treatment.

B. Persons licensed or registered 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. Practice only within the boundaries of their competence, based on their education, training, supervised experience and appropriate professional experience and represent their education, training and experience accurately to clients;

3. Stay abreast of new substance abuse treatment information, concepts, application, and practices that are necessary to providing appropriate, effective professional services;

4. Be able to justify all services rendered to clients as necessary and appropriate for diagnostic or therapeutic purposes;

5. 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 appropriate arrangements for the continuation of treatment for clients, when necessary, following termination of a counseling relationship;

6. Make appropriate arrangements for continuation of services, when necessary, during interruptions such as vacations, unavailability, relocation, illness, and disability;

7. Disclose to clients all experimental methods of treatment and inform clients of the risks and benefits of any such treatment. Ensure that the welfare of the clients is in no way compromised in any experimentation or research involving those clients;

8. Neither accept nor give commissions, rebates, or other forms of remuneration for referral of clients for professional services;

9. Inform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed; the limitations of confidentiality; and other pertinent information when counseling is initiated and throughout the counseling process as necessary. Provide clients with accurate information regarding the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements;

10. Select tests for use with clients that are valid, reliable, and appropriate and carefully interpret the performance of individuals not represented in standardized norms;

11. Determine whether a client is receiving services from another mental health service ~~provider~~ professional, and if so, ~~refrain from providing services to the client without having an informed consent discussion with the client and having been granted communication privileges with the other professional~~ document efforts to coordinate care;

12. Use only in connection with one's practice as a mental health professional those educational and professional degrees or titles that have been earned at a college or university accredited by an accrediting agency recognized by the U.S. Department of Education, or credentials granted by a national certifying agency, and that are counseling in nature;

13. Advertise professional services fairly and accurately in a manner that is not false, misleading or deceptive, including compliance with 18VAC115-60-80 regarding requirements for representation to the public by residents in counseling; ~~and~~

14. Not engage in conversion therapy with any person younger than 18 years of age;

15. Make appropriate referrals based on the interests of the client; and

16. 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 is beyond the control of the practitioner shall not be considered negligent or willful.

C. In regard to patient records, persons licensed or registered by the board shall:

1. Maintain timely, accurate, legible, and complete written or electronic clinical records for each client to include treatment dates and identifying information to substantiate diagnosis and treatment plan, client progress, and termination;

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. Disclose or release records to others only with clients' expressed written consent or that of their legally authorized representative in accordance with § 32.1-127.1:03 of the Code of Virginia;

4. Maintain client records for a minimum of five years or as otherwise required by law from the date of termination of the substance abuse treatment 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) or 10 years following termination, whichever comes later;

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; and

5. Ensure confidentiality in the usage of client records and clinical materials by obtaining informed consent from clients or their 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.

D. In regard to dual or multiple relationships, persons licensed or registered by the board shall:

1. Avoid dual or multiple relationships with clients that could impair professional judgment or increase the risk of harm to clients. Examples of such relationships include familial, social, financial, business, bartering, or close personal relationships with clients. Counselors shall take appropriate professional precautions when a dual relationship cannot be avoided, such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation or neglect occurs;

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and not counsel persons with whom they have had a romantic relationship or sexual intimacy. Licensed substance abuse treatment practitioners shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Licensed substance abuse treatment practitioners who engage in such relationship or intimacy after five years following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of or participation in sexual behavior or involvement with a licensed substance abuse treatment practitioner does not change the nature of the conduct nor lift the regulatory prohibition;

3. Not engage in any sexual intimacy or romantic relationship or establish a counseling or psychotherapeutic relationship with a ~~supervisee~~ person under supervision or student. Licensed substance abuse treatment practitioners shall avoid any nonsexual dual relationship with a ~~supervisee~~ person under supervision or student in which there is a risk of exploitation or potential harm to the ~~supervisee~~ person under supervision or the potential for interference with the supervisor's professional judgment; and

4. Recognize conflicts of interest and inform all parties of the nature and directions of loyalties and responsibilities involved.

E. Persons licensed or registered by this board shall report to the board known or suspected violations of the laws and regulations governing the practice of substance abuse treatment.

F. Persons licensed or registered by the board shall advise their clients of their right to report to the Department of Health Professions any information of which the licensee may become aware in his professional capacity indicating that there is a reasonable probability that a person licensed or certified as a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, may have engaged in unethical, fraudulent or unprofessional conduct as defined by the pertinent licensing statutes and regulations.

18VAC115-60-140. Grounds for revocation, suspension, probation, reprimand, censure, or denial of renewal of license or registration.

A. Action by the board to revoke, suspend, deny issuance or renewal of a license, or take other disciplinary action may be taken in accord with the following:

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 treatment, or any provision of this chapter;

2. ~~Procurement of~~ Procuring, attempting to procure, or maintaining a license~~, including submission of an application or supervisory forms,~~ or registration by fraud or misrepresentation;

3. Conducting one's practice in such a manner 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 treatment with reasonable skill and safety to clients by reason of illness, abusive use of alcohol, drugs, narcotics, chemicals, or other type of material or result of any mental or physical condition~~;

4. Demonstrating an inability to practice substance abuse treatment with reasonable skill and safety to clients by reason of illness or substance misuse or as a result of any mental, emotional, or physical condition;

5. Intentional or negligent conduct that causes or is likely to cause injury to a client;

~~5.~~ 6. Performance of functions outside the demonstrable areas of competency;

~~6.~~ 7. Failure to comply with the continued competency requirements set forth in this chapter;

~~7.~~ 8. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of licensed substance abuse ~~therapy~~ treatment, or any part or portion of this chapter; ~~or~~

~~8.~~ 9. Performance of an act likely to deceive, defraud, or harm the public;

10. Knowingly allowing persons under supervision to jeopardize client safety or provide care to clients outside of such person's scope of practice or area of responsibility;

11. Having an action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

12. Failing to cooperate with an employee of the Department of Health Professions in the conduct of an investigation; or

13. Failing to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia, or abuse of aged or incapacitated adults as required in § 63.2-1606 of the Code of Virginia.

B. Following the revocation or suspension of a license the licensee may petition the board for reinstatement upon good cause shown or as a result of substantial new evidence having been obtained that would alter the determination reached.

VA.R. Doc. No. R19-5799; Filed January 1, 2022, 3:50 p.m.

BOARD OF SOCIAL WORK

Proposed Regulation

Title of Regulation: **18VAC140-20. Regulations Governing the Practice of Social Work (amending 18VAC140-20-45, 18VAC140-20-110, 18VAC140-20-150).**

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

Public Hearing Information:

March 3, 2022 - noon - Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room 2, Henrico, VA 23233

Public Comment Deadline: April 1, 2022.

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. The specific authority of the Board of Social Work is found in § 54.1-3705 of the Code of Virginia.

Purpose: The amendments to the standards of practice are intended to address a situation in which a practitioner's action may be clearly unprofessional and detrimental to the welfare of a client, but the board does not have specific grounds to take some disciplinary action. Amendments will ensure that the board can take action as necessary to protect the health and safety of the public.

Substance: The board proposes the following amendments: (i) to eliminate all requirements for either supervised experience or active practice in another jurisdiction for licensure by endorsement for a licensed bachelor social worker, licensed master social worker, or licensed clinical social worker; (ii) to eliminate requirements for a person whose license has been lapsed for 10 or more years to provide evidence of either active practice in another jurisdiction or in an exempt setting, or supervised practice of no less than 360 hours in a 12-month period in order to reinstate or reactive a license; and (iii) to specify in the standards of practice that persons licensed by the board shall not engage in physical contact with a client when

there is a likelihood of psychological harm to the client and shall not sexually harass a client.

Issues: The advantages to the public are (i) less restrictive requirements for licensure by endorsement may result in an increase in the number of licensed social workers who can provide services in the Commonwealth; and (ii) more explicit rules on unprofessional conduct will provide greater protection for clients of social workers. There are no disadvantages to the public. There are no specific advantages or disadvantages to the agency.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Social Work (Board) proposes discretionary changes to: 1) eliminate a specified requirement for licensure by endorsement, 2) eliminate a specified requirement for reinstatement or reactivation of licensure for a person whose license has been lapsed or inactive for 10 or more years, and 3) specify that persons licensed by the Board who are in dual relationships with a client shall not engage in physical contact with a client when there is a likelihood of psychological harm to the client nor shall they sexually harass a client.

Background.

Licensure Levels. Pursuant to § 54.1-3700 of the Code of Virginia,[1] a licensed clinical social worker (LCSW) is a licensed social worker who, by education and experience, is professionally qualified at the autonomous practice level to provide direct diagnostic, preventive and treatment services where functioning is threatened or affected by social and psychological stress or health impairment. A licensed master's social worker (LMSW) is a licensed social worker who engages in the practice of social work and provides non-clinical, generalist services, including staff supervision and management. A licensed baccalaureate social worker (LBSW) is a licensed social worker who engages in the practice of social work under the supervision of a master's social worker and provides basic generalist services, including casework management and supportive services and consultation and education.

Licensure by Endorsement. Under the current regulation, 18VAC140-20-45 states that every applicant for licensure by endorsement shall submit:

> "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.
>
> 7. Certification that the applicant is not the respondent in any pending or unresolved Board action in another jurisdiction or in a malpractice claim."

As part of this regulatory change, the Board now proposes to eliminate the sixth required submission (i.e., verification).

Reinstatement and Reactivation. Under the current regulation, 18VAC140-20-110 indicates that (a) individuals applying for license reinstatement whose license has been lapsed for 10 or more years and (b) individuals applying for license reactivation who have been inactive for 10 or more years shall, among other requirements, provide evidence of competency to practice by documenting:

> 1. Active practice in another United States jurisdiction for at least 24 out of the past 60 months immediately preceding application;
>
> 2. Active practice in an exempt setting for at least 24 out of the past 60 months immediately preceding application; or
>
> 3. Practice as a supervisee under supervision for at least 360 hours in the 12 months immediately preceding reinstatement of licensure in Virginia. The supervised practice shall include a minimum of 60 hours of face-to-face direct client contact and nine hours of face-to-face supervision.

The Board now proposes to wholly eliminate this requirement to provide evidence of competency to practice. Other requirements do remain.[2]

Professional Conduct. Section 18VAC140-20-150 subsection D specifies requirements for licensees in regard to dual relationships. According to the National Association of Social Workers Code of Ethics, from which this language was taken, "Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively."[3] The Board proposes to add that licensees who are in a dual relationship with a client shall:

"6. Not engage in physical contact with a client when there is a likelihood of psychological harm to the client. Social workers who engage in physical contact are responsible for setting clear and culturally sensitive boundaries.

7. Not sexually harass clients. Sexual harassment includes sexual advances; sexual solicitation; requests for sexual favors; and other verbal written, electronic, or physical contact of a sexual nature."

Based upon its placement in the dual relationship section of the regulation (18VAC140-20-150, subsection D), and not elsewhere in the regulation, it appears that this proposed additional language would only apply to social workers who are in dual relationships, and not to other types of client interactions or relationships.

Estimated Benefits and Costs

Licensure by Endorsement. In 2020, the Board issued 377 LCSW, 81 LMSW, and 6 LBSW licenses by endorsement.[4] So far in 2021, the Board has issued 456 LCSW, 91 LMSW, and 12 LBSW licenses by endorsement.[5] The proposal to eliminate the requirement of verification of active practice or supervised experience for licensure by endorsement applicants would likely increase these numbers somewhat going forward by increasing the number of individuals who qualify for licensure by endorsement. This would be beneficial for such applicants, as well as employers in the Commonwealth looking to hire fully-licensed social workers.

Licensure by endorsement would still require: a) documentation of active social work licensure[6] in good standing in another jurisdiction as verified by the out-of-state licensing agency, b) verification of a passing score on a Board-approved national exam at the level for which the applicant is seeking licensure in Virginia, c) a current report from the NPDB, and d) certification that the applicant is not the respondent in any pending or unresolved Board action in another jurisdiction or in a malpractice claim. The Board believes that these remaining requirements are sufficient evidence of competency and good practice for candidates to be licensed by endorsement from another U.S. jurisdiction.[7]

Reinstatement and Reactivation. In 2020, the Board reinstated 29 LCSW, 3 LMSW, and 0 LBSW licenses.[8] So far in in 2021, the Board has reinstated 31 LCSW, 7 LMSW, and 0 LBSW licenses.[9] Data on reactivated licenses is not available. The proposal to eliminate the requirement of documentation of active practice or supervised experience for reinstatement or reactivation applicants whose license has been lapsed or inactive for 10 or more years would likely increase these numbers somewhat going forward by increasing the number of individuals who qualify for reinstatement or reactivation. This would be beneficial for such applicants, as well as employers in the Commonwealth looking to hire fully-licensed social workers.

Such a social worker reactivating would still be required to provide documentation of continued competency hours equal to the number of years the license has been inactive, not to exceed four years. Such a social worker reinstating would still be required to provide: a) documentation of having completed all applicable continued competency hours equal to the number of years the license has lapsed, not to exceed four years, b) documentation of any other health or mental health licensure or certification held in another United States jurisdiction, if applicable, and c) a current report from the NPDB. Additionally, the regulation does not require active practice to renew a full current license. Thus, the Board believes the remaining requirements are sufficient evidence of competency for an applicant to have their license reinstated or reactivated.

Professional Conduct. According to the Department of Health Professions, the proposed language specifying that persons licensed by the Board who are engaged in dual relationships with clients shall not engage in physical contact with a client when there is a likelihood of psychological harm to the client and shall not sexually harass a client, are added to address situations that have been reported to the Board in complaints filed by clients. In making a determination of probable cause to move forward with a disciplinary proceeding, Board members did not believe there were clear standards on which a case could be made. The proposed additions would address conduct that the Board believes is unprofessional and harmful to clients. To the extent that the proposed additional language helps enable the Board to properly discipline inappropriate behavior by licensees, it would be beneficial.

Businesses and Other Entities Affected. The proposed amendments potentially affect the 8,006 LCSWs, 966 LMSWs, and 31 LBSWs licensed in the Commonwealth, as well as entities that employ social workers. According to survey data from a July 2020 report (the most recent available) from the Virginia Healthcare Workforce Data Center,[10] the primary employers of LCSWs in the Commonwealth are distributed as follows:

Establishment Type	Percentage
Private Practice, Solo	16%
Private Practice, Group	13%
Mental Health Facility, Outpatient	13%
Community Services Board	10%
School (Providing Care to Clients)	7%
Hospital, General	7%
Community-Based Clinic or Health Center	7%
Hospital, Psychiatric	3%

Residential Mental Health/Substance Abuse Facility	2%
Administrative or Regulatory	2%
Academic Institution (Teaching Health Professions Students)	2%
Other Practice Setting	17%

Categorized by sector, the report presents the types of employers of LCSWs in Virginia as follows:

Sector	Percentage
For-Profit	48%
Non-Profit	21%
State/Local Government	22%
Veterans Administration	4%
U.S. Military	3%
Other Federal Government	1%

Similar data are not available for LBSWs and LMSWs.

The proposed amendments do not appear to adversely affect employers of social workers.

Small Businesses[11] Affected. The proposed amendments do not appear to adversely affect small businesses. The Board has not provided any information regarding the specific number of employers that are independent practitioners (small businesses).

Localities[12] Affected.[13] Local governments that are having difficulty finding enough qualified social workers to employ may be particularly affected by the proposed elimination of specified requirements for licensure by endorsement and reinstatement or reactivation of licensure for a person whose license has been lapsed or inactive for 10 or more years. The proposed amendments do not appear to introduce costs for local governments. The Board has not provided any information regarding how many employers are local government agencies or entities.

Projected Impact on Employment. The proposed elimination of specified requirements for licensure by endorsement and reinstatement or reactivation of licensure for a person whose license has been lapsed or inactive for 10 or more years may moderately increase the number of individuals who become licensed social workers in the Commonwealth. More licensed social workers would likely result in more individuals employed as social workers in Virginia.

Effects on the Use and Value of Private Property. The proposed elimination of specified requirements for licensure by endorsement and reinstatement or reactivation of licensure for a person whose license has been lapsed or inactive for 10 or more years may moderately increase the supply of licensed social workers. This may moderately reduce the cost to firms of hiring social workers, which may in turn have a small positive impact on their value.

The proposed amendments do not affect real estate development costs.

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[1]See https://law.lis.virginia.gov/vacode/54.1-3700/

[2]See discussion in the Estimated Benefits and Costs section, Reinstatement and Reactivation subsection.

[3] See Section 1.06 Conflicts of Interest, under Ethical Standards at https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

[4]Source: Department of Health Professions

[5]Ibid

[6]"Active social work licensure" means that the license is active, but does not necessarily mean that the license holder has been practicing actively.

[7]Source: Department of Health Professions

[8]Ibid

[9]Ibid

[10]See https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/behsci/0904LCSW2020.pdf

[11]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."

[12]"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.

[13]§ 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

Agency's Response to Economic Impact Analysis: The Board of Social Work concurs with the economic impact analysis (EIA) of the Department of Planning and Budget with one exception. On page 3, the EIA states that the prohibition on physical contact with a client when there is a likelihood of psychological harm or sexually harassment of a client would only apply to social workers who are in dual relationships. It would be the opinion of the board that those behaviors would constitute a "dual relationship" that is inappropriate and unethical and possibly grounds for disciplinary action.

Summary:

The proposed amendments (i) eliminate all requirements for either supervised experience or active practice in another jurisdiction for licensure by endorsement for a licensed bachelor social worker, licensed master social worker, or licensed clinical social worker; (ii) eliminate requirements for a person whose license has been lapsed for 10 or more years to provide evidence of either active practice in another jurisdiction or in an exempt setting or supervised practice of no less than 360 hours in a 12-

month period in order to reinstate or reactive a license; and (iii) specify in the standards of practice that persons licensed by the board shall not engage in physical contact with a client when there is a likelihood of psychological harm to the client and shall not sexually harass a client.

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.~~

~~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.

18VAC140-20-110. Late renewal; reinstatement; reactivation.

A. An LBSW, LMSW, or clinical social worker whose license has expired may renew that license within one year after its expiration date by:

1. Providing evidence of having met all applicable continuing education requirements.

2. Paying the penalty for late renewal and the renewal fee as prescribed in 18VAC140-20-30.

B. An LBSW, LMSW, or clinical social worker who fails to renew the license after one year and who wishes to resume practice shall apply for reinstatement and pay the reinstatement fee, which shall consist of the application processing fee and the penalty fee for late renewal, as set forth in 18VAC140-20-30. An applicant for reinstatement shall also provide:

1. Documentation of having completed all applicable continued competency hours equal to the number of years the license has lapsed, not to exceed four years;

2. Documentation of any other health or mental health licensure or certification held in another United States jurisdiction, if applicable; and

3. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank.

C. ~~In addition to requirements set forth in subsection B of this section, an applicant for reinstatement whose license has been lapsed for 10 or more years shall also provide evidence of competency to practice by documenting:~~

~~1. Active practice in another United States jurisdiction for at least 24 out of the past 60 months immediately preceding application;~~

~~2. Active practice in an exempt setting for at least 24 out of the past 60 months immediately preceding application; or~~

~~3. Practice as a supervisee under supervision for at least 360 hours in the 12 months immediately preceding reinstatement of licensure in Virginia. The supervised practice shall include a minimum of 60 hours of face-to-face direct client contact and nine hours of face-to-face supervision.~~

~~D.~~ An LBSW, LMSW, or clinical social worker wishing to reactivate an inactive license shall submit the difference between the renewal fee for active licensure and the fee for inactive licensure renewal and document completion of continued competency hours equal to the number of years the license has been inactive, not to exceed four years. ~~An applicant for reactivation who has been inactive for 10 or more years shall also provide evidence of competency to practice by documenting:~~

~~1. Active practice in another United States jurisdiction for at least 24 out of the past 60 months immediately preceding application;~~

~~2. Active practice in an exempt setting for at least 24 out of the past 60 months immediately preceding application; or~~

~~3. Practice as a supervisee under supervision for at least 360 hours in the 12 months immediately preceding reactivation of licensure in Virginia. The supervised practice shall include a minimum of 60 hours of face-to-face direct client contact and nine hours of face-to-face supervision.~~

18VAC140-20-150. Professional conduct.

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. Regardless of the delivery method, whether in person, by telephone, or electronically, these standards shall apply to the practice of social work.

B. Persons licensed as LBSWs, LMSWs, and clinical social workers shall:

1. Be able to justify all services rendered to or on behalf of clients as necessary for diagnostic or therapeutic purposes.

2. Provide for continuation of care when services must be interrupted or terminated.

3. Practice only within the competency areas for which they are qualified by education and experience.

4. Report to the board known or suspected violations of the laws and regulations governing the practice of social work.

5. Neither accept nor give commissions, rebates, or other forms of remuneration for referral of clients for professional services.

6. Ensure that clients are aware of fees and billing arrangements before rendering services.

7. Inform clients of potential risks and benefits of services and the limitations on confidentiality and ensure that clients have provided informed written consent to treatment.

8. Keep confidential their therapeutic relationships with clients and disclose client records to others only with written consent of the client, with the following exceptions: (i) when the client is a danger to self or others; or (ii) as required by law.

9. When advertising their services to the public, ensure that such advertising is neither fraudulent nor misleading.

10. As treatment requires and with the written consent of the client, collaborate with other health or mental health providers concurrently providing services to the client.

11. Refrain from undertaking any activity in which one's personal problems are likely to lead to inadequate or harmful services.

12. Recognize conflicts of interest and inform all parties of the nature and directions of loyalties and responsibilities involved.

13. Not engage in conversion therapy with any person younger than 18 years of age.

C. In regard to client records, persons licensed by the board shall comply with provisions of § 32.1-127.1:03 of the Code of Virginia on health records privacy and shall:

1. Maintain written or electronic clinical records for each client to include identifying information and assessment that substantiates diagnosis and treatment plans. Each record shall include a diagnosis and treatment plan, progress notes for each case activity, information received from all collaborative contacts and the treatment implications of that information, and the termination process and summary.

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. Disclose or release records to others only with clients' expressed written consent or that of their legally authorized representative or as mandated by law.

4. Ensure confidentiality in the usage of client records and clinical materials by obtaining informed consent from clients or their 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.

5. Maintain client records for a minimum of six years or as otherwise required by law from the date of termination of the therapeutic relationship with the following exceptions:

a. At minimum, records of a minor child shall be maintained for six years after attaining the age of majority or 10 years following termination, whichever comes later.

b. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

c. Records that have been transferred to another mental health professional or have been given to the client or ~~his~~ the client's legally authorized representative.

D. In regard to dual relationships, persons licensed by the board shall:

1. Not engage in a dual relationship with a client or a supervisee that could impair professional judgment or increase the risk of exploitation or harm to the client or supervisee. (Examples of such a relationship include familial, social, financial, business, bartering, or a close personal relationship with a client or supervisee.) Social workers shall take appropriate professional precautions when a dual relationship cannot be avoided, such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs.

2. Not have any type of romantic relationship or sexual intimacies with a client or those included in collateral therapeutic services, and not provide services to those persons with whom they have had a romantic or sexual relationship. Social workers shall not engage in romantic relationship or sexual intimacies with a former client within

a minimum of five years after terminating the professional relationship. Social workers who engage in such a relationship after five years following termination shall have the responsibility to examine and document thoroughly that such a relationship did not have an exploitive nature, based on factors such as duration of therapy, amount of time since therapy, termination circumstances, client's personal history and mental status, adverse impact on the client. A client's consent to, initiation of, or participation in sexual behavior or involvement with a social worker does not change the nature of the conduct nor lift the regulatory prohibition.

3. Not engage in any romantic or sexual relationship or establish a therapeutic relationship with a current supervisee or student. Social workers shall avoid any nonsexual dual relationship with a supervisee or student in which there is a risk of exploitation or potential harm to the supervisee or student, or the potential for interference with the supervisor's professional judgment.

4. Recognize conflicts of interest and inform all parties of the nature and directions of loyalties and responsibilities involved.

5. Not engage in a personal relationship with a former client in which there is a risk of exploitation or potential harm or if the former client continues to relate to the social worker in ~~his~~ the social worker's professional capacity.

6. Not engage in physical contact with a client when there is a likelihood of psychological harm to the client. Social workers who engage in physical contact are responsible for setting clear and culturally sensitive boundaries.

7. Not sexually harass clients. Sexual harassment includes sexual advances; sexual solicitation; requests for sexual favors; and other verbal written, electronic, or physical contact of a sexual nature.

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 licensed 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.

VA.R. Doc. No. R21-6341; Filed December 30, 2021, 2:42 p.m.

TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Proposed Regulation

Title of Regulation: **22VAC30-120. Adult Services Approved Providers (amending 22VAC30-120-10 through 22VAC30-120-160).**

Statutory Authority: § 51.5-131 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: April 1, 2022.

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 51.5-145 of the Code of Virginia gives the Department for Aging and Rehabilitative Services (DARS) the responsibility for the planning and oversight of adult services including homemaker, chore, and companion services. These services are to be delivered by the local department of social services (LDSS) 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 DARS. In addition, § 63.2-1601 of the Code of Virginia gives the Commissioner of DARS the authority over regulations related to the recruitment and approval for the provision of adult foster care services. Finally, § 51.5-131 of the Code of Virginia authorizes the Commissioner of the DARS to promulgate regulations necessary to carry out the provisions of the laws of the Commonwealth administered by DARS.

Purpose: This regulation will amend relevant content that describes the standards a local provider must meet in order to be approved by LDSS. The standards ensure that an adult's health and safety remain a primary focus when services are provided to older adults and individuals with disabilities. Many services provided by LDSS approved homemaker, chore, companion, and adult foster care providers promote the well-being of adults by strengthening the support systems, including family supports, that enable adults to live in community-based settings for as long as possible. This regulatory action will ensure that the regulation content is clearly written. Clarity in regulation content is essential to ensuring that the individual'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. There is some content regarding the adult foster care providers' need to ensure that weapons are not accessible to adults receiving care, which is more stringent than federal law and must be amended. Regulatory content has been carefully analyzed to ensure requirements adequately

address the safety of the adult who is receiving services, while also balancing the adult's right to self-determination. Person-centered language has been incorporated throughout the regulation. Other revisions to the regulation included comments made by regulatory workgroup members.

Issues: The primary advantage of the proposed amendments to the public is to clarify language that was unclear, inconsistent, or outdated, and an advantage to the agency is that amendments to the regulation clarify, but do not increase, LDSS staff responsibilities with regard to approving and monitoring providers. There are 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 changes to an existing regulation governing providers who are approved by a local department of social services (LDSS) to provide adult services to a client of the LDSS. The changes would: 1) require an LDSS to evaluate an individual's application to be a provider when an adult recipient requests that individual be his/her provider, 2) raise the minimum age to be a chore and companion service provider, and to be an assistant to an in-home provider, from 16 to 18, and 3) clarify content that is unclear, inconsistent, or obsolete.

Background. This regulation establishes standards for individuals operating as LDSS approved providers or who are interested in becoming one for services provided to adults, such as homemaker, chore, companion services, and adult foster care (AFC). The applicability of this regulation is limited to individual providers serving three or fewer adult clients of the LDSS.[1] Also, AFC is an optional program that a locality can chose to provide, and fewer than 20 localities currently provide AFC to their residents.

Estimated Benefits and Costs. Currently, LDSS are not required to accept new applications to be an adult services provider "when the local department has a sufficient number of providers for that service to meet the population needs." DARS proposes to require LDSS to evaluate a new application when an adult recipient identifies an individual whom they want to act as his/her provider. This change may increase the number of evaluations an LDSS must perform and may add to their costs in terms of staff time it takes to make an approval decision. On the other hand, this change will benefit the adult recipient by making it possible to receive services from his/her own preferred individual. In other words, this change will bolster the adult's choice in providers.

DARS also proposes to establish the minimum age to be a provider at 18 for all providers and provider assistants. Current language allows 16-year olds to be either a chore and companion service provider or an assistant to an in-home provider as long as he or she is competent to provide the service. The proposed change appears to be more stringent than the current age standard, but DARS is not aware of any providers who are less than 18 years old and currently approved by a LDSS. If in fact there are no approved providers or provider assistants who are less than 18 years old, this change would not have any adverse impact on any providers, but help ensure that the approved providers are mature and reduce potential risk to their client's health and safety.

The remaining changes to this regulation are clarifications in nature and address LDSS ability to grant a variance for a conviction of a barrier crime, criminal record background checks, use of restraints, presence of firearms in the provider home, etc. None of the changes in this category are expected to create any significant economic impact other than improving the clarity of the regulatory requirements for these issues and eliminating language that appears to conflict with state laws.

Businesses and Other Entities Affected. The proposed amendments to the regulation apply to individuals who are currently operating as LDSS-approved providers or may wish to become approved providers. DARS estimates that 3,000 to 4,000 adults receive in-home services and 60 individuals receive AFC from providers subject to this regulation. These regulations do not affect businesses, such as home care agencies, that are regulated by other state agencies. There are 120 LDSS statewide.

Localities[2] Affected.[3] The proposed amendments should not affect any locality more than others. The proposed amendments may introduce some administrative costs for local departments if and when they have to evaluate an individual to be a provider when specifically requested by an adult recipient.

Projected Impact on Employment. The proposed amendments would not affect total 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.[4] The proposed amendments do not appear to adversely affect small businesses.

[1]Providers serving more than three adults are licensed through or regulated by the Department of Health or the Department of Social Services.

[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 of the Code of Virginia defines "particularly affected" as bearing disproportionate material impact.

[4]Pursuant to § 2.2-4007.04, 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 Department for Aging and Rehabilitative Services raises no issues with the economic impact analysis performed by the Virginia Department of Planning and Budget.

Summary:

The proposed amendments (i) require a local department of social services to evaluate an individual's application to be a provider when an adult recipient requests that individual be that individual's provider; (ii) raise the minimum age to be a chore and companion service provider and to be an assistant to an in-home provider to 18 years of age; and (iii) clarify content, eliminate inconsistency within the regulation, remove obsolete text, and update text to use person-centered language.

22VAC30-120-10. Definitions.

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

"Activities of daily living" or "ADLs" means bathing, dressing, toileting, transferring, bowel control, bladder control and eating/feeding. A person's degree of independence in performing these activities is part of determining the appropriate level of care and services.

"Adult" means any individual 18 years of age or ~~over~~ older, or younger than 18 if legally emancipated.

"Adult abuse" means the willful infliction of physical pain, injury or mental anguish or unreasonable confinement of an adult as defined in § 63.2-1603.

~~"Adult day services provider" means a provider who gives personal supervision for up to three adults for part of a day. The provider promotes social, physical and emotional well-being through companionship, self-education, and satisfying leisure activities. Adult day services that are provided for more than three adults require licensure by the Virginia Department of Social Services.~~

"Adult exploitation" means the illegal, unauthorized, improper, or fraudulent use of an adult as defined in § 63.2-1603 or his 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 fund, 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 the 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.

"Adult foster care" means room and board, supervision, and special services to an adult who has a physical or mental condition ~~or an emotional or behavioral problem~~. Adult foster care may be provided by a single provider for up to three adults.

"Adult foster care provider" means a provider who gives room and board, supervision, and special services in ~~his~~ the provider's own home ~~for up to three adults who are unable to remain in their own homes because of~~ to an adult with a physical or mental condition ~~or an emotional or behavioral problem~~. Adult foster care may be provided by a single provider for up to three adults. Care provided for more than three adults requires licensure as an assisted living facility by the Virginia Department of Social Services.

"Adult neglect" means that an adult as defined in § 63.2-1603 is living under such circumstances that he is not able to provide for himself or is not being provided services 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 a written or oral expression of consent by that adult.

~~"Adult services" means services that are provided to adults 60 years of age and older and to adults 18 years of age and older who are impaired.~~

"Assistant" means any individual who is responsible to assist an ~~adult services~~ approved provider in caring for ~~adult clients~~ adults. Assistants ~~must~~ shall meet the ~~same requirements as the provider~~ standards set forth in this chapter.

"Chore provider" means a provider who performs nonroutine, heavy home maintenance tasks for ~~adult clients unable to perform such tasks for themselves. Chore services include~~ adults, including minor repair work on furniture and appliances in the adult's home; carrying coal, wood ~~and~~, or water; chopping wood; removing snow; yard maintenance; and painting.

~~"Client" means any adult who needs supervision and/or services and seeks assistance in meeting those needs from a local department of social services.~~

"Companion provider" means a provider who assists ~~adult clients unable to care for themselves without assistance and where there is no one available to provide the needed services without cost in~~ adults with activities such as light housekeeping, companionship, shopping, meal preparation, transportation, ~~household management activities of daily living (ADLs)~~ laundry, money management, and ADLs.

"Department" means the Virginia Department for Aging and Rehabilitative Services.

~~"Home-based services" means companion, chore, and homemaker services that allow individuals to attain or maintain self-care and are likely to prevent or reduce dependency.~~

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specific health care services consistent with the laws of the Commonwealth.

"Homemaker ~~services~~ provider" means a provider who gives instruction in or, where appropriate, performs activities such as personal care, ~~home~~ household management, household maintenance, nutrition, consumer or hygiene education.

"In-home provider" means an individual who provides care in the home of the adult ~~client needing supervision and/or services~~. In-home providers ~~include~~ are companion, chore, and homemaker providers.

"Instrumental activities of daily living" or "IADLs" means meal preparation, ~~housekeeping/light housework~~ light housekeeping, shopping ~~for personal items~~, money management, laundry, ~~or~~ using the telephone, and home maintenance. An ~~adult client's~~ adult's degree of independence in performing these activities is part of determining ~~the appropriate level of care and services~~ an adult's service needs.

~~"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 this Commonwealth.

"Local department-approved provider" means a provider that is not subject to licensure by the Virginia Department of Health or the Virginia Department of Social Services and is approved by a local department ~~of social services~~ to provide in-home or adult foster care services to ~~clients~~ adults.

~~"Out-of-home provider" means an individual who provides care in the individual's own home to adult clients who enter the home for purposes of receiving needed supervision and/or services.~~

"Personal care services" means the provision of nonskilled services to the adult including ~~assistance in the activities of daily living~~ ADLs, and may include ~~instrumental activities of daily living related to the needs of the adult client~~ IADLs, to maintain the adult ~~client's health and safety~~ safely in ~~their~~ the adult's home.

"Personal toiletries" means hygiene items provided to the individual by the adult foster care provider, including deodorant, razor, shaving cream, shampoo, soap, toothbrush, and toothpaste.

"Responsible person" means an individual ~~designated by or for an adult client~~ who is authorized by state law to make decisions concerning the adult ~~client and/or~~ and to receive information about the adult ~~client~~.

"Significant change" means a change in an adult's condition that is expected to last longer than 30 calendar days. It does not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclic pattern of clinical signs and symptoms associated with a previously diagnosed condition for which an appropriate course of treatment is in progress.

22VAC30-120-20. Local department-approved providers.

A. This regulation applies to ~~providers approved by a~~ local ~~department~~ department-approved providers and ~~does~~ shall not apply to facilities or organizations licensed or regulated by ~~a licensing or regulatory agency~~ the Virginia Department of Health or the Virginia Department of Social Services. A local department shall not approve a provider that does not meet the standards set ~~out~~ forth in this ~~regulation~~ chapter.

B. This ~~regulation~~ chapter is applicable to the following providers:

1. ~~Out-of-home providers including: a. Adult day services providers; b.~~ Adult foster care providers; and

2. In-home providers ~~including: a. Chore providers; b. Companion providers;c. Homemaker providers~~.

C. The local department is not required to accept provider applications ~~for any type of service~~ when the local department has a sufficient number of approved providers for that service ~~to meet the client population needs or,~~ does not offer the type of service, or chooses to contract with an agency or organization licensed or regulated by the Virginia Department of Health or the Virginia Department of Social Services to provide in-home providers. However, if the local department approves its own providers and the adult identifies an individual to be a provider, the local department shall initiate the approval process for that individual as long as the service is offered by that locality. The individual identified by the adult shall meet the standards set forth in this chapter.

D. Prior to approving an ~~out-of-home~~ adult foster care provider ~~located in another~~ that is not approved by the local department in the whose jurisdiction the provider is located, the local department wanting to approve the provider shall seek written permission from the local department in the jurisdiction where the adult foster care provider ~~will provide services~~ is located.

E. Local departments may use an approved in-home or adult foster care provider from another jurisdiction without ~~performing another approval study~~ initiating the approval process when the local department obtains written permission and a copy of the approval documents from the local department that ~~conducted the approval study~~ approved the in-home or adult foster care provider.

22VAC30-120-30. Standards for providers and other persons.

A. Age requirements include:

1. All local department-approved ~~adult services homemaker~~ providers shall be at least 18 years of age.

2. ~~All local department-approved adult services chore and companion providers shall be at least 16 years of age. If the local department chooses to approve a chore or companion provider who is at least 16 years of age but less than 18 years of age, the local department must determine that the provider is competent and able to provide the service~~ Any assistant to a local department-approved provider shall be at least 18 years of age.

~~3. Any assistant to a local department approved in home provider for adult services shall be at least 16 years of age.~~

B. Criminal record background checks and additional requirements include:

1. ~~The provider and any assistant, the spouse of the provider, or other adult household members who come in contact with adults in care shall identify any criminal convictions and consent to a criminal record search.~~ An individual applying to become an in-home or adult foster care provider shall identify any criminal convictions and consent to a criminal record search. The local department shall obtain criminal history record information from the Central Criminal Records Exchange of any individual the local department is considering approving as an in-home or adult foster care provider. The local department may also obtain a criminal records search on all adult household members residing in the home of an individual the local department is considering approving as an adult foster care provider. A new criminal record background check shall be required at the time of provider renewal.

2. Convictions of any offense set forth in clause (i) of the definition of barrier crime in § 19.2-392.02 of the Code of Virginia shall prohibit ~~a~~ any provider~~, the assistant, spouse of the provider, or other adult household members who come in contact with adults in care to receive approval as a provider~~ individual from being approved as a local-department approved provider. In addition, if the provider or, for adult foster care and adult day services, the assistant, spouse of the provider, or other adult household members who come in contact with adults in care, has been convicted of any other felony or misdemeanor that, in the judgment of the local department jeopardizes the safety or proper care of adults, the provider shall be prohibited from being approved as a provider of services to adults.

3. Conviction of any offense set forth in clause (i) of the definition of barrier crime in § 19.2-392.02 of the Code of Virginia will result in the revocation of the in-home or adult foster care provider's approval ~~unless an allowable variance is granted by the local department~~. The local department shall terminate the provision of services by an in-home provider or the adult shall be removed from the adult foster care home immediately if any adult in the home has been convicted of any offense set forth in clause (i) of the definition of barrier crime in § 19.2-392.02 of the Code of Virginia.

4. ~~When the provider and any assistant, and for adult foster care, spouse of the provider, or other adult household members who come in contact with adults in care, has been convicted of a felony or misdemeanor not listed in clause (i) of the definition of barrier crime in § 19.2 392.02 of the Code of Virginia, the local department may approve the provider if the local department determines that the conviction does not jeopardize the safety or proper care of the adult.~~ If approval as a local department-approved provider is denied because of information obtained through a Central Criminal Records Exchange search, the local department, upon request, shall provide a copy of the information obtained to the individual who is the subject of the search. Except as provided by law, further dissemination of the criminal history record information is prohibited.

C. Interview, references, and employment history requirements include:

1. The provider shall participate in interviews with the local department.

2. The provider shall provide at least two references from persons who have knowledge of the provider's ability, skill, or experience in the provision of services and who shall not be related to the provider.

3. The provider shall provide information on the provider's employment history.

4. The local department shall use the interviews, references, and employment history to assess that the provider is:

a. Knowledgeable of and physically and mentally capable of providing the necessary care for adults;

b. Able to sustain positive and constructive relationships with adults ~~in care~~, and ~~to~~ relate to adults with respect, courtesy, and understanding;

c. Capable of handling emergencies with dependability and good judgment; and

d. Able to communicate and follow instructions sufficiently to ensure adequate care, safety and protection for adults.

5. For adult foster care ~~and adult day services~~ providers, at least one interview shall occur in the home where the care is to be provided. All adult household members shall be interviewed to ensure that they understand the demands and expectations of the care to be provided.

6. For homemaker providers, the local department shall further use the interview, references, and employment history to assess that the provider has knowledge, skills, and ability, as appropriate, in:

a. Home management and household maintenance;

b. The types of personal care of ~~the elderly~~ older adults or adults with a disability permitted by regulation;

c. Nutrition education and meal planning and preparation, including special diets; and

d. Personal hygiene and consumer education.

7. For adult foster care providers, the local department shall further use the interview, references, and employment history to assess that the provider has sufficient financial income or resources to meet the basic needs of his own family and has the knowledge, skills, and abilities to care for adults, including~~, but not limited to~~:

a. Provision of a furnished room in the home that meets applicable zoning, building, and fire safety codes.

b. Housekeeping services based on the needs of the adult ~~in care~~.

c. Nutritionally balanced meals and snacks, including extra portions and special diets as necessary.

d. Provision of clean bed linens and towels at least once a week and as needed by the adult.

e. Assistance with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence.

f. Provision of ~~generic~~ personal toiletries ~~including soap and toilet paper~~.

g. Assistance with the following: care of personal possessions, care of personal funds if requested by the adult and adult foster care home's policy permits it, use of telephone, arranging transportation, obtaining necessary personal items and clothing, making and keeping appointments, and correspondence.

h. Securing health care and transportation when needed for medical treatment.

i. Providing social and recreational activities as required by the local department ~~and consistent with licensing regulations~~.

j. General supervision for safety.

D. Training requirements include:

1. The local department shall provide basic orientation to any approved provider.

2. The provider shall attend any orientation and training required by the local department. The provider shall bear the cost of any required training unless the local department subsidizes the cost for all local department-approved providers.

E. Medical requirements include:

1. The in-home provider~~; for out-of-home care~~, ~~the~~ an assistant~~;~~, the ~~provider's spouse;~~ adult foster care provider, and all other adult household members in the adult foster care home who come in contact with adults ~~in~~ receiving care shall submit a statement from ~~the local health department or licensed physician~~ a health care professional that ~~he~~ the individual submitting the statement is believed to be free of tuberculosis in a communicable form.

2. The provider and assistant shall submit the results of a physical and mental health examination when requested by the local department.

F. All ~~local department approved~~ adult foster care providers shall ~~keep~~ notify the local department ~~informed~~ within one business day of changes in the household composition that may affect approval of the provider.

G. The provider shall have the capability to ~~fully~~ perform the requirements of the position, have the moral and business integrity and reliability to ensure good faith performance and be determined by the local department to meet the requirements of the position.

H. Any provider who causes the local department to make an improper payment by withholding information or providing false information ~~may~~ shall be required to repay the amount of the improper payment. Failure to repay any improper payment shall result in a referral for criminal or civil prosecution.

22VAC30-120-40. Standards ~~for~~ of care ~~for adult services~~ for local department-approved providers.

A. The provider shall provide care that does not discriminate on the basis of race, ethnicity, sex, national origin, age, religion, disability, or impairment.

B. Supervision requirements include:

1. The provider shall have a plan for seeking assistance from police, ~~firefighters~~ the fire department, and medical professionals in an emergency.

2. A responsible adult or an approved assistant shall always be available to provide appropriate care for the adult in case of an emergency.

3. ~~If extended absence of the provider is required, the local department shall approve any substitute arrangements the provider wishes to make~~ The adult foster care provider shall inform the local department prior to an extended absence. An extended absence shall be defined as greater than one calendar day. Each adult foster care provider shall identify to the local department a substitute provider who will provide care during the adult foster care provider's extended

absence. Each substitute provider shall also meet the standards set forth in this chapter.

4. The provider shall ensure that adequate care and supervision are provided to ~~adults in care~~ each adult and that the adult's health, safety, and well-being are protected.

5. The provider shall notify the local department within 24 hours of any significant changes in the adult's mental or physical condition.

C. The following standards apply to food provided to ~~adult clients~~ adults by ~~adult day services and~~ adult foster care providers:

1. Adults ~~in care~~ shall receive nutritionally balanced meals and snacks appropriate to the length of time in care each day ~~and~~, the daily nutritional needs of each adult, and the time of day care is provided.

2. Adults ~~in care~~ shall receive special diets if prescribed by a ~~licensed physician~~ health care professional or in accordance with religious or ethnic requirements, the adult's preferences, or other special needs.

3. Adequate drinking water shall be available at all times.

D. Requirements for transportation of adults include:

1. ~~If the provider and, for out-of-home services, the assistant; spouse of the provider; volunteer; or any other agent involved in the day-to-day operation of the adult day services or adult foster care transports adults in care, the~~ As part of the service, only the approved provider ~~or the person providing the~~ or assistant shall provide transportation for the adult and shall have a valid driver's license and automobile liability insurance. When the approved provider or assistant is unable to provide transportation for the adult, the approved provider shall coordinate and assist the adult in obtaining backup transportation.

2. The vehicle used to transport adults shall have a valid license and inspection sticker.

3. ~~Providers or the person who transports adults in care must~~ The vehicle operator shall ensure that all passengers use safety belts in accordance with ~~requirements of~~ Virginia law.

E. Requirements for medical care include:

1. The provider shall have the name, address, and telephone number of each adult's ~~physician~~ health care professional and responsible person easily accessible.

2. The provider shall be able to meet the identified needs of the adult as assessed by the local department before ~~accepting the adult for care and in order to continue~~ providing services or continuing to provide services to the adult.

3. The adult foster care provider shall not administer medications. The adult foster care ~~and adult day services~~ provider shall:

a. Ensure that the adult receives prescription ~~drugs~~ medications only in accordance with ~~an order signed by a licensed physician or authentic prescription label~~ the prescription label and~~,~~ with the adult's responsible person's written consent, as ~~appropriate~~ applicable;

b. Document all medications taken by adults ~~in care~~, including over-the-counter medications;

c. Ensure that the adult ~~in care~~ receives ~~nonprescription drugs~~ over the counter medications only with the adult's or the adult's responsible person's written consent, as ~~required~~ applicable;

d. Keep medications separate from food except those items that must be refrigerated;

e. Report all major injuries to and accidents experienced by the adult to the local department and the adult's responsible person immediately;

f. Have authorization for emergency medical care for each adult ~~in care~~; and

g. Have first aid supplies easily accessible in case of accidents.

4. Admission or ~~retention~~ continued residence of adults in an adult foster care home is prohibited when the adult's care needs cannot be met by the provider as determined by the assessment ~~of~~ by the ~~adult services worker~~ local department or by the adult's ~~physician~~ health care professional.

F. The ~~adult day services and~~ adult foster care provider shall provide recreational and other planned activities appropriate to the needs, interests, and abilities of the adults ~~in care~~.

G. All providers ~~of adult services~~ shall immediately report any suspected abuse, neglect, or exploitation of any adult in care to the local department or to the 24-hour toll-free hotline (hotline number: 888-83-ADULT). Providers covered by this regulation are mandatory reporters in accordance with § 63.2-1606 of the Code of Virginia. Failure to report could result in the imposition of civil penalties.

H. The adult foster care provider shall ensure that adults in care have adequate, properly fitting, and seasonal clothing and that all clothing is properly laundered or cleaned and altered or repaired as necessary.

22VAC30-120-50. Standards for the home of the adult foster care ~~or adult day services~~ provider.

A. Physical accommodations requirements include:

1. The home shall have appropriate space and furnishings for each adult receiving care ~~in the home to include~~, including:

a. Space to keep clothing and other personal belongings;

b. Accessible and adequate basin and toilet facilities;

c. Comfortable sleeping or napping furnishings;

d. For adults unable to use stairs unassisted, sleeping space on the first floor of the home;

e. Adequate space for recreational activities; and

f. Sufficient space and equipment for food preparation, service, and proper storage.

2. All rooms used by adults shall be heated in winter, dry, and well-ventilated.

3. All doors and windows used for ventilation shall be appropriately screened.

4. Rooms used by adults ~~in care~~ shall have adequate lighting for activities and the comfort of adults.

5. The ~~provider and any adult in care shall have access to a working telephone in the~~ home shall have a working telephone that the adult shall be permitted to use.

6. The home shall be in compliance with all local ordinances.

7. Additional standards for adult foster care include:

a. No more than two adults shall share a sleeping room unless they request, or if applicable, each adult's responsible person requests and ~~consent~~ consents in writing to sharing such a sleeping arrangement.

b. There shall be space in the household for privacy outside of the sleeping rooms for the adult to entertain visitors and talk privately.

c. There shall be at least one toilet, one basin, and one tub or shower for every five persons residing in the home.

B. Home safety requirements include:

1. The home and grounds shall be free from litter and debris and present no ~~hazard to the safety of the adults receiving care~~ safety hazards.

2. The provider shall permit a fire inspection of the home by appropriate authorities if conditions indicate a need for approval and the local department requests it.

3. The provider shall have a written emergency plan that includes~~, but is not limited to,~~ fire ~~or natural disaster and rehearse the plan at least twice a year~~ and natural disasters. The provider shall rehearse the plan at least twice per year and review the plan with each new adult ~~placed in~~ admitted to the home. The written plan shall be provided to the local department upon request.

4. ~~Attics or basements used by adults in care shall have two emergency exits. One of the emergency exits shall lead directly outside and may be a door or an escapable window.~~ The provider shall ensure the adult is able to evacuate all living spaces safely during an emergency. The provider shall include emergency evacuation procedures in the written emergency plan and shall consider the adult's ability to ambulate during an emergency.

5. Possession of any weapons, including firearms, in the home shall be in compliance with federal, state, and local laws and ordinances. The provider shall store all weapons, firearms, and ammunition ~~in a locked cabinet with safety mechanisms activated. The key or combination to the cabinet shall not be accessible to the adult in care. Any glass cabinets used to store any weapons, including firearms, shall be shatterproof~~ owned by the provider or other household members in a manner that prohibits access by the adult. If the provider permits an adult to possess weapons, firearms, or ammunition in the home, the provider shall have a written policy detailing such permissions, and the provider shall require the adult to safely store all weapons, firearms, or ammunition. The provider may have a written policy prohibiting all weapons, firearms, and ammunition in the home, and the provider may choose not to accept into care an adult if the adult possesses weapons, firearms, or ammunition.

6. The provider shall protect adults from household pets that may be a health or safety hazard. Household pets shall be inoculated as required by state or local ordinances. Documentation of inoculations shall be made available upon local department request.

7. The provider shall keep cleaning supplies and other toxic substances stored away from food and out of the reach of adults ~~in~~ receiving care ~~who are mentally incapacitated~~.

8. The provider shall provide and maintain at least one approved, properly installed, and operable battery-operated smoke detector, at a minimum, in each sleeping area and on each additional floor. Existing installations that have been approved by the state or local fire marshal are exempted from this requirement.

C. Sanitation requirements include:

1. The provider shall permit an inspection of the home's private water supply and sewage disposal system by the local health department if conditions indicate a need for approval and the local department requests it.

2. The home and grounds shall be free of garbage, debris, insects, and rodents that would present a hazard to the health of ~~the adult in care~~ adults.

D. Capacity standards include:

1. The provider shall not exceed the maximum allowable capacity for the type of care provided and approved by the local department.

2. ~~The adult day services provider shall not accept more than three adults in the home at any one time. A provider who has more than three adults receiving day services shall be licensed by the Department of Social Services.~~

~~3.~~ The adult foster care provider shall not accept more than three adults for the purpose of receiving room, board,

supervision, or special services, regardless of relationship of any adult to the provider. ~~A provider who accepts more than three adults for these purposes shall be licensed as an assisted living facility by the Department of Social Services.~~

E. The adult foster care provider shall display the Adult Protective Services hotline number and the toll free number of the State Long-term Care Ombudsman in a manner and method accessible to adults in the home.

22VAC30-120-60. Record requirements for adult foster care ~~and adult day services providers.~~

A. The provider shall maintain written, legible, and current information on each adult ~~in~~ receiving care.

B. Information on the adult ~~in care~~ shall include:

1. ~~Identifying~~ The adult's identifying information ~~on the adult in care~~;

2. Name, address, and home and work telephone numbers of the adult's responsible persons;

3. Name and telephone number of person to be called in an emergency ~~when~~ if the adult's responsible person cannot be reached;

4. Name, address, and home and work telephone numbers of persons authorized to ~~pick up~~ transport the adult ~~in care~~;

5. Name of persons not authorized to call or visit the adult ~~in care~~;

6. Date of admission and discharge of the adult ~~in care~~;

7. ~~Daily attendance records, where applicable. Daily attendance records are required for adult day services;~~

~~8. Medical~~ Pertinent medical information ~~pertinent to the health care of the adult in care~~;

~~9.~~ 8. Correspondence related to the adult ~~in care~~ as well as other written ~~adult~~ information about the adult provided by the local department; and

~~10.~~ 9. Placement agreement between the provider and the adult and ~~his~~ the adult's responsible person, ~~where~~ if applicable.

C. ~~Adult~~ All records are confidential and shall not be shared without the approval of the adult ~~in care~~ or the adult's responsible person, except as required under federal and state law.

D. The local department ~~and its representatives~~ shall have access to all records.

E. The department ~~and its representative~~ shall have access to all records.

22VAC30-120-70. Approval period.

The approval period for ~~a provider~~ all providers may be up to 24 months when the provider meets the standards. ~~In the case of adult day services and adult foster care, the home shall also meet the standards.~~

22VAC30-120-80. Allowable variance.

A. The grant or denial of a variance is within the discretion of the local department. The provider may request ~~an allowable~~ a variance on a standard if the variance does not jeopardize the safety and proper care of ~~the~~ any adult or prospective adult receiving care or violate federal, state, or local law and the local department approves the request.

B. ~~The local department shall consult with the state adult services consultant prior to granting an allowable variance~~ The allowable variance, if granted by the local department, shall be documented in writing with a copy maintained by the local department and the provider.

C. ~~The allowable variance shall be in writing with a copy maintained by the local department and the provider~~ The local department and the provider shall develop a plan to meet the applicable standard for which the allowable variance has been granted.

D. ~~The local department and the provider shall develop a plan to meet the applicable standard for which the allowable variance has been granted~~ The variance shall be requested by the provider, and if granted by the local department, issued prior to the approval of the provider or at the time of the provider's renewal.

~~E. The allowable variance shall be requested and granted by the local department, prior to the approval of the provider or at the time of the provider's renewal.~~

22VAC30-120-90. Emergency approval.

A. Emergency approval of a provider may be granted under the following conditions:

1. The court orders emergency placement; or

2. The adult or ~~his~~ the adult's responsible person requests placement or service in an emergency.

B. ~~A representative of~~ For emergency approval of an adult foster care provider, the local department shall visit the provider's home prior to the emergency placement to ensure that minimum safety standards are evident and that the provider is capable of providing ~~the~~ care ~~prior to the emergency placement of the adult in adult foster care or adult day services~~ for the adult.

C. For emergency approval of an in-home provider, ~~the representative of~~ the local department shall interview the provider to ensure that the emergency provider is capable of providing the needed services.

D. Emergency approval of a provider shall not exceed 30 calendar days.

E. The provider ~~must~~ shall meet all applicable standards if services ~~shall~~ are to be provided beyond the 30-day emergency approval ~~or if the emergency approval is extended beyond 30 days~~.

22VAC30-120-100. Provider monitoring.

A. For ~~adult day services or~~ adult foster care providers, the local department ~~representative~~ shall visit the home of the provider as often as necessary, but at least semi-annually to monitor the performance of the provider.

B. For ~~home based care~~ in-home providers, the local department ~~representative~~ shall interview the provider face-to-face as often as necessary, but at least semi-annually, to monitor the performance of the provider. At least one monitoring visit shall occur in the home of each adult who is receiving care.

C. Provider monitoring shall include interviews with adults receiving care from the provider.

D. The adult ~~in care~~ or ~~his~~ the adult's responsible person shall have access to ~~all~~ provider monitoring reports ~~completed by the local department~~ for that specific adult and that adult's provider upon request.

22VAC30-120-110. Renewal process.

The local department shall reapprove the provider prior to the end of the approval period if the provider continues to meet the standards, and if the local department continues to offer this service. ~~In the case of adult day services or adult foster care providers, the home also shall continue to meet the standards.~~

22VAC30-120-120. Inability to meet standards.

A. If the provider cannot meet the standards ~~for adult services approved providers~~ set forth in this chapter, the local department shall grant provisional approval, suspend approval, or revoke approval depending on the duration and nature of noncompliance.

B. The local department may grant provisional approval if noncompliance with the standards set forth in this chapter does not jeopardize the safety or proper care of the adults ~~in care~~. Provisional approval shall not exceed ~~three months~~ 90 calendar days.

C. The local department may suspend approval if noncompliance with the standards set forth in this chapter may jeopardize the safety and proper care of ~~the adults in care~~ adults. Suspension shall not exceed ~~three months~~ 90 calendar days. During the suspension, the provider ~~can give no~~ shall not provide care to adults ~~referred by the local department~~ receiving services arranged by the local department.

D. If the provider is found to be out of compliance with the standards set forth ~~herein and~~ in this chapter cannot meet standards within ~~three months~~ 90 calendar days, and a variance is not granted, the approval shall be revoked.

E. The local department shall immediately revoke its approval if noncompliance with the standards set forth in this chapter jeopardizes the health, safety, and proper care of ~~the~~ adults ~~in care~~. ~~Adults in adult foster care and adult day services shall be removed within five calendar days from the date of the decision.~~ The local department shall terminate services and find alternative services for all affected adults who are receiving adult foster care no later than five calendar days from the date of the local department's revocation decision. For in-home providers, the local department shall find alternative services for the adult no later than 30 calendar days from the date of the local department's revocation decision.

F. The decision to grant provisional approval, suspend approval or revoke approval shall be in writing with the effective date of the decision noted.

22VAC30-120-130. Relocation of ~~out of home~~ adult foster care provider.

A. If the ~~out of home provider moves~~ adult foster care provider relocates within the locality, the local department approving the provider shall determine continued compliance with standards related to the home as soon as possible, but no later than 30 calendar days after relocation, to avoid disruption of services to the adult ~~in~~ receiving care.

B. ~~If an out of home provider moves outside of the locality that approved the provider, the local department in the new place of residence may accept the provider approval of the initial local department based upon the recommendation of the initial local department or may initiate the approval process itself~~ If the adult foster care provider relocates within the Commonwealth to a locality other than the locality that originally approved the adult foster care provider, the local department that originally approved the adult foster care provider (original local department) shall notify the local department in the new locality (new local department) of the relocation. If the new local department offers adult foster care services, the new local department may accept the adult foster care provider approval from the original local department based upon the recommendation of the original local department or the new local department may initiate an approval process. If the new local department does not offer adult foster care services, the original local department shall request written permission from the new local department for the adult foster care provider to continue to provide adult foster care services for the original local department.

22VAC30-120-140. Right to review.

A. The provider shall have the right to request that the decision of the local department be reviewed by the ~~local~~ director of ~~social services~~ the local department.

B. The provider must request the review within 10 calendar days from the effective date of the ~~notice of action~~ local department's decision.

C. All written findings and actions of the local department or its director, including the decision of the local department director at the conclusion of the review, are final and shall not be (i) appealable to the Commissioner of the Department 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).

22VAC30-120-150. Rights of adults ~~in~~ receiving care.

A. Adults ~~in the~~ receiving care ~~of~~ from local department-approved providers shall have the rights ~~and responsibilities~~ specified in this section. The provisions of this section shall not be construed to restrict or abridge any right that any adult has under the law. The provider shall ~~establish policies and procedures to~~ ensure that adults ~~in care~~ or the adult's responsible person are aware of and understand the ~~following~~ rights~~:~~ described in subsection B of this section. The adult and, if appropriate, the adult's responsible person shall acknowledge in writing receipt of this information, which shall be filed in the adult's record.

B. Adults receiving care from local department-approved providers shall have the right:

1. To be fully informed, prior to the beginning of the provision of services, (i) of his rights and of all rules and expectations governing his conduct and responsibilities~~; the adult and, if appropriate, his responsible persons shall acknowledge, in writing, receipt of this information, which shall be filed in his record~~ and (ii) charges, if any, for the services to be provided;

2. To be ~~fully informed, prior to the beginning of the provision of services, of services available and of related charges, if any; this shall be reflected by the adult's written acknowledgment of having been so informed, which shall be filed in his record~~ free from adult abuse, neglect, and exploitation; to be free from forced isolation, threats, or other degrading or demeaning acts against him; and to be treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;

3. ~~Unless a conservator of such person has been appointed, to be free to manage his personal finances and funds; to be entitled to access to personal account statements reflecting financial transactions made; and, when receiving adult foster care, to be given at least a quarterly accounting of financial transactions made on his behalf~~ To be free to voice grievances and recommend changes in policies and services without fear of reprisal;

4. To be afforded confidential treatment of his ~~personal affairs and~~ records and to approve or refuse their release to any individual ~~outside the home~~ except as otherwise provided in law and ~~except in case of his transfer to another setting~~ when services may need to be transferred to another provider;

5. ~~When receiving adult foster care or adult day services, to be transferred or discharged only when provided with a statement of reasons, or for nonpayment for his stay, and to be given advance notice of at least 30 days; upon notice of discharge or upon giving reasonable advance notice of his desire to move, the adult shall be afforded reasonable assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record; the local department that made the placement shall be given advance notice of at least 30 days for any transfer or discharge~~ To be encouraged to function at his highest mental, emotional, physical, and social potential;

6. ~~An adult receiving adult foster care or adult day services may be discharged immediately if his physical or mental health conditions or his behavior places himself or others at risk of serious bodily harm or injury; the discharge must be to a setting that will ensure the protection of the adult's health, safety and welfare; the local department that made the placement must be notified of the emergency discharge as soon as practicable but no later than 24 hours after the emergency discharge~~ To be afforded the opportunity to participate in the planning of his program of care and medical treatment and the right to refuse medical treatment unless there has been a court adjudication of incapacity;

7. ~~In the event a medical condition should arise while he is under the care of the provider, to be afforded the opportunity to participate in the planning of his program or care and medical treatment and the right to refuse treatment;~~ To be afforded privacy including:

a. In the care of his personal needs except when assistance may be needed;

b. In any medical examination or health-related consultations that the adult may have;

c. In any communications; and

d. During visitation with other persons; and

8. ~~When receiving care from an adult foster care or adult day services provider, to not be required to perform services for the home except as voluntarily contracted pursuant to an agreement for services that states the terms of consideration or remuneration and is documented in writing and retained in his record;~~ To be free of physical, mechanical, or chemical restraints.

~~9. To be free to select health care services from reasonably available resources;~~

~~10. To be free from mental, emotional, physical, sexual, and financial abuse or exploitation; to be free from forced isolation, threats, or other degrading or demeaning acts against him; and, when receiving care from an adult foster care or adult day services provider, to not have his known needs neglected or ignored by the provider;~~

11. To be treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;

12. To be free to voice grievances and recommend changes in policies and services, free of coercion, discrimination, threats, or reprisal;

13. When receiving care from an out-of-home local department approved provider, to be permitted to retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other adults;

14. To be encouraged to function at his highest mental, emotional, physical, and social potential;

15. To receive and send uncensored, unopened mail;

16. To refuse medication unless there has been a court finding of incapacity;

17. To choose which services are included in the service agreement and to receive all physician-prescribed treatments. Adults also have the right to refuse services, if doing so does not endanger the health or safety of other adults;

18. To be free of physical, mechanical or chemical restraint except in the following situations and with appropriate safeguards, including training for the provider on the use of restraints:

a. As necessary to respond to unmanageable behavior in an emergency situation that threatens the immediate safety of the adult or others; and

b. As medically necessary, as authorized in writing by a physician, to provide physical support to a weakened adult;

19. To be free of prescription drugs except where medically necessary, specifically prescribed, and supervised by the attending physician;

20. To be accorded respect for ordinary privacy in every aspect of daily living, including but not limited to the following:

a. In the care of his personal needs except as assistance may be needed;

b. In any medical examination or health-related consultations that the adult may have at the home;

c. In communications, in writing, or by telephone;

d. During visitations with other persons;

e. When receiving care from an out-of-home provider, in the adult's room or portion thereof; adults shall be permitted to have guests or other adults in their rooms unless to do so would infringe upon the rights of other adults; staff shall not enter an adult's room without making their presence known except in an emergency or in accordance with safety oversight requirements included in regulations administered by the Commissioner for Aging and Rehabilitative Services; and

f. When receiving care from an out-of-home provider, in visits with his spouse; if both are adults of the home they are permitted, but not required, to share a room unless otherwise provided in the adult's agreements; and

21. Is permitted to meet with and participate in activities of social, faith-based, and community groups at his discretion unless medically contraindicated as documented by his physician in his medical record.

B. If the adult is unable to fully understand and exercise the rights and responsibilities contained in this section, the local department shall require that a responsible person, of the adult's choice when possible, designated in writing in the adult's record, be made aware of each item in this section and the decisions that affect the adult or relate to specific items in this section; an adult shall be assumed capable of understanding and exercising these rights unless a physician determines otherwise and documents the reasons for such determination in the adult's record.

C. The out-of-home provider shall make available in an easily accessible place a copy of these rights and responsibilities and shall include in them the name and telephone number of the Adult Protective Services Hotline as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program and any state ombudsman program serving the area.

D. The out-of-home provider shall make its policies and procedures for implementing this section available and accessible to adults, relatives, agencies, and the general public.

E. Each out-of-home provider shall provide appropriate staff training to implement each adult's rights included in this section.

F. Adults in care have the right to be fully informed in advance about recommended care and treatment and of any recommended changes in that care or treatment.

G. Adults in care have the right to freedom from searches of personal belongings without the adult or responsible person's permission, unless the care provider has reason to suspect that the adult possesses items that are illegal or prohibited in the out-of-home provider setting and the adult is present during the search.

H. When receiving care from an out-of-home provider, adults have the right to be notified before the adult's room or roommate is changed.

I. When receiving care from an out-of-home provider, adults have the right to communicate privately and without restriction with any other adult who does not object to the communications.

C. In addition to the rights described in subsection B of this section, adults receiving care from an adult foster care provider shall have the following additional rights:

1. To be free to manage his personal finances and funds, to be entitled to access personal account statements reflecting financial transactions made, and to be given at least a quarterly accounting of financial transactions made on his behalf, unless a conservator has been appointed by a court to manage the adult's financial affairs;

2. To be permitted to retain and use personal clothing and possession as space permits, unless to do so would infringe upon the rights of other adults;

3. To be permitted to have guests in the adult's room or portion thereof, unless to do so would infringe upon the rights of other adults;

4. To have the adult foster care provider only enter the room after the provider makes his presence known except in a case of emergency or pursuant to oversight as required in this chapter;

5. To be permitted but not required to share a room with a spouse also residing in the home;

6. To be permitted to participate in social, faith-based, and other community activities at the adult's discretion, unless contraindicated as documented by the adult's health care professional;

7. To be notified before the adult's room or roommate is changed;

8. To be free from searches of personal belongings without the adult's or the adult's responsible person's permission, unless the adult foster care provider has reason to suspect that the adult possesses items that are illegal or prohibited in the provider's home and the adult or the adult's responsible person is present during the search;

9. To be discharged only when the provider gives the adult, the adult's responsible person, and the local department that made the placement a 30 calendar day written notice stating the reason for discharge;

10. To be afforded reasonable assistance to ensure an orderly discharge upon notice of discharge or upon the adult giving notice of his desire to move; and

11. To not be required to perform services in the home except as voluntarily contracted pursuant to an agreement for the service provision that states the terms of consideration

D. The adult foster care provider shall ensure that any assistants providing care also understand and uphold the rights included in this section.

22VAC30-120-160. Responsibilities of adults in adult foster care ~~or adult day services~~.

A. Adults ~~in~~ receiving care shall follow the rules of the provider unless these rules are in violation of ~~adults'~~ an adult's rights.

B. Adults ~~in~~ receiving care, ~~or~~ the local department ~~when appropriate~~ or the adult's responsible person, if applicable, shall give ~~a two-week~~ two weeks written notice of the intent to leave the placement.

C. Adults ~~in~~ receiving care or the adult's responsible person, if applicable, shall notify providers if there are changes in the adult's health status.

VA.R. Doc. No. R18-5298; Filed December 30, 2021, 1:06 p.m.

STATE BOARD OF SOCIAL SERVICES

Fast-Track Regulation

Title of Regulation: **22VAC40-901. Community Services Block Grant Program (amending 22VAC40-901-10, 22VAC40-901-50, 22VAC40-901-60, 22VAC40-901-70).**

Statutory Authority: §§ 2.2-5402 and 63.2-217 of the Code of Virginia; 42 USC § 9909.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: March 2, 2022.

Effective Date: March 17, 2022.

Agency Contact: Matt Fitzgerald, Community Service Program Manager, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7088, FAX (800) 726-7088, or email matt.fitzgerald@dss.virginia.gov.

Basis: Section 63.2-217 of the Code of Virginia authorizes the State Board of Social Services to promulgate regulations necessary to carry out Title 63.2 of the Code of Virginia. The regulatory changes are promulgated under Department of Social Services authority as the designated Community Action Act agency, as set out in § 2.2-5401 of the Code of Virginia.

Purpose: This chapter sets parameters for evaluation, recommendation, and designation of community action agencies. The rationale for the changes is aligning sections for uniformity and clarity and removing provisions not appropriate for a regulation. The Community Services Block Grant (CSBG) Program provides services that are essential to protect the welfare of citizens, and the chapter sets out clear framework for administration of the program.

Rationale for Using Fast-Track Rulemaking Process: The rulemaking is considered noncontroversial for two reasons. One, the main changes were deemed by the Office of Attorney General (OAG) to be an alignment to all of the other language that required final approval by the Secretary and Governor, and to the Virginia Community Action Act (which lists the

Secretary and Governor in the process for expansion approval). Although 22VAC40-901-50 did not previously detail the requirement for approval beyond the department level, which was the process being followed, as the expansion of an existing agency into a service area does require the modification of funding allocation and changing of a designation letter to include the localities served. Second, the other changes were removals of language OAG deemed better for guidance than regulation, as it included some criteria for review that wasn't required, but more helpful.

Substance: This regulatory change clarifies and aligns regulations that detail the process for evaluation, recommendation, and designation of a community action agency. The amendments ensure that language in 22VAC40-901-50, 22VAC40-901-60, and 22VAC40-901-70 align with 22VAC40-901-80. Specifically, language was modified in 22VAC40-901-50 to make clear that the department evaluates and makes a recommendation to the Secretary of Health and Human Resources, for preparation of a recommendation to the Governor for designation. Beyond this language alignment, the remaining changes were to remove two statements that strongly encouraged those seeking designation to pursue technical assistance prior to seeking designation. These items were removed, as they are more guidance than regulation.

Issues: The primary advantage to the public is having a regulation that is uniform and aligned with statute and consistent and that does not include nonregulatory guidance. The primary advantage to the agency is also uniformity and alignment, in evaluating requests for designation. There are no disadvantages to the action.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to a periodic review, and recommendations by the Office of the Attorney General (OAG), the State Board of Social Services (Board) proposes to make a number of changes in order to align sections of the regulation that detail the process for evaluation, recommendation, and designation of a community action agency (CAA) with the Code of Virginia (Code).

Background. CAAs are local organizations with the mission of reducing poverty through locally-designed and delivered programs and services that are targeted to the specific needs of the community. CAAs receive funding from the federal Community Services Block Grant (CSBG) and General Assembly appropriations.[1] 22VAC40-901 sets out the framework for the allocation formula, expansion of CAA service areas, designation of community agencies and localities as CAAs, and the process for evaluating requests for designation.

During a periodic review initiated in May 2019, the OAG identified and recommended a number of changes that would align the regulation with Code §2.2-5400 et al (Community Action Act) that the Board seeks to implement through this action.[2] Specifically, in 22VAC40-901-50, Expansion of a community action agency service area, the Board proposes to add language saying the department is responsible for evaluating and making recommendations to the Governor on any request for the designation of an existing community action agency in a previously unserved locality. Upon completion of this evaluation, the department will forward to the Secretary of Health and Human Resources a recommendation on what action the Governor should take regarding designation of the existing community action agency. If the Governor designates the existing community action agency in the locality, the locality will be added to the service area of the existing community action agency. This language reflects the current process, since the expansion of an existing CAA into a new service area requires the modification of funding allocation and the changing of a Designation letter to include the localities served.

Further, the Board proposes to simplify and clarify the requirements contained in 22VAC40-901-50, Expansion of a community action agency service area, 22VAC40-901-60, Designation of a community organization as a community action agency and 22VAC40-901-70, Designation of a locality or group of localities as a community action agency. The proposed changes in language would serve to align these sections with the Community Action Act and more accurately reflect the process currently being followed by the Department of Social Services (DSS).[3]

Lastly, the Board seeks to remove two statements that "strongly encouraged" organizations and localities seeking designation to pursue technical assistance from DSS. This language was deemed better for guidance than regulation by the OAG, as it included some criteria for review that was not required.[4]

Estimated Benefits and Costs. To the extent that the proposed changes serve to clarify the process for evaluation, recommendation, and designation of a community action agency, readers of the regulation including current and new CAAs would likely benefit from greater clarity and alignment with the Code.

Businesses and Other Entities Affected. There are currently 28 local CAAs and three statewide CAAs. The proposed amendments do not appear to affect businesses since most CAAs are either public entities or private nonprofits.

Small Businesses[5] Affected. The proposed amendment would not affect small businesses.

Localities[6] Affected.[7] The proposed amendment would not affect local governments. DSS has indicated that the following localities are currently unserved by a local CAA: Chesterfield, Colonial Heights, Harrisonburg, Henrico, Highland, Loudon, Poquoson, Rockingham, Winchester, and York. If the proposed changes lead to any of these localities being served by a CAA, then that locality would benefit from the proposed changes.

Projected Impact on Employment. The proposed amendments would not affect employment by DSS, its local departments, or by CAAs.

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.

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[1]The CSBG was enacted under the CSBG Act in 1981 and authorizes block grants to states. It is administered by the Office of Community Services within the U.S. Department of Health and Human Services. States are required to pass through 90% of their block grant allotments to CAAs, and may keep up to five percent of allotments for administrative costs. The remainder is used for statewide activities. See https://www.vacap.org/who-we-are/.

[2]See https://townhall.virginia.gov/l/ViewPReview.cfm?PRid=1799.

[3]This includes adding a definition of low-income person in Section 10 that is identical to the definition in the Code.

[4]See the Agency Background Document https://townhall.virginia.gov/l/GetFile.cfm?File=73\5694\9220\AgencyStatement_DSS_9220_v6.pdf.

[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."

[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.

Agency's Response to Economic Impact Analysis: The Department of Social Services reviewed the economic impact analysis prepared by the Department of Planning and Budget and has no comments.

Summary:

The amendments align regulation text found in 22VAC40-901-50, 22VAC40-901-60, and 22VAC40-901-70 with that found in 22VAC40-901-80. The amendments detail the process for evaluation, recommendation, and designation of a community action agency, including (i) clarifying that the Department of Social Services evaluates and makes a recommendation for designation to the Secretary of Health and Human Resources for preparation of a recommendation to the Governor and (ii) removing two statements (nonregulatory in nature) that strongly encouraged organizations and localities seeking designation to pursue technical assistance from the department.

22VAC40-901-10. Definitions.

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

"Community action agency" means a local subdivision of the Commonwealth, a combination of political subdivisions, a separate public agency, or a private, nonprofit agency that has the authority under its applicable charter or laws to receive funds to support community action activities and other appropriate measures designed to identify and deal with the causes of poverty in the Commonwealth, and that is designated as a community action agency by federal law, federal regulations, or the Governor.

"Community action statewide organization" means community action programs, organized on a statewide basis, to enhance the capability of community action agencies.

"Community organization" means a private nonprofit organization, including faith-based organizations.

"Department" means the Virginia Department of Social Services.

"Local share" means cash or in-kind goods and services donated to community action agencies or community action statewide organizations to carry out their responsibilities.

"Locality" means a county or city in the Commonwealth.

"Low-income person" means a person who is a member of a household with a gross annual income equal to or less than 125% of the poverty standard accepted by the federal agency designated to establish poverty guidelines.

22VAC40-901-50. Expansion of community action agency service area.

A. A locality that is not served by a designated community action agency may ~~reach an agreement~~ develop a request with an existing community action agency for the provision of services in that locality. ~~The locality and the community action agency may submit a proposal to the department that includes plans for the expansion of services into the locality and a provision describing how the locality will be represented on the board of the community action agency. Upon department approval of the proposal, the governing body of the locality may adopt a resolution designating the community action agency as their community action agency and forward this resolution to the Department of Social Services. In adopting the resolution, the governing body must have allowed the opportunity for public comment. Upon receipt of the resolution, the locality will be included in the community action agency's service area.~~ The request will include:

1. A description of the way in which the locality will be represented on the board of the existing community action agency.

2. A resolution adopted by the locality requesting the designation of the existing community action agency as the community action agency for the locality. In adopting the resolution, the governing body must have allowed the opportunity for public comment.

3. A description of the existing community action agency's history of successfully providing a variety of services to low-income individuals. Examples would include operating four or more programs aimed at various segments of the low-

income population and can include community and economic development.

4. Documentation that the low-income population in the proposed designated service area is large enough to justify funding a variety of programs.

5. Documentation that demonstrates the financial stability of the existing community action agency.

6. The detailed financial procedures that demonstrate how the existing community action agency meets generally accepted accounting principles (GAAP).

7. The existing community action agency plan for providing Community Services Block Grant funded services within the proposed service area. This plan must be developed with input from a variety of sources, including the low-income population of the proposed service area.

B. The department is responsible for evaluating and making recommendations to the Governor on any request for the designation of an existing community action agency in a previously unserved locality. Upon completion of this evaluation, the department will forward to the Secretary of Health and Human Resources a recommendation on what action the Governor should take regarding designation of the existing community action agency. If the Governor designates the existing community action agency in the locality, the locality will be added to the service area of the existing community action agency.

22VAC40-901-60. Designation of a community organization as a community action agency.

A. To be designated as a community action agency, a community organization's purpose shall include working for the reduction of poverty and the revitalization of low-income communities through the identification of local needs and the provision of a broad range of services to meet those needs. The organization must have the recommendation of the governing body of the localities to be served, must be financially viable, and must meet administrative standards, financial management standards, and other requirements established by federal and state laws and regulations. In order for the department to support the designation of a community organization to become a community action agency, the following conditions should exist:

1. The organization's governing board must meet, or be in the process of changing to meet, the requirements of federal and state law related to community action agency boards.

2. Each locality in the proposed service area must have approved a resolution recommending the designation of the organization as a community action agency. In adopting the resolution, the governing body must have allowed the opportunity for public comment.

3. The organization and its management should have a history of successfully providing a variety of services to low-income individuals. Examples would include operating four or more programs aimed at various segments of the low-income population. ~~This can include community and economic development. Services currently being provided by the community organization should not be limited to a single segment of the population.~~

4. The low-income population in the proposed designated service area should be large enough to justify funding a variety of programs.

5. The organization ~~should be financially stable~~ must be able to demonstrate financial stability. ~~This would include funding from a variety of federal and/or state sources as well as private and/or local government funding. The organization should have a sufficient reserve of unrestricted funds to avoid cash flow problems; for example, a reserve equal to or exceeding three months' operating expenses.~~

6. The organization must have financial procedures in place to meet ~~Generally Accepted Accounting Principles~~ generally accepted accounting principles (GAAP). ~~This would normally be supported by a review of prior independent audits.~~

7. The organization must have developed a plan for providing Community Services Block Grant funded services within the proposed service area. This plan must ~~have been~~ be developed with input from a variety of sources including the low-income population of the proposed service area.

B. A community organization wishing to be designated as a community action agency must submit a written request to the department. The request must include documentation verifying that all of the criteria listed in this section are met. ~~Any community organization wishing to become a community action agency is strongly encouraged to contact the department and request technical assistance in this process.~~ The request will be evaluated per 22VAC40-901-80.

22VAC40-901-70. Designation of a locality or group of localities as a community action agency.

If no existing community action agency or other community organization is willing and able to provide services, a locality or group of localities can request that the department ~~designate~~ recommend one or more localities for designation as a community action agency. ~~Any locality or group of localities wishing to become a community action agency are strongly encouraged to contact the department and request technical assistance in this process.~~ This request must include the following documentation:

1. A description of the efforts made to obtain services through an existing community action agency or a community organization that could have been designated as a community action agency.

2. A resolution adopted by the locality or each of a group of localities requesting that it be designated as a community action agency. In adopting the resolution, the governing body or bodies must have allowed the opportunity for public comment.

3. A resolution adopted by the locality or each of a group of localities establishing a community action board that meets the requirements of federal and state law related to public community action agencies.

4. A plan for providing CSBG-funded services within the proposed service area. This plan must ~~have been~~ be developed with input from a variety of sources including the low-income population of the proposed service area.

The request submitted to the department will be evaluated per 22VAC40-901-80.

VA.R. Doc. No. R21-6591; Filed January 3, 2022, 12:30 p.m.

Final Regulation

Title of Regulation: **22VAC40-920. Appeals of Financial Sanctions for Local Departments of Social Services (adding 22VAC40-920-10 through 22VAC40-920-40).**

Statutory Authority: § 63.1-217 of the Code of Virginia; 2 CFR 200.341.

Effective Date: March 4, 2022.

Agency Contact: Torsheba Givens, Manager, Local Reimbursement Unit, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7298, or email torsheba.givens@dss.virginia.gov.

Summary:

The regulation establishes procedures for local departments of social services to appeal a financial recovery levied by the Virginia Department of Social Services.

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

Chapter 920
Appeals of Financial Sanctions for Local Departments of Social Services

22VAC40-920-10. Definitions.

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

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

["Disallowed costs" means those charges to a program that the department determines to be unallowable, in accordance with applicable state and federal statutes, regulations, or policy.]

"Department" means the Virginia Department of Social Services.

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

"Notification of a recovery" means any report, letter, email, or other type of communication describing the noncompliance action or recovery.

["Recovery" means the repayment by the local department of a disallowed cost in a manner prescribed by the department, in accordance with applicable state and federal statutes, regulations, or policy.]

22VAC40-920-20. Objections to notifications of recovery.

A local department that wants to appeal a notification of recovery shall:

1. Within [~~15~~ 21] calendar days of issuance of a notification of a recovery, provide written notice to the commissioner of its objection to the recovery; and

2. Within [~~15~~ 21] calendar days of filing its notice of objection with the commissioner, submit all relevant additional information, documentation, or other pertinent data to the commissioner supporting its appeal of the recovery [~~, termination action,~~] or the disallowed costs.

22VAC40-920-30. Dismissal; burden of proof.

A. If the local department fails to appeal the recovery within the timeframe specified in 22VAC40-920-20, the right to appeal is lost.

B. The local department has the burden of proof to provide additional information that would reduce or remove the recovery.

C. If the local department fails to timely file a notice of appeal or fails to timely provide additional information for appealing the recovery, the requirements of the recovery shall become effective 30 calendar days from the date of issuance of the notification of a recovery.

22VAC40-920-40. Final decision by the commissioner.

A. [~~The commissioner shall provide an opportunity for a hearing, reasonable notice of which shall be given in writing to the local department. All hearings and meetings related to appeals shall be held in the Richmond, Virginia, area~~ If the local department timely files a notice of appeal, the commissioner shall provide an opportunity for a hearing at a time, date, location, and in a manner to be determined by the commissioner. A written notice of the hearing shall be given to the local department at least five calendar days before the hearing.]

1. The local department is entitled to be represented by counsel at all hearings and meetings related to appeals.

2. The local department will forfeit its right to further its appeal if it fails to show for the hearing, unless the

commissioner approves the local department's request to reschedule the hearing.

B. The commissioner shall issue a final decision within 60 [calendar] days following the date the local department filed its objection with the commissioner. The final decision shall be based on the commissioner's review of the recovery details in addition to the evidence, information, and documentation provided by the local department pertaining to the recovery being appealed. The final decision shall be made in accordance with all applicable laws, regulations, and policies.

C. The final decision of the commissioner is (i) final, (ii) binding, and (iii) not subject to judicial review.

D. The local department shall implement the decision within 30 [calendar] days of the date of the final decision.

VA.R. Doc. No. R16-4569; Filed January 10, 2022, 11:45 a.m.

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TITLE 24. TRANSPORTATION AND MOTOR VEHICLES

COMMONWEALTH TRANSPORTATION BOARD

Final Regulation

REGISTRAR'S NOTICE: The Commonwealth Transportation Board is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The Commonwealth Transportation Board will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **24VAC30-151. Land Use Permit Regulations (amending 24VAC30-151-710).**

Statutory Authority: § 33.2-210 of the Code of Virginia.

Effective Date: March 4, 2022.

Agency Contact: Jo Anne P. Maxwell, Regulatory Coordinator, Policy Division, Virginia Department of Transportation, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-1830, FAX (804) 225-4700, or email joanne.maxwell@vdot.virginia.gov.

Summary:

Pursuant to Chapter 387 of the 2021 Acts of Assembly, Special Session I, the amendment updates a reference to the Code of Virginia where a section cited was repealed.

24VAC30-151-710. Fees.

A. Single use permit. A nonrefundable application fee shall be charged to offset the cost of reviewing and processing the permit application and inspecting the project work, in accordance with the requirements in this subsection:

1. The application fee for a single permit is $100.

2. Additive costs shall be applied as indicated in this subdivision. The district administrator's designee will determine the total permit fees using the following schedule:

Activity	Fee
Private Entrances	none
Commercial Entrance	$150 for first entrance $50 for each additional entrance
Street Connection	$150 for first connection $50 for each additional connection
Temporary Logging Entrance	$10 for each entrance
Temporary Construction Entrance	$10 for each entrance
Turn Lane	$10 per 100 linear feet
Crossover	$500 per crossover
Traffic Signal	$1,000 per signal installation
Reconstruction of Roadway	$10 per 100 linear feet
Curb and Gutter	$10 per 100 linear feet
Sidewalk	$10 per 100 linear feet
Tree Trimming (for outdoor advertising)	in accordance with § 33.2-1221 of the Code of Virginia
Tree Trimming (all other activities)	$10 per acre or 100 feet of frontage
Landscaping	$10 per acre or 100 feet of frontage
Storm Sewer	$10 per 100 linear feet
Box Culvert or Bridge	$5 per linear foot of attachment
Drop Inlet	$10 per inlet
Paved Ditch	$10 per 100 linear feet
Under Drain or Cross Drain	$10 per crossing
Above-ground Structure (including poles, pedestals, fire hydrants, towers, etc.)	$10 per structure
Pole Attachment	$10 per structure
Span Guy	$10 per crossing
Additive Guy and Anchor	$10 per guy and anchor

Underground Utility - Parallel	$10 per 100 linear feet
Overhead or Underground Crossing	$10 per crossing
Excavation Charge (including Test Bores and Emergency Opening)	$10 per opening
Two Month Commuter Lot Mobile Food Vending (available in Planning District 8 only) (weekdays and weekends)	$150
Single Weekend Commuter Lot Mobile Food Vending (available in Planning District 8 only) (per weekend)	$10

3. Time extensions for active permits shall incur a monetary charge equal to one-half the application fee charged to the initial permit. Expired permits may be reinstated; however, fees for reinstatement of expired permits shall equal the application fee. Notwithstanding 24VAC30-151-80, commuter lot mobile food vending permits may not be extended or reinstated.

4. If a permit is cancelled prior to the beginning of the permitted activity, the application fee and one-half of the additive fee will be retained as compensation for costs incurred by VDOT during plan review.

5. The district administrator's designee may establish an account to track plan review and inspection costs and may bill the permittee not more often than every 30 calendar days. If an account is established for these costs, the permittee shall be responsible for the nonrefundable application fee and the billed costs. When actual costs are billed, the district administrator's designee shall waive the additive fees in subdivision 2 of this subsection.

B. Districtwide permits. Districtwide permits, as defined in 24VAC30-151-30, are valid for a period of two years. The biennial fee for a districtwide permit for utilities and logging operations is $750 per district. The biennial fee for a districtwide permit for surveying is $200 per district. The central office permit manager may exercise discretion in combining requests for multijurisdictional districtwide permits.

C. Miscellaneous permit fees. To connect the facility to the transmission grid pipeline, the operator of a nonutility renewable energy facility that produces not more than two megawatts of electricity from a renewable energy source, not more than 5,000 mmBtus/hour of steam from a renewable energy source, or landfill gas from a solid waste management facility, shall remit to VDOT a one-time permit fee of $1,500 per mile as full compensation for the use of the right-of-way in accordance with ~~§ 67-1103~~ § 56-617 of the Code of Virginia.

D. No-fee permits. The following permits shall be issued at no cost to the applicant:

1. In-place permits as defined in 24VAC30-151-30 and 24VAC30-151-390.

2. Prior-rights permits as defined in 24VAC30-151-30 and 24VAC30-151-390.

3. As-built permits as defined in 24VAC30-151-30.

4. Springs and wells as defined in 24VAC30-151-280.

5. Crest stage gauges and water level recorders as defined in 24VAC30-151-500.

6. Filming for movies as defined in 24VAC30-151-520.

7. Roadside memorials as defined in 24VAC30-151-550.

8. No loitering signs as defined in 24VAC30-151-570.

VA.R. Doc. No. R22-7052; Filed January 6, 2022, 9:53 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 4 of the Code of Virginia, which exempts regulations relating to grants of state or federal funds or property.

Title of Regulation: **24VAC30-451. Airport Access Fund Policy (repealing 24VAC30-451-10, 24VAC30-451-20).**

Statutory Authority: §§ 33.2-210 and 33.2-1509 of the Code of Virginia.

Effective Date: March 2, 2022.

Agency Contact: Jo Anne P. Maxwell, Regulator Coordinator, Policy Division, Department of Transportation, 1401 East Broad Street, 11th Floor, Richmond, VA 23219, telephone (804) 786-1830, FAX (804) 225-4700, or email joanne.maxwell@vdot.virginia.gov.

Summary:

The action repeals Airport Access Fund Policy (24VAC30-451). The Commonwealth Transportation Board has adopted a policy for the Airport Access Program, and the department has developed a guidance document consistent with that policy to provide additional details for the program, which provides sufficient guidance without the need for a regulation. Because the enabling legislation does not specifically require regulation, the regulation is being repealed.

VA.R. Doc. No. R22-7053; Filed January 6, 2022, 10:20 a.m.

EXECUTIVE ORDER NUMBER ONE (2022)

Ending the Use of Inherently Divisive Concepts, Including Critical Race Theory, and Restoring Excellence in K-12 Public Education in the Commonwealth

By virtue of the authority vested in me as Governor, I hereby issue this Executive Order to ensure excellence in K-12 public education in the Commonwealth by taking the first step on Day One to end the use of inherently divisive concepts, including Critical Race Theory, and to raise academic standards.

Importance of the Initiative

The future of the Commonwealth of Virginia is chiefly dependent on the education of our children. Education has life-shaping power, and our educational system should instill in Virginia students a love for lifelong learning to ensure that they become their own best teachers. We must enable our students to take risks, to think differently, to imagine, and to see conversations regarding art, science, and history as a place where they have a voice.

Political indoctrination has no place in our classrooms. The vast majority of learning in our schools involves imparting critical knowledge and skills in math, science, history, reading and other areas that should be non-controversial. Inherently divisive concepts, like Critical Race Theory and its progeny, instruct students to only view life through the lens of race and presumes that some students are consciously or unconsciously racist, sexist, or oppressive, and that other students are victims. This denies our students the opportunity to gain important facts, core knowledge, formulate their own opinions, and to think for themselves. Our children deserve far better from their education than to be told what to think.

Instead, the foundation of our educational system should be built on teaching our students how to think for themselves. Virginia must renew its commitment to teaching our children the value of freedom of thought and diversity of ideas. We must equip our teachers to teach our students the entirety of our history – both good and bad. From the horrors of American slavery and segregation, and our country's treatment of Native Americans, to the triumph of America's Greatest Generation against the Nazi Empire, the heroic efforts of Americans in the Civil Rights Movement, and our country's defeat of the Soviet Union and the ills of Communism, we must provide our students with the facts and context necessary to understand these important events. Only then will we realize Dr. Martin Luther King Jr.'s dream that our children "will not be judged by the color of their skin but by the content of their character."

The Constitution of Virginia requires that the Governor shall take care that the laws be faithfully executed. It further provides a right to be free from any governmental discrimination upon the basis of religious conviction, race, color, sex, or national origin. Critical race theory and related concepts are teaching our children to engage in the very behavior the Constitution prohibits.

Directive

Accordingly, pursuant to the authority vested in me as the Chief Executive Officer of the Commonwealth, and pursuant to Article V of the Constitution and the laws of Virginia, I hereby order the following:

1. The Superintendent of Public Instruction shall review all policies within the Department of Education to identify those that promote inherently divisive concepts. Such policies shall be ended.

2. The Superintendent of Public Instruction shall immediately review all guidelines, websites, best practices, and other materials produced by the Department of Education to identify those that promote or endorse divisive or inherently racist concepts. Such shall be removed.

3. Executive Employees shall be prohibited from directing or otherwise compelling students to personally affirm, adopt, or adhere to inherently divisive concepts.

4. The Superintendent of Public Instruction shall review the Department of Education's Cultural Competency Training to determine if it or any portion promotes inherently divisive concepts, and take action consistent with the laws of Virginia to modify such training to end the use of inherently divisive concepts. In addition, the Superintendent shall make recommendations on how the Department of Education and school division can develop and make available to all teachers and school leaders model professional development and training so teachers and schools are prepared to engage students on important civics and historical issues in a fair and unbiased manner without imposing their own personal beliefs.

5. The Superintendent of Public Instruction shall review and revise or rescind Superintendent's Memo #050-19 to remove reference to any inherently divisive concepts.

6. The Superintendent of Public Instruction shall review all changes made to the Commonwealth of Virginia's public education curriculum within the last 48 months to identify inherently divisive concepts, including concepts or ideas related to Critical Race Theory, and initiate, through the regular curriculum re-evaluation process, changes that will replace them with concepts and lessons that ensure all Virginia students are taught to respect all individuals regardless of their race, sex, or faith.

7. The Superintendent of Public Instruction shall review the "EdEquityVA" program and end any portion that promotes inherently divisive concepts.

8. The Superintendent of Public Instruction shall end the Virginia Math Pathways Initiative.

9. The Superintendent of Public Instruction shall provide a report to me and the Secretary of Education within 30 days any policies, programs, training, or curricula that falls

within the definition of inherently divisive concepts and within 90 days identify any necessary executive and legislative actions needed to end use of all inherently divisive concepts in public education.

10. The Superintendent of Public Instruction shall review and immediately end the use of any portion of any Governor's School program that promotes inherently divisive concepts.

11. The Superintendent of Public Instruction shall raise standards in K-12 education and immediately take steps to:

a. increase the transparency and honesty of performance measures for public elementary and secondary schools in the Commonwealth and ensure that such measures do not obscure or conceal disparities in performance among student groups;

b. ensure that performance measures for public elementary and secondary schools prioritize the attainment of grade-level proficiency in reading and mathematics for all students, especially in grades K-5;

c. ensure that the Commonwealth's proficiency standards on Standards of Learning assessments in reading and mathematics are rigorous in comparison with assessments administered by other states and national assessments in reading; and

d. increase the number of academic-year Governor's Schools in the Commonwealth and maintain standards of excellence for students in all such schools.

e. ensure that parents are empowered with open access to information on primary instructional materials utilized in any school and that fair and open policies are in place to address any concerns or complaints in a timely and respectful manner.

12. The Superintendent of Public Instruction shall issue a report to the Secretary of Education and me within 90 days on the status of efforts to close the "achievement gap" in K-12 education, with recommendations for additional executive and legislative actions that should be undertaken to ensure all students are graduating high school career and college ready.

13. The Superintendent of Public Instruction will initiate, through the regular curriculum re-evaluation process, changes that ensure Virginia students are given thorough and comprehensive education of world, United States, and Virginia history without the influence of inherently divisive concepts.

For the purposes of this Executive order "inherently divisive concepts" means advancing any ideas in violation of Title IV and Title VI of the Civil Rights Act of 1964, including, but not limited to of the following concepts (i) one race, skin color, ethnicity, sex, or faith is inherently superior to another race, skin color, ethnicity, sex, or faith; (ii) an individual, by virtue of his or her race, skin color, ethnicity, sex or faith, is racist, sexist, or oppressive, whether consciously or subconsciously, (iii) an individual should be discriminated against or receive adverse treatment solely or partly because of his or her race, skin color, ethnicity, sex or faith, (iv) members of one race, ethnicity, sex or faith cannot and should not attempt to treat others as individuals without respect to race, sex or faith, (v) an individual's moral character is inherently determined by his or her race, skin color, ethnicity, sex, or faith, (vi) an individual, by virtue of his or her race, skin color, ethnicity, sex, or faith, bears responsibility for actions committed in the past by other members of the same race, ethnicity, sex or faith, (vii) meritocracy or traits, such as a hard work ethic, are racist or sexist or were created by a particular race to oppress another race.

Effective Date

This Executive Order shall be effective upon its signing and shall remain in force and effect unless amended or rescinded by further executive order or directive.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 15th day of January, 2022.

/s/ Glenn Youngkin, Governor

EXECUTIVE ORDER NUMBER TWO (2022) AND ORDER OF PUBLIC HEALTH EMERGENCY ONE

Reaffirming the Rights of Parents in the Upbringing, Education, and Care of Their Children

By virtue of the authority vested in me as Governor, I hereby issue this Executive Order reaffirming the rights of parents in the upbringing, education, and care of their children.

Importance of the Issue

There is no greater priority than the health and welfare of Virginia's children. Under Virginia law, parents, not the government, have the fundamental right to make decisions concerning the care of their children.

Recent government orders requiring virtually every child in Virginia wear masks virtually every moment they are in school have proven ineffective and impractical. They have also failed to keep up with rapidly changing scientific information. For example, the August 12, 2021 Order of the State Health Commissioner explicitly relates to the Delta variant and not the Omicron variant, which results in less severe illness. The order states children under the age of 12 cannot obtain vaccines. Now children five and older are eligible. The order also states vaccination rates for children that are now out of date. The order notes that "universal and correct mask use" helps reduce transmission. As parents and educators have observed, many children wear masks incorrectly, providing little or no health benefit. The masks worn by children are often ineffective because they are made from cloth material, and they are often not clean, resulting in the collection of impurities, including bacteria and parasites. Additionally, wearing masks for

prolonged periods of time, such as for an entire school day, decreases their effectiveness. Masking may be more or less effective dependent on the age of the child.

At the same time that a universal masking requirement in schools has provided inconsistent health benefits, the universal requirement has also inflicted notable harm and proven to be impracticable. Masks inhibit the ability of children to communicate, delay language development, and impede the growth of emotional and social skills. Some children report difficulty breathing and discomfort as a result of masks. Masks have also increased feelings of isolation, exacerbating mental health issues, which in many cases pose a greater health risk to children than COVID-19. Two years into the COVID-19 pandemic, mask mandates in schools have proved demoralizing to children facing these and other difficulties.

While the Center for Disease Control (CDC) recommends masks, its research has found no statistically significant link between mandatory masking for students and reduced transmission of COVID-19. And the CDC has acknowledged that certain masks may be ineffective due to the material from which they are made or how they are worn. A review of CDC, WHO, and other local and international health authorities' recommendations reveals a lack of consensus on the costs and benefits of mask-wearing for children in school for many of the reasons noted above.

In light of the variety of circumstances confronted by students in the Commonwealth, parents should have the ability to decide whether their child should wear masks for the duration of the school day. This approach is consistent with the broad rights of parents. The Commonwealth recognizes in § 1-240.1 of the Code of Virginia, that "a parent has a fundamental right to make decisions concerning the upbringing, education, and care of the parent's child." Permitting parents to make decisions on where and when to wear masks permits the Commonwealth's parents to make the best decision for the circumstances confronting each child. Parents can assess the risks and benefits facing their child, consult their medical providers, and make the best decision for their children based on the most up to date health information available.

While parents of some students with conditions that increase the risks of COVID-19 infection might require their children to remained masked during the duration of the school day, other parents may require masks for a more limited duration, if at all.

Masks are not the only method to reduce transmission of COVID-19. Local schools must ensure they are improving inspection, testing, maintenance, repair, replacement and upgrades of equipment to improve the indoor air quality in school facilities, including mechanical and non-mechanical heating, ventilation, and air conditioning systems, filtering, purification, fans, control systems and window and door repair. Other mitigation efforts can be made in consultation with health authorities. The benefit of mitigation efforts must always be weighed against the cost to children's overall wellbeing.

Directive

Therefore, by virtue of the authority vested in me as Governor by Article V of the Constitution of Virginia, by § 44-146.17 of the Code of Virginia, by any other applicable law, and by virtue of the authority vested in the State Health Commissioner pursuant to §§ 32.1-13, 32.1-20, and 35.1-10 of the Code of Virginia, Executive Order Number Seventy-Nine (2021) is rescinded and the following is ordered:

1. The State Health Commissioner shall terminate Order of Public Health Emergency Order Ten (2021).

2. The parents of any child enrolled in a elementary or secondary school or a school based early childcare and educational program may elect for their children not to be subject to any mask mandate in effect at the child's school or educational program.

3. No parent electing that a mask mandate should not apply to his or her child shall be required to provide a reason or make any certification concerning their child's health or education.

4. A child whose parent has elected that he or she is not subject to a mask mandate should not be required to wear a mask under any policy implemented by a teacher, school, school district, the Department of Education, or any other state authority.

5. The Superintendent of Public Instruction shall rescind the Interim Guidance for COVID-19 Prevention in Virginia PreK-12 Schools, issued January 14, 2021, and updated October 14, 2021, and issue new guidance for COVID-19 Prevention consistent with this Order.

6. School districts should marshal any resources available to improve inspection, testing, maintenance, repair, replacement and upgrades of equipment to improve the indoor air quality in school facilities, including mechanical and non-mechanical heating, ventilation, and air conditioning systems, filtering, purification, fans, control systems and window and door repair.

Effective Date of this Executive Order

This Executive Order shall be effective 12:00 a.m., Monday, January 24, 2022, and shall remain in full force and effect until amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 15th day of January, 2022.

/s/ Glenn Youngkin, Governor

EXECUTIVE ORDER NUMBER THREE (2022)

Restoring Integrity and Confidence in the Virginia Parole Board and the Commonwealth's System of Criminal Justice

By virtue of the authority vested in me as Governor, I hereby issue this Executive Order to restore integrity and confidence in the Commonwealth's System of Criminal Justice by terminating the current Virginia Parole Board, naming five highly qualified individuals to the Parole Board, directing the Secretary of Public Safety to perform a programmatic review of the Parole Board's procedures, and requesting the Attorney General conduct a full investigation.

Importance of the Initiative

Article I, Section 8-A of the Constitution of Virginia affords certain rights to victims of crime in the Commonwealth, including the right to reasonable and appropriate notice, information, and protection. Virginia law further requires the Virginia Parole Board provide notice of its decision to grant discretionary parole or the conditional release of an inmate. Virginia law and internal policy and procedure manuals govern the Virginia Parole Board's decisions.

The Virginia Office of the State Inspector General ("OSIG") recently conducted an independent investigation into allegations involving the Virginia Parole Board. These allegations were brought forward by citizens, crime victims and their relatives, and elected Commonwealth's Attorneys. The OSIG investigation revealed some of the inmates released by the Virginia Parole Board had been recently denied parole or otherwise deemed ineligible for parole, raising questions about the lawfulness of the abrupt reversals of these decisions. The Virginia Parole Board also violated victims' rights and broke Virginia law by releasing multiple violent offenders without complying with the legally required notification to the victim or the prosecutor.

To this day, the family members and victims have no answers as to how or why the Virginia Parole Board failed to abide by the laws governing its operations, and no one has been held accountable.

We therefore must ensure confidence and integrity in our criminal justice system. Too often, victims of violent crime are ignored, silenced, and overlooked. Victims deserve to know their voices matter. In order to ensure that these mistakes never happen again, we must fully understand the decisions that led to them.

The Parole Board's failure to uphold the laws enacted by the General Assembly has damaged the integrity of the Commonwealth's System of Criminal Justice and undermined the confidence of our citizens. We therefore must reform the Virginia Parole Board and replace the current members with qualified and committed public safety experts who will uphold the law, properly apply the policies of the Board, and restore confidence and integrity in our system of criminal justice.

Directive

Accordingly, pursuant to the authority vested in me as Chief Executive of the Commonwealth and pursuant to § 53.1-134 of the Code of Virginia, I hereby terminate the current parole board, and hereby appoint:

- The Honorable Chadwick Dotson of Wise County, Chairman
- Tracy Banks of the City of Charlottesville
- Cheryl Nici-O'Connell of Chesterfield County
- The Honorable Hank Partin, Sheriff, of Montgomery County
- Carmen Williams of Chesterfield County

Further, the Secretary of Public Safety and Homeland Security is directed to perform a programmatic review of the Parole Board's duties, procedures, and administration. The review shall include, but not be limited to, increasing the transparency of Parole Board votes, recording reasons for granting parole, and reviewing the management, personnel, and operations of the Parole Board.

This review shall provide recommendations for legislative, administrative, and policy changes that will improve the administration of the agency in fulfilling its solemn public safety mission.

This review shall be submitted to me no later than September 1, 2022.

Attorney General Authorization

By virtue of the authority vested in me by § 2.2-511 of the Code of Virginia, I hereby request the Attorney General to coordinate the prosecutorial and investigative efforts and to bring such cases as he may deem appropriate in order to protect the citizens of the Commonwealth and hold accountable any individuals who have violated existing law or violated the rights of victims of crime.

Effective Date

This Executive Directive shall be effective upon its signing and shall remain in force and effect unless amended or rescinded by future executive order or directive.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 15th day of January, 2022.

/s/ Glenn Youngkin, Governor

EXECUTIVE ORDER NUMBER FOUR (2022)

Authorizing an Investigation of Loudoun County Public Schools by the Attorney General

By virtue of the authority vested in me as Governor, I hereby issue this Executive Order requesting the Attorney General conduct a full investigation into Loudoun County Public Schools.

Importance of the Issue

In the Spring of 2021, the Loudoun County School Board and the administration of the Loudoun County Public Schools were made aware of a sexual assault that occurred in a Loudoun County high school. A decision was made to transfer the assailant to another Loudoun County high school, where the student was able to commit a second sexual assault. The Loudoun County School Board and school administrators withheld key details and knowingly lied to parents about the assaults.

Neither the Loudoun County School Board, nor the administrators of the Loudoun County school system, have been held accountable for deceiving the very Virginians they serve. Virginia parents deserve answers and assurances that the safety of their children will never be compromised.

Attorney General Authorization

By virtue of the authority vested in me by § 2.2-511 of the Code of Virginia, I am requesting the Attorney General to initiate and coordinate investigative and prosecutorial efforts and to take such actions as he may deem appropriate in order to protect the citizens of the Commonwealth and hold accountable any individuals who have violated existing law or violated the rights of victims of crime.

Effective Date

This Executive Directive shall be effective upon its signing and shall remain in force and effect unless amended or rescinded by future executive order or directive.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 15th day of January, 2022.

/s/ Glenn Youngkin, Governor

EXECUTIVE ORDER NUMBER FIVE (2022)

Establishing the Position of Commonwealth Chief Transformation Officer and Initiating Review of the Department of Motor Vehicles and the Virginia Employment Commission

By virtue of the authority vested in me as Governor, I hereby issue this Executive Order establishing the position of Commonwealth Chief Transformation Officer within the Office of the Governor, and direct him to begin his review of all government agencies with the Department of Motor Vehicles and the Virginia Employment Commission.

Importance of the Initiative

Virginia is fortunate to have many dedicated and hard-working individuals serving our Commonwealth. The workforce of our state government is one of our Commonwealth's greatest resources. However, we must constantly pursue improvements to the function of our government. The performance of the state government should be measured by the satisfaction of its citizens. And when government fails to meet the needs of its citizens, it is the duty of the Chief Executive Officer to hear these complaints, duly consider their merits, and produce speedy reforms. Sometimes, in the performance of this duty, it will be necessary and beneficial to utilize outside experts to assist state government in performing at the standards our citizens demand.

The performance of two state agencies, in particular, underscores the necessity of our continued pursuit of improvement in our government. In recent years, the Virginia Employment Commission (VEC) and the Department of Motor Vehicles (DMV) have fallen short of performing at the high standard set by our citizens. Both agencies provide essential services to Virginians, and the success of their missions are directly dependent on their ability to serve their customers.

These and other agencies require analysis to identify areas of improvement and ensure that our government is transparent, accountable, and working for the citizens of the Commonwealth. A team with expertise, imagination, and enthusiasm for delivery of services, the Commonwealth's operations and finances, and customer satisfaction is necessary to accomplish these goals.

Directive

By virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia, and the Code of Virginia, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby establish the position of Commonwealth Chief Transformation Officer within the Office of the Governor. The Commonwealth Chief Transformation Officer will serve in the Governor's Cabinet.

The Commonwealth Chief Transformation Officer, and such other employees within the Office of the Governor as so designated, shall comprise the Office of Transformation.

The primary responsibilities of the Commonwealth Chief Transformation Officer will be to help build a culture of transparency, accountability, and constructive challenge across our government; ensure employees at all levels of government are reminded that our government works for the citizens of Virginia; drive changes improving the effectiveness and efficiency of our government through tracking key performance metrics; identify, coordinate, and lead targeted

transformation efforts; and all other duties and responsibilities as determined and assigned by the Governor.

While the Commonwealth Chief Transformation Officer's work will stretch across all government, he shall begin his work with a review of the operations of the Virginia Employment Commission and the Virginia Department of Motor Vehicles.

Effective Date

This Executive Order shall be effective upon its signing and shall remain in force and effect unless amended or rescinded by further executive order or directive.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 15th day of January, 2022.

/s/ Glenn Youngkin, Governor

EXECUTIVE ORDER NUMBER SIX (2022)

Reinvigorating Job Growth by Removing Burdensome Regulations from Virginia's Business Community

By virtue of the authority vested in me as Governor, I hereby issue this Executive Order to ensure Virginia is open for business.

Importance of the Initiative

Businesses across the Commonwealth of Virginia faced unprecedented challenges throughout the COVID-19 pandemic. From government mandated closures, lockdowns, and restrictions to supply chain disruptions to staffing shortages, the effects of the pandemic undoubtedly made running a business in Virginia more difficult. Unfortunately, our government contributed to these difficulties.

The "Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19," as implemented by the Safety and Health Codes Board, is not having a measurable impact on preventing the spread of COVID-19 while presenting a significant burden on businesses. Overly burdensome and time-consuming training requirements for employees inhibit the hiring of new workers. Conflicting state and federal regulations cause confusion. Unnecessary restrictions impede daily activities.

Further, it appears the "Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19" was not enacted consistent with the Administrative Process Act as required by law and, in any event, was adopted in a rushed process that provided limited opportunity for the public to review and comment on the proposed permanent regulations. It is critical that a standard such as this, which substantially impacts the lives and legal rights of our businesses and our citizens, be enacted through a process consistent with the law and the democratic principles fundamental to our Commonwealth.

The Department of Labor and Industry has many important responsibilities in protecting the interests of Virginia's workers, and our government and our businesses must work together to combat COVID-19.

However, regulations that do little to protect our citizens while imposing heavy burdens on our businesses are not in the best interest of our Commonwealth. This is particularly true when a regulation substantially impacts the legal rights our business and our citizens and is of questionable legality. Under these circumstances, to protect the rights of the citizens of our Commonwealth, our government should focus its limited resources on enforcement activities that further the interests of our citizens.

Directive

By virtue of the authority vested in me as Governor, by Article V, Sections 1 and 7 of the Constitution of Virginia, and by § 2.2-103 of the Code of Virginia, I direct the following:

1. The Safety and Health Codes Board is to convene an emergency meeting of their membership to discuss whether there is a continued need for the "Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19." The board is directed to consider federal action in regard to the Occupational Safety and Health Administration Emergency Temporary Standard. The Board should report its findings to the Governor within 30 days.

2. The Board and the Department of Labor of Industry is directed to seek guidance from the Office of the Attorney General regarding whether the proper legal and administrative procedures were followed during adoption and promulgation of the Permanent Standards.

3. As a matter of enforcement discretion, all Virginia Agencies of the Commonwealth under my authority are directed to focus their limited resources on enforcement activities that have the most impact with the least burden on our business and citizens.

Effective Date

This Executive Order shall be effective upon its signing and shall remain in force and effect unless amended or rescinded by future executive order or directive.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 15th day of January, 2022.

/s/ Glenn Youngkin, Governor

EXECUTIVE ORDER NUMBER SEVEN (2022)

Establishing the Commission on Human Trafficking Prevention and Survivor Support

By virtue of the authority vested in me as Governor, I hereby issue this Executive Order establishing a commission to prevent human trafficking and provide support to its victims.

Importance of the Initiative

Human trafficking is a global epidemic. Through force, fraud, or coercion, criminals exploit men, women, and children into sex trafficking and forced labor. Around the world, at any given moment, an estimated 24.9 million people are victims of this criminal exploitation. Our Commonwealth has not been spared from the reach of these abhorrent crimes. According to Polaris, a nonprofit resource and advocacy center combating human trafficking, there were 179 cases of trafficking and seventy-seven traffickers identified in Virginia in 2019 alone.

Virginia is committed to ending the scourge of human trafficking. Each day, our law enforcement officers and court systems work to apprehend, prosecute, and bring to justice those responsible for the exploitation of their fellow human beings. The conviction of human traffickers, restitution for their victims, and assistance for the survivors remains a top public safety priority for the Commonwealth. We must remain proactive in our efforts and ensure the dedicated professionals who work tirelessly to combat human trafficking are equipped with the tools necessary to win this fight.

Establishment of the Commission

Accordingly, by virtue of the authority vested in me as Governor, under Article V of the Constitution of Virginia and §§ 2.2-134 and 2.2-135 of the Code of Virginia, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby establish the Human Trafficking Prevention and Survivor Support Commission (Commission).

Composition and Support of the Commission

The Governor will appoint the members and chair(s) of the Commission; the Sex Trafficking Response Coordinator will also participate in the Commission.

The Governor will select survivors of human trafficking, law enforcement officers, prosecutors, experts, and scholars with knowledge of and/or experience with human trafficking, and victims of human trafficking. In carrying out its duties, the Commission may appoint working groups as it deems appropriate, and may solicit participation from relevant subject matter experts, law enforcement, practitioners, and analysts.

Staff support for the Commission will be provided by the Office of the Governor and any other agencies or offices as may be designated by the Governor. An estimated 250 hours of staff time will be required to support the work of the Commission. No direct costs are expected for the work of the Commission.

Duties of the Commission

The Commission will be responsible for coordinating with the Secretary of Public Safety, the Secretary of Education, the Secretary of Labor, the Office of Attorney General, as well as the State Coordinator and any other federal, state, local, or private sector entity to accomplish the following goals:

1. Increase enforcement by:

a. Coordinating with state and local law enforcement, Commonwealth's Attorneys, and U.S. Attorneys to increase prosecution and seek jail time as opposed to just fines for those who solicit prostitution;

b. Increasing targeting of illicit massage businesses by coordinating with local law enforcement, private property owners, regulatory boards, and increasing investigation into tax compliance;

c. Collaborating with authorities to ensure social media and technology companies actively fight trafficking on their platforms;

d. Ensuring all law enforcement officers are thoroughly trained in identifying trafficking cases and protocols for working with victims;

2. Empower survivors by:

a. Partnering with nonprofits and the private sector to increase the provision of resources survivors need for mental and behavioral recovery and wellness;

b. Fostering public private partnerships to educate, train, and empower survivors towards a career path;

c. Fostering public private partnerships to assist victims in securing temporary and long-term housing options.

3. Enhance education by:

a. Increasing awareness of the signs of potential trafficking and appropriate ways to intervene, including for teachers and school officials;

b. Requiring schools to provide online safety training and education;

c. Expanding awareness of the National Trafficking Hotline and other resources for victims to report and receive assistance to escape trafficking.

The Commission and its subgroups will meet upon the call of the Chair(s) and will issue an interim report with its findings and recommendations no later than September 1, 2022, and any additional reports and recommendations as necessary or as requested by the Governor. This report may also include a proposed framework for the continuation of the Commission's work. The Commission's findings and recommendations will be distributed to promote best practices across the Commonwealth.

Effective Date of the Executive Order

This Executive Order shall be effective upon signing and shall remain in full force and effect for one year from its signing, unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 15th day of January, 2022.

/s/ Glenn Youngkin, Governor

EXECUTIVE ORDER NUMBER EIGHT (2022)

Establishing the Commission to Combat Antisemitism

By virtue of the authority vested in me as Governor, I hereby issue this Executive Order establishing a commission to combat antisemitism in the Commonwealth of Virginia.

Importance of the Initiative

The Commonwealth of Virginia has been a pioneer for religious freedom since the earliest days of our nation. Tomorrow, January 16, 2022, will be the 236th anniversary of the Virginia General Assembly enacting the Virginia Statute for Religious Freedom; promising that no man "shall otherwise suffer on account of his religious opinions or belief." These words – as important today as when first written – remain enshrined in our Constitution and provide the basis of our enduring commitment to religious tolerance and equality.

Our nation and our Commonwealth have seen an intolerable rise in antisemitism in recent years. Antisemitism, as defined by the International Holocaust Remembrance Alliance, "is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities." Sadly, in 2020, Virginians experienced a record number of antisemitic incidents. This disturbing trend has brought to the forefront the necessity of a targeted effort to combat the rising threat of antisemitism and ensure all Virginians are free to live their lives without the threat of harassment, violence, or discrimination. Every manifestation of antisemitism or Holocaust denial is an affront to our society and will not be accepted in the Commonwealth of Virginia.

Virginia must once again lead the way in ensuring religious freedom and equality for all citizens. We must reaffirm our commitment to stand against hatred and intolerance, and develop an actionable plan to combat antisemitism in our Commonwealth. A commission will help us better understand the scourge of antisemitism and represents a meaningful first step towards ensuring a Commonwealth free from antisemitic harassment, violence, or discrimination in the lives of Jewish Virginians.

Establishment of the Commission to Combat Antisemitism

Accordingly, by virtue of the authority vested in me as Governor, under Article V of the Constitution of Virginia and §§ 2.2-134 and 2.2-135 of the Code of Virginia, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby establish the Commission to Combat Antisemitism (Commission).

The purpose of this Commission is to study antisemitism in the Commonwealth, propose actions to combat antisemitism and reduce the number of antisemitic incidents, as well as compile materials and provide assistance to Virginia's public school system and state institutions of higher education in relation to antisemitism and its connection to the Holocaust.

The Commission shall make recommendations to the Governor and General Assembly with the goal of identifying ways to reverse increasing antisemitic incidents in the Commonwealth.

Composition and Support of the Commission

The Governor will appoint the members and Chair(s) of the commission. The Governor will select community and faith leaders, experts, and scholars with experience of and/or knowledge of antisemitism.

The Governor may appoint other members at any time to carry out the assigned functions of the Commission. The Commission will have an advisory role and the members will serve without compensation, in accordance with § 2.2- 2100 of the Code of Virginia. In carrying out its duties, the Commission may appoint working groups as it deems appropriate, and may solicit participation from relevant subject matter experts, practitioners, and analysts.

Staff support for the Commission will be provided by the Office of the Governor and any other agencies or offices as may be designated by the Governor. An estimated 250 hours of staff time will be required to support the work of the Commission. No direct costs are expected for the work of the Commission.

Duties of the Commission

The Commission will meet upon the call of the Chair(s) and will issue an interim report with its findings and recommendations no later than December 1, 2022, International Holocaust Remembrance Day, and any additional reports and recommendations as necessary or as requested by the Governor. This report may also include a proposed framework for the continuation of the Commission's work. The Commission's findings and recommendations will be distributed to promote best practices across the Commonwealth.

Effective Date of the Executive Order

This Executive Order shall be effective upon signing and shall remain in full force and effect for one year from its signing, unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 15th day of January 2022.

/s/ Glenn Youngkin, Governor

EXECUTIVE ORDER NUMBER NINE (2022)

Protecting Ratepayers from the Rising Cost of Living Due to the Regional Greenhouse Gas Initiative

By virtue of the authority vested in me as Governor, I hereby issue this Executive Order to re-evaluate Virginia's participation in the Regional Greenhouse Gas Initiative and immediately begin regulatory processes to end it.

Importance of the Initiative

Reliable and affordable access to electricity is imperative to the health and safety of all Virginians. Our hospitals, schools, businesses, and homes all rely on this essential service. And the unpredictable and rising cost of electricity poses a significant and immediate threat to our Commonwealth and its citizens. In 2019, alone, over 100,000 Virginian households required Energy Assistance with a cost of $46 million to the Commonwealth.

Virginia's participation in the Regional Greenhouse Gas Initiative (RGGI) risks contributing to the increased cost of electricity for our citizens. Virginia's utilities have sold over $227 million in allowances in 2021 during the RGGI auctions, doubling the initial estimates. Those utilities are allowed to pass on the costs of purchasing allowances to their ratepayers. Under the initial bill "RGGI rider" created for Dominion Energy customers, typical residential customer bills were increased by $2.39 a month and the typical industrial customer bill by was raised by $1,554 per month. In a filling before the State Corporation Commission, Dominion Energy stated that RGGI will cost ratepayers between $1 billion and $1.2 billion over the next four years.

Simply stated, the benefits of RGGI have not materialized, while the costs have skyrocketed. Re-evaluation of the Initiative represents a meaningful step toward alleviating this financial burden on the Commonwealth's businesses and households. Regulations must be evaluated in view of the costs and benefits to all Virginians.

Directive

Accordingly, by virtue of the authority vested in me as the Chief Executive Officer of the Commonwealth, and pursuant to Article V of the Constitution and the laws of Virginia, I hereby direct the Director of the Department of Environmental Quality, in coordination with the Secretary of Natural and Historic Resources, to take the following actions in accordance with the provisions and requirements of § 10.1-1300, et seq. and § 2.2-4000, et seq. of the Code of Virginia:

1. Provide me a full report re-evaluating the costs and benefits of participation in the Regional Greenhouse Gas Initiative Inc. in view of all available data, within 30 days.

2. During this same period, develop a proposed emergency regulation for the State Air Pollution Control Board's consideration to repeal 9VAC5-140.

3. During this same period, take all necessary steps to so that any proposed regulation to the State Air Pollution Control Board can be immediately presented for consideration for approval for public comment in accordance with the Board's authority pursuant to § 10.1-1308 of the Code of Virginia.

4. During this same period, notify the Regional Greenhouse Gas Initiative Inc. (RGGI Inc.) of the review and the Governor's intent to withdraw from RGGI, whether by legislative or regulatory action.

Effective Date

This Executive Order shall be effective upon its signing and shall remain in force and effect unless amended or rescinded by further executive order or directive.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 15th day of January 2022.

/s/ Glenn Youngkin, Governor

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.

ALCOHOLIC BEVERAGE CONTROL AUTHORITY

Title of Document: Definitions for the words "designer" and "vintage" as they are used within the context of 3VAC5-70-230 of the Virginia Administrative Code.

Public Comment Deadline: March 2, 2022.

Effective Date: March 3, 2022.

Agency Contact: LaTonya D. Hucks-Watkins, Senior Legal Counsel, Alcoholic Beverage Control Authority, 7450 Freight Way, Mechanicsville, VA 23116, telephone (804) 213-4698, or email latonya.hucks-watkins@virginiaabc.com.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Title of Document: 2021 Edition of the NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty By Reason of Insanity (NGRI).

Public Comment Deadline: March 2, 2022.

Effective Date: March 3, 2022.

Agency Contact: Ruth Anne Walker, Director of Regulatory Affairs, Department of Behavioral Health and Developmental Services, Jefferson Building, 1220 Bank Street, 4th Floor, Richmond, VA 23219, telephone (804) 225-2252, or email ruthanne.walker@dbhds.virginia.gov.

STATE BOARD OF EDUCATION

Titles of Documents: Guidance for the Development of Postsecondary Goals.

Assessment Requirements for Virginia Licensure.

Special Education and Related Services in Local and Regional Jails: Guidelines for Best Practice.

Public Comment Deadline: March 2, 2022.

Effective Date: March 3, 2022.

Agency Contact: Jim Chapman, Regulatory and Legal Coordinator, Department of Education, James Monroe Building, 25th Floor, 101 North 14th Street, Richmond, VA 23219, telephone (804) 225-2540, or email jim.chapman@doe.virginia.gov.

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT

Title of Document: Virginia Homeless and Special Needs Housing Funding Guidelines, 2022-2024.

Public Comment Deadline: March 2, 2022.

Effective Date: March 3, 2022.

Agency Contact: Kyle Flanders, Senior Policy Analyst, Department of Housing and Community Development, Main Street Centre, 600 East Main Street, Suite 300, Richmond, VA 23219, telephone (804) 786-6761, or email kyle.flanders@dhcd.virginia.gov.

BOARD OF JUVENILE JUSTICE

Title of Document: A Guidance Document to Supplement 6VAC35-210, the Compulsory Minimum Training Standards for Direct Care and Security Employees in Juvenile Correctional Centers.

Public Comment Deadline: March 2, 2022.

Effective Date: March 18, 2022.

Agency Contact: Ken Davis, Regulatory Affairs Coordinator, Department of Juvenile Justice, 600 East Main Street, 20th Floor, Richmond, VA 23219, telephone (804) 807-0486, or email kenneth.davis@djj.virginia.gov.

DEPARTMENT OF RAIL AND PUBLIC TRANSPORTATION

Title of Document: Commuter Assistance Program Strategic Plan Requirements and Guidance.

Public Comment Deadline: March 2, 2022.

Effective Date: March 3, 2022.

Agency Contact: Andrew Wright, Senior Legislative and Policy Specialist, Department of Rail and Public Transportation, 600 East Main Street, Suite 2102, Richmond, VA 23219, telephone (804) 241-0301, or email andrew.wright@drpt.virginia.gov.

BOARD FOR BRANCH PILOTS

Board for Branch Pilots Regulatory Review Committee Meeting Minutes

The Virginia Board for Branch Pilots Regulatory Review Committee met on Friday, December 10, 2021, at the Virginia Port Authority, 600 World Trade Center, Norfolk, Virginia, with the following members present: Aaron Anseeuw, Captain E. Waightstill Avery, Michael W. Coleman, Captain January N. Collins.

Staff present for all or part of the meeting were: Mary Broz-Vaughan, Director, Tom Payne, Deputy Director, Kathleen R. Nosbisch, Executive Director, Amy Goobic, Executive Assistant.

Elizabeth Peay was present from the Office of the Attorney General.

Members of the Audience included: Captain J.W. Whiting Chisman, III, and Mark Coberly, Manager, Maritime Law Department, Representative from Vandeventer Black.

Call to Order: The meeting was called to order at 12:00 p.m.

Public Comment Period: There were no public comments.

Election of Chair: The floor was opened for nominations for Chair. Captain Avery nominated Mr. Coleman as Chair. Captain Collins seconded the motion. Mr. Coleman accepted the nomination. There were no additional nominations for Chair. There being none, the floor was closed for nominations. The motion was unanimously approved by: Messrs., Mme. and Captains: Anseeuw, Avery, Coleman, and Collins. By acclamation, Mr. Coleman was name Chair.

Regulatory Review: Ms. Broz-Vaughan informed the Committee that Board regulations are required to have a "Periodic Review" every four years. The Board for Branch Pilots last conducted periodic review in 2019, with the Board voting to take no action ("retain as is"). Ms. Broz-Vaughan further stated that there have been no changes to the regulations, other than "exempt actions," since 2012. The Board formed this Committee at its last meeting to initiate a comprehensive regulatory review through the standard, three-stage process.

Mr. Coleman indicated he had concerns with the changes in regulatory language required by SB 1406, related to misdemeanor marijuana-related convictions, and that the Virginia Regulatory Town Hall website indicated "Board Action" in the heading when no vote was taken by the Board. Ms. Broz-Vaughan stated that she would confer with the Registrar's office to determine the appropriate course of action.

The Committee requested DPOR and the Attorney General's Office to provide information, including Virginia Code references, that requires action from the board to amend regulations to comply with changes to marijuana related offenses, and specifically what changes are required, and to advise of any exceptions. In addition, the Committee requested clarification if out-of-state marijuana related misdemeanor convictions can be considered; if the law specifically requires the board to ignore any and all misdemeanor marijuana related drug charges in issuance of a license; and to advise of any conflicts it may pose with federal law and pilot licensing. Lastly, the Committee discussed and requested to receive clarification about the board's four-year periodic review as required by law or executive order and this regulatory review process.

The Committee determined that the exempt action changes made to the regulations effective December 1, 2021, were invalid as they were not voted on by the board. There is no provision in the law that initiated these changes automatically. The Committee requested information be sent to the board regarding the disposition, and which set of regulations are currently effective.

Ms. Nosbisch stated that the Committee should meet again prior to the March 15, 2022, board meeting. A tentative date of February 17, 2022, was set.

Adjourn: The meeting adjourned at 12:15 p.m.

Contact Information: Kathleen R. Nosbisch, Executive Director, Board for Branch Pilots, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8514, FAX (866) 465-6206.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Blue Orchard Solar LLC Notice of Intent for Small Renewable Energy Project (Solar) - Carroll County

Blue Orchard Solar LLC, has provided the Department of Environmental Quality a notice of intent to submit the necessary documents for a permit by rule for a small renewable energy project (solar) in Carroll County, Virginia. Blue Orchard Solar LLC will be located in Cana, Virginia where Bear Trail forms a portion of the western boundary and Flint Hill Road and Caution Tape Road traverse the central portion of the tract. The project is located on two parcels totaling approximately 96 acres with the following coordinates: Latitude: 36.634542, Longitude: -80.648119. The project will have a rated capacity of 10 megawatts alternating current and use approximately 26,596 photovoltaic solar panels.

Contact Information: Mary E. Major, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 659-2665, FAX (804) 698-4510, or email mary.major@deq.virginia.gov.

Buckhorn Mountain Solar Project Notice of Intent for Small Renewable Energy Project (Solar) - Tazewell County

Buckhorn Mountain Solar Project has provided the Department of Environmental Quality a notice of intent to submit the necessary documents for a permit by rule for a small renewable energy project (solar) in Tazewell County, Virginia. Buckhorn Mountain Solar Project will be located midway between the communities of Tazewell and Gratton on State Route 61 on one465-acre parcel with the following coordinates: Latitude: 37.123700, Longitude: -81.462450. The project will have a rated capacity of 16.5 megawatts alternating current and use approximately 44,680 photovoltaic solar panels.

Contact Information: Mary E. Major, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 659-2665, FAX (804) 698-4510, or email mary.major@deq.virginia.gov.

Fairy Stone Solar LLC Notice of Intent for Small Renewable Energy Project (Solar) - Patrick County

Fairy Stone Solar LLC, has provided the Department of Environmental Quality a notice of intent to submit the necessary documents for a permit by rule for a small renewable energy project (solar) in Patrick County, Virginia. Fairy Stone Solar LLC will be located in the City of Stuart on two adjoining parcels for a total of approximately 169 acres with the following coordinates: Latitude: 36.628942, Longitude: -80.242878. The project will have a rated capacity of 12 megawatts alternating current and use approximately 33,500 photovoltaic solar panels supported by 17 separate metal skids supported by driven piles.

Contact Information: Mary E. Major, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 659-2665, FAX (804) 698-4510, or email mary.major@deq.virginia.gov.

River Trail Solar LLC Notice of Intent for Small Renewable Energy Project (Solar) - Carroll County

River Trail Solar LLC, has provided the Department of Environmental Quality a notice of intent to submit the necessary documents for a permit by rule for a small renewable energy project (solar) in Carroll County, Virginia. River Trail Solar LLC, will be located in the city of Galax on three adjoining parcels for a total of approximately 389 acres with the following coordinates: Latitude: 36.715243, Longitude: -80.895323. The project will have a rated capacity of 20 megawatts alternating current and use approximately 56,500 photovoltaic solar panels.

Contact Information: Mary E. Major, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 659-2665, FAX (804) 698-4510, or email mary.major@deq.virginia.gov.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Nursing Facility Value Based Purchasing Program Methodology

In 2021, the Virginia General Assembly directed the Department of Medical Assistance Services (DMAS) to establish a nursing facility (NF) value-based purchasing (VBP) program designed to improve the quality of care furnished to Medicaid members to begin by July 1, 2022. DMAS has posted the document "Final DMAS SFY 2023 NF VBP Program Methodology" on the website to outline the program for state fiscal year 2023. The document can be found at https://www.dmas.virginia.gov/media/4207/final-dmas-sfy-2023-nf-vbp-program-methodology.pdf.

Contact Information: Pooja Seth, Project Manager for the NF VBP Program, Department of Medical Assistance Services, 600 East Broad Street, Richmond, VA 23219, telephone (804) 638-7718, or email ovbp@dmas.virginia.gov.

STATE WATER CONTROL BOARD

Proposed Enforcement Action for Global Auto Parts Inc.

An enforcement action has been proposed for Global Auto Parts Inc. for violations of the State Water Control Law and regulations at the Global Auto Parts facility located in Woodford, Virginia. The State Water Control Board proposes to issue a consent order to resolve violations associated with the Global Auto Parts facility. A description of the proposed action is available at the Department of Environmental Quality office listed or online at www.deq.virginia.gov/permits-regulations/public-notices/enforcement-orders. The staff contact will accept comments by email or postal mail from February 1, 2022, through March 3, 2022.

Contact Information: Mark Miller, Department of Environmental Quality, Northern Regional Office, 13901 Crown Court, Woodbridge, VA 22193, or email mark.miller@deq.virginia.gov.

Proposed Enforcement Action for Rappahannock Regional Solid Waste Management Board

An enforcement action has been proposed for the Rappahannock Regional Solid Waste Management Board for violations of the State Water Control Law and regulations and applicable permit at the R-Board Landfill located in Stafford County, Virginia. A description of the proposed action is

available at the Department of Environmental Quality office listed or online at www.deq.virginia.gov/permits-regulations/public-notices/enforcement-orders. The staff contact will accept comments by email or postal mail from February 1, 2022, through March 3, 2022.

Contact Information: Jim Datko, Department of Environmental Quality, Northern Regional Office, 13901 Crown Court, Woodbridge, VA 22193, or email james.datko@deq.virgnia.gov.

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.

STATE WATER CONTROL BOARD

Title of Regulation: **9VAC25-260. Water Quality Standards.**

Publication: 38:11 VA.R. 948 January 17, 2022.

Correction to Final Regulation:

Page 948, under "Public Hearing Information:" add

"March 1, 2022 - 2 p.m. - Department of Environmental Quality, Valley Regional Office, 4411 Early Road, Harrisonburg, VA"

VA.R. Doc. No. R21-6555; Filed January 19, 2022, 3:44 p.m.

Errata