

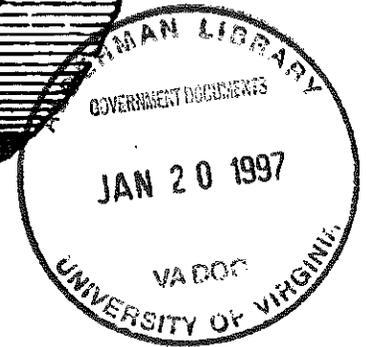
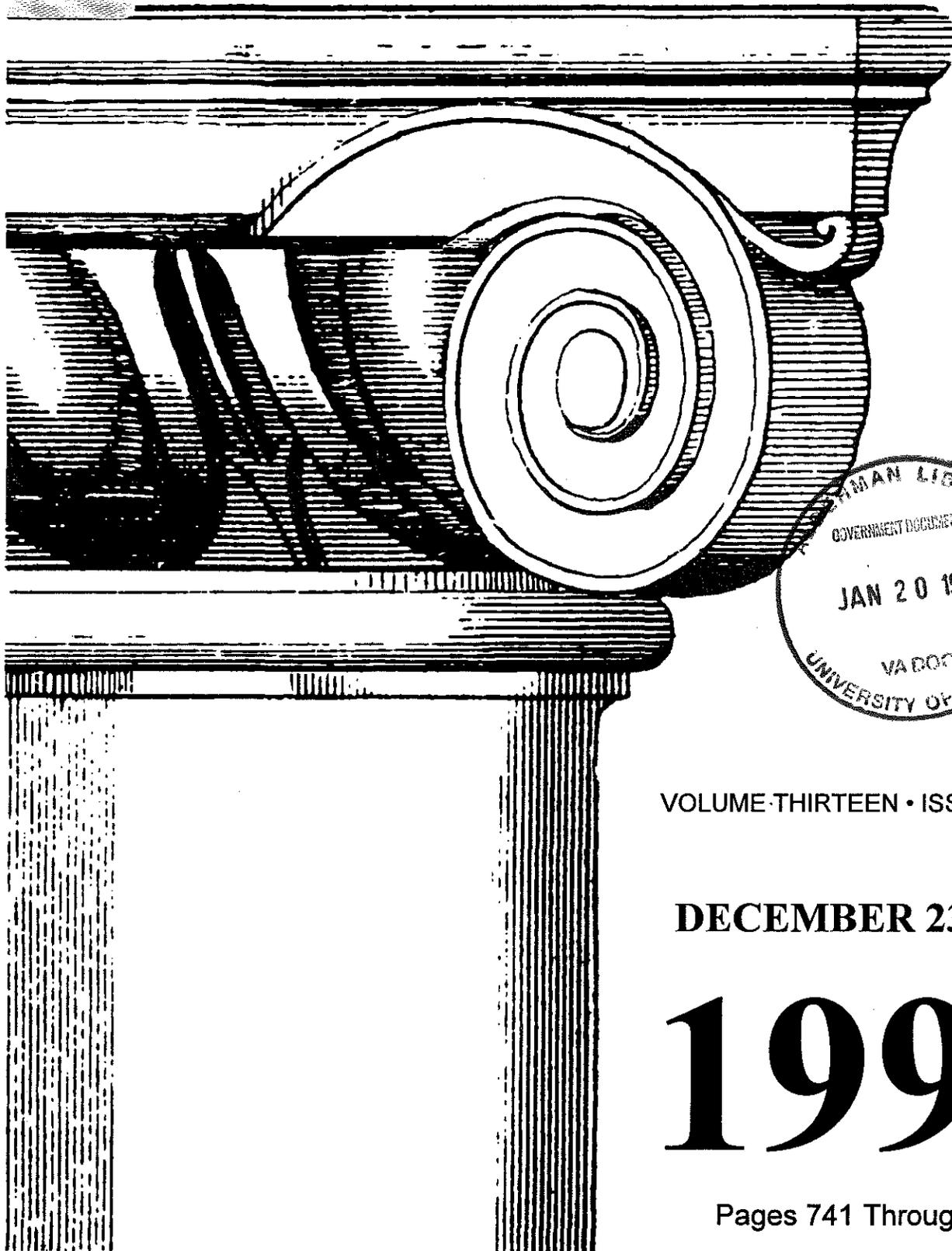
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THE VIRGINIA REGISTER

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THE VIRGINIA REGISTER is an official state publication issued every other week throughout the year. Indexes are published quarterly, and the last index of the year is cumulative. **THE VIRGINIA REGISTER** has several functions. The new and amended sections of regulations, both as proposed and as finally adopted, are required by law to be published in **THE VIRGINIA REGISTER OF REGULATIONS**. In addition, **THE VIRGINIA REGISTER** is a source of other information about state government, including all emergency regulations and executive orders issued by the Governor, the Virginia Tax Bulletin issued periodically by the Department of Taxation, and notices of public hearings and open meetings of state agencies.

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

An agency wishing to adopt, amend, or repeal regulations must first publish in the *Virginia Register* a notice of intended regulatory action; a basis, purpose, substance and issues statement; an economic impact analysis prepared by the Department of Planning and Budget; the agency's response to the economic impact analysis; a summary; a notice giving the public an opportunity to comment on the proposal; and the text of the proposed regulation.

Following publication of the proposal in the *Virginia Register*, the promulgating agency receives public comments for a minimum of 60 days. The Governor reviews the proposed regulation to determine if it is necessary to protect the public health, safety and welfare, and if it is clearly written and easily understandable. If the Governor chooses to comment on the proposed regulation, his comments must be transmitted to the agency and the Registrar no later than 15 days following the completion of the 60-day public comment period. The Governor's comments, if any, will be published in the *Virginia Register*. Not less than 15 days following the completion of the 60-day public comment period, the agency may adopt the proposed regulation.

The appropriate standing committee of each branch of the General Assembly may meet during the promulgation or final adoption process and file an objection with the Registrar and the promulgating agency. The objection will be published in the *Virginia Register*. Within 21 days after receipt by the agency of a legislative objection, the agency shall file a response with the Registrar, the objecting legislative committee, and the Governor.

When final action is taken, the agency again publishes the text of the regulation as adopted, highlighting all changes made to the proposed regulation and explaining any substantial changes made since publication of the proposal. A 30-day final adoption period begins upon final publication in the *Virginia Register*.

The Governor may review the final regulation during this time and, if he objects, forward his objection to the Registrar and the agency. In addition to or in lieu of filing a formal objection, the Governor may suspend the effective date of a portion or all of a regulation until the end of the next regular General Assembly session by issuing a directive signed by a majority of the members of the appropriate standing committees and the Governor. The Governor's objection or suspension of the regulation, or both, will be published in the *Virginia Register*. If the Governor finds that changes made to the proposed regulation have substantial impact, he may require the agency to provide an additional 30-day public comment period on the changes. Notice of the additional public comment period required by the Governor will be published in the *Virginia Register*.

The agency shall suspend the regulatory process for 30 days when it receives requests from 25 or more individuals to solicit additional public comment, unless the agency determines that the changes have minor or inconsequential impact.

A regulation becomes effective at the conclusion of the 30-day final adoption period, or at any other later date specified by the promulgating agency, unless (i) a legislative objection has been filed, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 21-day extension period; (ii) the Governor exercises his authority to require the agency to provide for additional public comment, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the period for which the Governor has provided for additional public comment; (iii) the

Governor and the General Assembly exercise their authority to suspend the effective date of a regulation until the end of the next regular legislative session; or (iv) the agency suspends the regulatory process, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 30-day public comment period.

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

EMERGENCY REGULATIONS

If an agency demonstrates that (i) there is an immediate threat to the public's health or safety; or (ii) Virginia statutory law, the appropriation act, federal law, or federal regulation requires a regulation to take effect no later than (a) 280 days from the enactment in the case of Virginia or federal law or the appropriation act, or (b) 280 days from the effective date of a federal regulation, it then requests the Governor's approval to adopt an emergency regulation. The emergency regulation becomes operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified. Emergency regulations are limited to addressing specifically defined situations and may not exceed 12 months in duration. Emergency regulations are published as soon as possible in the *Register*.

During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures. To begin promulgating the replacement regulation, the agency must (i) deliver the Notice of Intended Regulatory Action to the Registrar in time to be published within 60 days of the effective date of the emergency regulation; and (ii) deliver the proposed regulation to the Registrar in time to be published within 180 days of the effective date of the emergency regulation. If the agency chooses not to adopt the regulations, the emergency status ends when the prescribed time limit expires.

STATEMENT

The foregoing constitutes a generalized statement of the procedures to be followed. For specific statutory language, it is suggested that Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of the Code of Virginia be examined carefully.

CITATION TO THE VIRGINIA REGISTER

The *Virginia Register* is cited by volume, issue, page number, and date. 12:8 VA.R. 1096-1106 January 8, 1996, refers to Volume 12, Issue 8, pages 1096 through 1106 of the *Virginia Register* issued on January 8, 1996.

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The *Virginia Register of Regulations* is published pursuant to Article 7 (§ 9-6.14:22 et seq.) of Chapter 1.1:1 of the Code of Virginia. Individual copies, if available, may be purchased for \$4.00 each from the Registrar of Regulations.

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Staff of the Virginia Register: E. M. Miller, Jr., Acting Registrar of Regulations; Jane D. Chaffin, Deputy Registrar of Regulations.

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February 12, 1997		March 3, 1997
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NOTICES OF INTENDED REGULATORY ACTION

Symbol Key

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

DEPARTMENT OF EDUCATION (STATE BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Education intends to consider promulgating regulations entitled: **8 VAC 20-630-10 et seq. Technology Standards for Instructional Personnel**. The purpose of the proposed action is to promulgate technology standards that will set forth those competencies required of instructional personnel in Virginia schools. The agency intends to hold a public hearing on the proposed regulation after publication.

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

Public comments may be submitted until December 26, 1996.

Contact: Thomas A. Elliott, Division Chief for Compliance, Department of Education, P. O. Box 2120, Richmond, VA 23218-2120, telephone (804) 371-2522 or FAX (804) 225-2381.

VA.R. Doc. No. R97-413; Filed November 6, 1996, 11:26 a.m.

STATE MILK COMMISSION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Milk Commission intends to consider amending regulations entitled: **2 VAC 15-10-10 et seq. Public Participation Guidelines**. The purpose of the proposed action is to more appropriately define the process of regulatory development and to standardize the style, form and format of the regulations to provide consistency and uniformity with other state agencies. Major provisions of the existing regulations will remain essentially the same. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 3.1-430 and 9-6.14:7.1 of the Code of Virginia.

Public comments may be submitted until January 8, 1997.

Contact: Edward C. Wilson, Jr., Deputy Administrator, State Milk Commission, 200-202 N. Ninth St., Suite 1015, Richmond, VA 23219, telephone (804) 786-2013 or FAX (804) 786-3779.

VA.R. Doc. No. R97-137; Filed November 7, 1996, 9:16 a.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Milk Commission intends to consider amending regulations entitled: **2 VAC 15-20-10 et**

seq. Rules and Regulations for the Control, Regulation and Supervision of the Milk Industry in Virginia. The purpose of the proposed action is to amend the regulations to conform to established guidelines of the Virginia Registrar and the Virginia Code Commission. The proposed amendments will reflect substantive changes to improve, reduce, or eliminate certain regulatory requirements on the Virginia milk industry. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: § 3.1-430 of the Code of Virginia.

Public comments may be submitted until January 8, 1997.

Contact: Edward C. Wilson, Jr., Deputy Administrator, State Milk Commission, 200-202 N. Ninth St., Suite 1015, Richmond, VA 23219, telephone (804) 786-2013 or FAX (804) 786-3779.

VA.R. Doc. No. R97-138; Filed November 7, 1996, 9:16 a.m.

VIRGINIA RACING COMMISSION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Racing Commission intends to consider amending regulations entitled: **11 VAC 10-130-10 et seq. Virginia Breeders Fund**. The purpose of the proposed action is to establish more efficient procedures for the registration of racehorses and payment of awards from the fund. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 59.1-369 and 59.1-372 of the Code of Virginia.

Public comments may be submitted until December 26, 1996.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, P.O. Box 1123, Richmond, VA 23218, telephone (804) 371-7363 or FAX (804) 371-6127.

VA.R. Doc. No. R97-124; Filed November 6, 1996, 2:07 p.m.

DEPARTMENT FOR THE VISUALLY HANDICAPPED

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department for the Visually Handicapped intends to consider repealing regulations entitled: **22 VAC 45-60-10 et seq. Regulations Governing Provision of Services for the Infants, Children and Youth Program**. The purpose of the proposed action is to repeal this regulation as the Office of the Attorney General has reported that the Department for the Visually Handicapped does not have the authority to promulgate such a regulation.

Notices of Intended Regulatory Action

Statutory Authority: § 63.1-85 of the Code of Virginia.

Public comments may be submitted until January 8, 1997.

Contact: William J. Pega, Special Assistant to the Commissioner, Department for the Visually Handicapped, 397 Azalea Ave., Richmond, VA 23227, telephone (804) 371-3140, FAX (804) 371-3351, toll-free 1-800-662-2155, or (804) 371-3140/TDD 📞

VA.R. Doc. No. R97-139; Filed November 19, 1996, 9:57 a.m.

PUBLIC COMMENT PERIODS - PROPOSED REGULATIONS



PUBLIC COMMENT PERIODS REGARDING STATE AGENCY REGULATIONS

Effective July 1, 1995, publication of notices of public comment periods in a newspaper of general circulation in the state capital is no longer required by the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia). Chapter 717 of the 1995 Acts of Assembly eliminated the newspaper publication requirement from the Administrative Process Act. In *The Virginia Register of Regulations*, the Registrar of Regulations has developed this section entitled "Public Comment Periods - Proposed Regulations" to give notice of public comment periods and public hearings to be held on proposed regulations. The notice will be published once at the same time the proposed regulation is published in the Proposed Regulations section of the *Virginia Register*. The notice will continue to be carried in the Calendar of Events section of the *Virginia Register* until the public comment period and public hearing date have passed.

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

DEPARTMENT OF LABOR AND INDUSTRY

Safety and Health Codes Board

January 23, 1997 - 10 a.m. -- Public Hearing
Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, Virginia.

February 28, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Safety and Health Codes Board intends to adopt regulations entitled: **16 VAC 25-35-10 et seq. Regulation Concerning Certified Lead Contractor Notification, Lead Project Permits and Permit Fees.** The proposed regulation requires all certified lead contractors who engage in lead abatement projects in Virginia with a contract value of \$2,000 or more to notify the Department of Labor and Industry in writing at least 20 days before the beginning of such lead project. Such notification shall be provided on a department form accompanied by the payment of a lead project permit fee. The regulation also requires filing of amended notifications prior to changes in or cancellation of lead abatement projects.

Statutory Authority: §§ 40.1-22(5) and 40.1-51.20 of the Code of Virginia.

Public comments may be submitted until February 28, 1997, to Bonnie H. Robinson, Regulatory Coordinator, Department of Labor and Industry, 13 South 13th Street, Richmond, VA 23219.

Contact: Clarence H. Wheeling, Director of Occupational Health Compliance, Department of Labor and Industry, 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-0574, FAX (804) 786-8418, or (804) 786-2376/TDD ☎

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

February 21, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending regulations entitled: **12 VAC 30-70-10 et seq. Methods and Standards for Establishing Payment Rates--Inpatient Hospital Services and 12 VAC 30-80-10 et seq. Methods and Standards for Establishing Payment Rates--Other Types of Care.** The purpose of the proposed action is to promulgate a new reimbursement methodology (diagnosis related groupings) for inpatient hospital services to replace the current per diem methodology.

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

Public comments may be submitted until February 21, 1997, to Scott Crawford, Division of Financial Operations, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

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

February 21, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Medical Assistance Services intends to consider adopting regulations entitled: **12 VAC 30-100-250 through 12 VAC 30-100-370 et seq. HIV Premium Assistance Program.** The purpose of the proposed regulation is to promulgate permanent regulations for the administration of the HIV Premium Assistance Program consistent with § 32.1-330.1 of the Code of Virginia.

Public Comment Periods - Proposed Regulations

Statutory Authority: §§ 32.1-325 and 32.1-330.1 of the Code of Virginia.

Public comments may be submitted until February 21, 1997, to Michael Lupien, Division of Program Delivery Systems, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

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

PROPOSED REGULATIONS

For information concerning Proposed Regulations, see Information Page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates proposed new text.
Language which has been stricken indicates proposed text for deletion.

DEPARTMENT OF LABOR AND INDUSTRY

Safety and Health Codes Board

Title of Regulation: 16 VAC 25-35-10 et seq. Regulation Concerning Certified Lead Contractors Notification, Lead Project Permits and Permit Fees.

Statutory Authority: §§ 40.1-22(5) and 40.1-51.20 of the Code of Virginia.

Public Hearing Date: January 23, 1997 - 10 a.m.

Public comments may be submitted until February 28, 1997.

(See Calendar of Events section for additional information)

Basis: The statutory authority for this proposed regulation is §§ 40.1-51.20 through 40.1-51.22 of the Code of Virginia. These sections require certified lead contractors to notify the Department of Labor and Industry prior to commencement of each lead project and authorize the board to promulgate a regulation concerning this notification by certified lead contractors, the issuance of lead project permits, and the assessment of permit fees.

Purpose: The purpose of the regulation is to implement the lead project notification and permit requirements of § 40.1-51.20 of the Code of Virginia. The notification and permit requirements enable the Department of Labor and Industry to monitor lead contractors' compliance with state and federal requirements for the safe removal and disposal of lead through onsite inspection of lead projects.

During the 1995 session, the General Assembly amended § 40.1-51.20 of the Code of Virginia to require certified lead contractors to comply with the same notification and permitting requirements as those of licensed asbestos contractors. The amendment to the Code was in response to interim draft regulations of the U.S. Environmental Protection Agency (EPA) (40 CFR Part 745).

This proposed regulation is necessary to implement the statutory requirements of § 40.1-51.20 by providing lead contractors with detailed instructions regarding notification of the department and payment of lead project permit fees.

This proposed regulation protects public health, safety, and welfare by ensuring that the elimination of lead hazards is undertaken by trained and qualified contractors according to reliable, effective and safe work practice standards.

Substance: The major provisions of the proposed regulation are summarized below:

1. All certified lead contractors who engage in lead abatement projects in Virginia with a contract value of \$2,000 or more will be required to notify the department in writing at least 20 days before the beginning of any such lead project.

2. A lead project permit fee, calculated as the greater of \$100 or 1.0% of the contract price, with a maximum of \$500 is proposed.

3. Upon a determination that the revenues from the department's lead program will exceed related expenses by at least 15%, the commissioner may reduce the minimum and maximum fees and contract percentage.

4. Filing of amended notifications prior to changes in or cancellation of lead abatement projects will be required.

5. Lead abatement projects in certain residential buildings are exempt from the payment of the fee, but contractors must still provide notification to the department.

Issues: The primary advantages and disadvantages of implementation of and compliance with the regulation by the public and the department are discussed below.

1. **Public:** The regulation is essential for protecting the health of the citizens of the Commonwealth. The notification and permit requirements will enable the Department of Labor and Industry to monitor lead contractors' compliance with state and federal requirements for the safe removal and disposal of lead through onsite inspection of lead projects.

The primary disadvantages of this program are the cost of the permit fee, which lead abatement contractors will likely pass on to owners, and the delay in beginning abatement work necessitated by the 20-day advance notification requirement. Both the permit fee and the advance notification are required by § 40.1-51.20 of the Code of Virginia. With only a minimum of planning, abatement contractors can avoid any adverse consequences related to the advance notice and payment of the permit fee.

2. **Department:** The department must add personnel to handle the increase in oversight and monitoring required by the new program. However, the program will be supported with permit fees collected from certified contractors performing lead abatement projects. The regulation contains a provision which would decrease the amount of the lead project permit fee charged to contractors if the commissioner determines that the revenues from the program exceed the expenses of its administration by a certain amount.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 9-6.14:7.1 G of the Administrative Process Act and Executive Order Number 13 (94). Section 9-6.14:7.1 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types

Proposed Regulations

of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic effects.

Summary of the Proposed Regulation. The proposed regulation establishes notification criteria and sets permit fees for certified lead contractors engaged in abatement projects in Virginia with contract prices of \$2,000 or greater. This regulation implements the notification and permit requirements of § 40.1-51.20 of the Code of Virginia. The key provisions of the regulation that are likely to have economic consequences are as follows:

- a requirement that written notification be made to DLI of lead abatement projects with contract prices of \$2,000 or greater 20 days in advance of the start of the project;
- a requirement that the notification be accompanied by a permit fee equal to \$100 or 1.0% of the contract fee, up to a maximum of \$500; and
- an exemption from permit fees for residential building lead abatement projects.

Estimated Economic Impact. In assessing economic impact it is important to recall that the proposed regulation only mandates notification and permitting of lead abatement projects, it does not mandate lead abatement itself. It is anticipated that the proposed regulation will have two primary economic consequences. The first is that it will enhance DLI's ability to monitor lead abatement contractors' compliance with state and federal requirements for the safe removal and disposal of lead. Better compliance will have a positive effect on public health and safety, although it would be cost prohibitive to quantify the exact magnitude of that positive effect.

The second economic consequence of the proposed regulation is that it will increase the regulatory compliance costs associated with lead abatement. These increased costs are attributable to the notification requirement itself, the requirement that notification be made 20 days in advance of the start of a project, and the required permit fee. Some, if not all of these costs, will be passed on by lead abatement contractors to their customers.

Businesses and Entities Particularly Affected. The proposed regulation particularly affects the approximately 58 certified lead abatement contractors working in Virginia, their employees, their customers, and the general public.

Localities Particularly Affected. No localities are particularly affected by the proposed regulation

Projected Impact on Employment. The proposed regulation is not anticipated to have a significant effect on employment.

Effects on the Use and Value of Private Property. The proposed regulation is not anticipated to have a significant effect on the use and value of private property.

Summary of Analysis. The proposed regulation establishes notification criteria and sets permit fees for certified lead

contractors engaged in abatement projects in Virginia with contract prices of \$2,000 or greater. It is anticipated that the proposed regulation will have two primary economic effects: (i) a positive, but unquantifiable, impact on public health and safety attributable to better monitoring of compliance by lead abatement contractors; and (ii) an increase in the regulatory compliance costs associated with lead abatement in Virginia.

Agency's Response to Department of Planning and Budget's Economic Impact Analysis: The Department of Labor and Industry takes no issue with the economic impact analysis prepared by the Department of Planning and Budget.

Summary:

This proposed regulation requires all certified lead contractors who engage in lead abatement projects in Virginia with a contract value of \$2,000 or more to notify the department in writing at least 20 days before the beginning of such lead project and no work shall begin prior to approval of the completed form and submission of a permit fee. Such notification shall be provided on a detailed department form accompanied by the payment of a lead project permit fee based on a percentage of contract price. The regulation also requires filing of amended notifications prior to changes in or cancellation of lead abatement projects.

The regulation provides for emergency abatement situations. The regulation does not require notification for renovation and remodeling activities primarily to repair, restore or remodel a given structure or interim controls or maintenance and not to permanently eliminate lead-based paint.

CHAPTER 35.

REGULATION CONCERNING CERTIFIED LEAD CONTRACTORS NOTIFICATION, LEAD PROJECT PERMITS AND PERMIT FEES.

16 VAC 25-35-10. Definitions.

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

"Certified lead contractor" means an individual, company, partnership, corporation, sole proprietorship, association, or other business entity that offers to perform lead-based paint activities which has been issued an authorization by the Department of Professional and Occupational Regulation permitting the individual or firm to enter into contracts to perform abatement activities.

"Commercial building" means any building used primarily for commercial or industrial activity, which is generally not open to the public or occupied or visited by children, including but not limited to warehouses, factories, storage facilities, aircraft hangars, garages, and wholesale distribution facilities.

"Demolition" means the act of pulling down or destroying any building or structure.

"Department" means the Department of Labor and Industry.

"Encapsulation" means a process that makes lead-based paint inaccessible by providing a barrier between the lead-based paint and the environment with this barrier being formed using a liquid applied coating or an adhesively bonded material and when the primary means of attachment is by the bonding of the product to the surface either by itself or through the use of an adhesive. This excludes painting unless abrasive surface preparation is performed.

"Facility" means a building or portion of a commercial building, or rooms in a residential dwelling or unit, or bare soil on residential real property that contains lead at or in excess of levels identified as hazardous under guidance issued by the United States Environmental Protection Agency pursuant to § 403 of the Toxic Substances Control Act (15 USC § 2683).

"Lead abatement project" is a project in which any measure or set of measures designed to permanently eliminate lead-based paint hazards is employed. A lead abatement project includes, but is not limited to:

1. The removal of lead-based paint and lead-contaminated dust, the permanent containment or encapsulation of lead-based paint, the replacement of lead-painted surfaces or fixtures; and
2. All preparation, cleanup, disposal, and post-abatement clearance testing activities associated with such measures.

Lead abatement projects include, but are not limited to, the following:

1. Projects for which there is a written contract stating that an individual or firm will be conducting activities in or to a residential dwelling unit that will permanently eliminate lead-based paint hazards;
2. Projects involving the permanent elimination of lead-based paint and conducted by firms or individuals certified in accordance with the regulations of the Department of Professional and Occupational Regulation;
3. Projects involving the permanent elimination of lead-based paint and conducted by firms or individuals who, through their company name, promotional literature, or otherwise, advertise or hold themselves out to be lead abatement professionals; or
4. Projects where abatement is conducted in response to state or local abatement orders.

Lead abatement projects do not include renovation and remodeling activities when the primary intent is not to permanently eliminate lead-based paint hazards, but is instead to repair, restore or remodel a given structure or dwelling even though these activities may incidentally result in a reduction in lead-based paint hazards.

Furthermore, lead abatement projects do not include interim controls, operations and maintenance or other measures and activities designed to temporarily reduce lead-based paint hazards.

"Lead supervisor" means a person who has met the requirements of and is certified as a lead supervisor by the Virginia Department of Professional and Occupational Regulation.

"Residential building" means site-built homes, modular homes, condominium units, mobile homes, manufactured housing, and duplexes, or other multi-unit dwellings consisting of four units or less which are currently in use or intended for use only for residential purposes.

16 VAC 25-35-20. Authority and application.

A. This regulation is established in accordance with § 40.1-51.20 of the Code of Virginia.

B. This regulation shall apply to all certified lead contractors who engage in lead abatement projects.

C. The application of this regulation to contractors who work on federal property will be decided by the department based on a review of the facts in each case. The contractor shall contact the department to determine the applicability of the regulation to a specific project.

D. This regulation shall not affect the reporting requirements under § 40.1-51.20 C of the Code of Virginia or any other notices or inspection requirements under any other provision of the Code of Virginia.

16 VAC 25-35-30. Notification and permit fee.

A. Written notification of any lead abatement project, the contract price of which is \$ 2,000 or more, shall be made to the department on a department form. Such notification shall be sent by facsimile transmission as set out in subsection J of this section, by certified mail, or hand-delivered to the department. Notification shall be postmarked or made at least 20 days before the beginning of any lead project.

B. The department form shall include the following information:

1. Name, address, telephone number, and the certification number of each person intending to engage in a lead abatement project.
2. Name, address, and telephone number of the owner or operator of the facility in which the lead abatement project is to take place.
3. Type of notification: amended, emergency, renovation or demolition.
4. Description of facility in which the abatement or demolition is to take place, including present use or uses, prior use or uses, age, and address.
5. Estimate of amount of lead and method of estimation.
6. Amount of the lead project fee submitted.
7. Scheduled setup date, removal date or dates, and completion date of lead abatement work and times during which abatement will take place.
8. Name and certificate number of the lead supervisor on site.

Proposed Regulations

9. Name, address, telephone number, contact person, and landfill permit number of the waste disposal site or sites where the lead-containing material will be disposed.

10. Detailed description of the abatement methods to be used.

11. Procedures and equipment used to control the emission of lead-contaminated dust, to contain or encapsulate lead-based paint, and to replace lead-painted surfaces or fixtures in order to protect public health during abatement, removal, transit, loading and unloading.

12. If a facsimile transmission is to be made pursuant to subsection J of this section, the credit card number, expiration date, and signature of cardholder.

13. Any other information requested on the department form.

C. A lead abatement project permit fee shall be submitted with the completed project notification form. The fee shall be in accordance with the following schedule:

1. The greater of \$100 or 1.0% of the contract price, with a maximum of \$500.

2. If, at any time, the Commissioner of Labor and Industry determines that projected revenues from lead project permit fees may exceed projected administrative expenses related to the lead program by at least 15%, the commissioner may reduce the minimum and maximum fees and contract price percentage set forth in subdivision 1 of this subsection.

D. A blanket notification, valid for a period of one year, may be granted to a contractor who enters into a contract for lead abatement on a specific site which is expected to last for one year or longer.

1. The contractor shall submit the notification required in subsection A of this section to the department at least 20 days prior to the start of the requested blanket notification period. The notification submitted shall contain the following additional information:

a. The dates of work required by subdivision B 7 of this section shall be every work day during the blanket notification period, excluding weekends and state holidays.

b. The estimate of lead to be removed required under subdivision B 5 of this section shall be signed by the owner and the owner's signature authenticated by a notary.

c. A copy of the contract shall be submitted with the notification.

2. The lead abatement project permit fee for blanket notifications shall be as set forth in subsection C of this section.

3. The contractor shall submit an amended notification at least one day prior to each time the contractor will not be present at the site. The fee for each amended notification will be \$15.

4. Cancellation of a blanket notification may be made at any time by submitting a notarized notice of cancellation signed by the owner. The notice of cancellation must include the actual amount of lead removed and the actual amount of payments made under the contract. The refund shall be the difference between the original lead permit fee paid and 1.0% of the actual amount of payments made under the contract.

E. Notification of fewer than 20 days may be allowed in case of an emergency involving protection of life, health or property. In such cases, notification and the lead permit fee shall be submitted within five working days after the start of the emergency abatement. A description of the emergency situation shall be included when filing an emergency notification.

F. A notification shall not be effective unless a complete form is submitted and the proper permit fee is enclosed with the completed form. A notification made by facsimile transmission pursuant to subsection J of this section shall not be effective if the accompanying credit card payment is not approved.

G. On the basis of the information submitted in the lead notification, the department shall issue a permit to the contractor within seven working days of the receipt of a completed notification form and permit fee.

1. The permit shall be effective for the dates entered on the notification.

2. The permit or a copy of the permit shall be kept on site during work on the project.

H. Amended notifications may be submitted for modifications of subdivisions B 3 through B 11 of this section. No amendments to subdivision B 1 or B 2 of this section shall be allowed. A copy of the original notification form with the amended items circled and the permit number entered shall be submitted at any time prior to the removal date on the original notification.

1. No amended notification shall be effective if an incomplete form is submitted or if the proper permit amendment fee is not enclosed with the completed notification.

2. A permit amendment fee shall be submitted with the amended notification form. The fee shall be in accordance with the following schedule:

a. For modifications to subdivisions B 3, B 4, and B 6 through B 10 of this section, \$15.

b. For modifications to subdivision B 5 of this section, the difference between the permit fee in subsection C of this section for the amended amount of lead and the original permit fee submitted, plus \$15.

3. Modifications to the completion date may be made at any time up to the completion date on the original notification.

4. If the amended notification is complete and the required fee is included, the department will issue an amended permit if necessary.

I. The department must be notified prior to any cancellation. A copy of the original notification form marked "canceled" must be received no later than the scheduled removal date. Cancellation of a project may also be done by facsimile transmission. Refunds of the lead project permit fee will be made for timely cancellations when a notarized notice of cancellation signed by the owner is submitted.

The following amounts will be deducted from the refund payment: \$15 for processing of the original notification, \$15 for each amendment filed, and \$15 for processing the refund payment.

J. Notification for any lead abatement project, emergency notification, or amendment to notification may be done by facsimile transmission if the required fees are paid by credit card.

16 VAC 25-35-40. Exemption.

No lead abatement project fees will be required for residential buildings. Notification for lead projects shall otherwise be in accordance with applicable portions of this chapter.

Proposed Regulations



PERMIT NUMBER: _____

LEAD PERMIT APPLICATION AND NOTIFICATION FOR DEMOLITION/RENOVATION

1. TYPE OF NOTIFICATION: ORIGINAL AMENDED CANCEL

2. FACILITY INFORMATION: (facility owner, removal, demolition & other contractors)

OWNER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT: _____ TELEPHONE: () _____

REMOVAL CONTRACTOR: _____ LICENSE # _____

FEDERAL EMPLOYER IDENTIFICATION NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT: _____ TELEPHONE: () _____

DEMOLITION CONTRACTOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT: _____ TELEPHONE: () _____

OTHER OPERATOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT: _____ TELEPHONE: () _____

3. TYPE OF OPERATION: DEMO RENO EMER.-RENO ENCAPSULATE

4. FACILITY DESCRIPTION (INCLUDE BUILDING NAME, NUMBER AND FLOOR OR ROOM NUMBER):

BUILDING NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SITE LOCATION: _____

BUILDING SIZE: _____ # FLOORS: _____

5. SCHEDULED DATES: REMOVAL START: ____/____/____ FINISH: ____/____/____

REMOVAL TIMES: DAYS OF OPERATION: (MONDAY-SUNDAY) _____

WORKSHIFT HOURS: (MONDAY-FRIDAY) _____

(SATURDAY-SUNDAY) _____

LEAD PERMIT APPLICATION AND NOTIFICATION FOR DEMOLITION/RENOVATION

6. SCHEDULED DATES: DEMOLITION START: / / FINISH: / /

7. LEAD TO BE REMOVED	AMOUNT	8. % LEAD NOT REMOVED
DESCRIPTION		PERCENT
SURFACE AREA		%
SOIL ABATEMENT	CUFT	%

9. DESCRIPTION OF PLANNED DEMOLITION OR RENOVATION WORK, AND METHOD(S) TO BE USED:

10. DESCRIPTION OF WORK PRACTICES AND ENGINEERING CONTROLS TO BE USED TO PREVENT EMISSIONS OF LEAD AT THE DEMOLITION OR RENOVATION SITE:

11. WASTE TRANSPORTER #1: NAME: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIPCODE: _____
 CONTACT: _____ TELEPHONE: () _____

WASTE TRANSPORTER #2: NAME: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIPCODE: _____
 CONTACT: _____ TELEPHONE: () _____

12. WASTE DISPOSAL SITE: NAME: _____
 LOCATION: _____
 CITY: _____ STATE: _____ ZIPCODE: _____
 TELEPHONE: () _____ LANDFILL PERMIT #: _____

13. IF DEMOLITION ORDERED BY A GOVERNMENT AGENCY, IDENTIFY THE AGENCY BELOW:

NAME: _____ TITLE: _____
 AUTHORITY: _____
 DATE OF ORDER: DATE: / / DATE ORDERED TO BEGIN: DATE: / /

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulations: 12 VAC 30-70-10 et seq. **Methods and Standards for Establishing Payment Rates; Inpatient Hospital Care** (printing 12 VAC 30-70-10 through 12 VAC 30-70-150, adding 12 VAC 30-70-200 through 12 VAC 30-70-490).

12 VAC 30-80-10 et seq. Methods and Standards for Establishing Payment Rates--Other Types of Care (repealing 12 VAC 30-80-140).

Statutory Authority: § 32.1-325 of the Code of Virginia and Item 322 J of Chapter 912 of the 1996 Virginia Acts of Assembly.

Public Hearing Date: N/A -- Public comments may be submitted until February 21, 1997.

(See Calendar of Events section for additional information)

Basis and Authority: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Administrative Process Act (APA) also provides for this agency's promulgation of proposed regulations subject to the Governor's review.

Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA. The emergency regulation became effective on July 9, 1996. Section 9-6.14:4.1 C requires the agency to publish the Notice of Intended Regulatory Action within 60 days of the effective date of the emergency regulation if it intends to promulgate a permanent replacement regulation. The Notice of Intended Regulatory Action for this regulation was published in the Virginia Register on September 2, 1996, for its preliminary comment period until October 2, 1996. These proposed regulations must be filed no later than December 4, 1996, for their Register publication.

This regulation will carry out the directive of the 1996 General Assembly (Chapter 912, Item 322. J.) to "...implement a fully prospective reimbursement system for hospital inpatient services..." using a "...Diagnosis Related Groups (DRGs) methodology." This regulation also fulfills the final terms of the "VHA (Virginia Hospital Association)/Wilder" settlement agreement. This agreement, signed in 1990, settled litigation under the federal Boren Amendment, but lapsed on June 30, 1996. Among other things, the agreement required that DMAS and the VHA (now the VHHA) jointly develop a reimbursement methodology to replace the one that operated under the terms of the settlement agreement. This regulation implements the methodology that has been developed jointly by DMAS and the VHHA, and, therefore, fulfills this one remaining term of the settlement agreement.

Purpose: The purpose of this proposal is to promulgate permanent regulations, to supersede the existing emergency regulations, which provide for a new reimbursement methodology for inpatient hospital services. Coverage of inpatient hospital services is federally mandated for the protection of the health of Medicaid recipients. This new

methodology is known as Diagnosis Related Groupings or DRGs.

In December 1990, the Department of Medical Assistance Services (DMAS) and the Virginia Hospital and Healthcare Association (VHHA) (formerly the Virginia Hospital Association) signed a settlement agreement, putting an end to a multi-year litigation brought under the provisions of the federal Boren Amendment. This agreement prescribed a reimbursement methodology for hospitals to be in effect during state fiscal years 1992 through 1996. It also required that starting January 1995, DMAS and the VHHA would form a joint task force and develop a reimbursement methodology for the time period following June 30, 1996, on which date the agreement would lapse.

DMAS and the VHHA did form the joint task force. The deliberations of the task force produced a reimbursement system design that is the basis of these regulations. In support of the need to implement the system timely, the 1996 General Assembly authorized implementation of a new reimbursement system based on DRGs and required that it be effective July 1, 1996.

The current reimbursement system pays for inpatient hospital services by means of prospectively determined per diem rates. Hospitals are paid their per diem rate times the number of days of care provided. The new system will base payment on the "case" rather than the day. Each case will be paid according to the diagnosis and procedure or procedures that are specific to the case. The greater the complexity of the case, the higher the payment. This methodology, referred to as Diagnosis Related Groupings (DRGs), allows fully prospective pricing of inpatient services while recognizing that not all patients cost the same to treat. On the other hand, payment is not greater simply because the patient remains in the hospital longer. It is expected that the transition to DRGs will increase fairness in the distribution of payments to hospitals and will increase the incentive to control costs. It is not anticipated that the new system will increase the required appropriation for inpatient hospital services to the agency.

Additional payments to hospitals with a "disproportionate share" of Medicaid patients will continue under these regulations but will be targeted to a smaller group of hospitals that have a very high proportion of Medicaid and low income patients.

Medical education and capital costs will, during the two-year transition period, at least, continue to be paid as they have been in the past -- that is, based on reasonable cost incurred.

Psychiatric and rehabilitation inpatient hospital cases will continue to be paid on a per diem basis into the foreseeable future.

State teaching hospitals will continue to be treated as a separate peer group in this methodology.

The change to DRGs will not occur all at once. There will be two years when final reimbursement will be based partly on DRGs and partly on the current methodology of per diem rates. This will allow time for hospitals to adjust to the new system.

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The differences in the preceding emergency regulation and this proposed permanent regulation are:

Issues: The proposed new reimbursement methodology will promote a more fair and equitable distribution of Medicaid funds for inpatient hospital services. There are no identified disadvantages. The primary affected parties are hospitals. The Virginia Hospital and Healthcare Association was directly involved in the development and design of the proposed methodology, and therefore is likely to support most of the proposed regulatory changes. The agency projects no negative issues involved in implementing this proposed change.

Fiscal/Budget Impact: All hospitals that provide services to Medicaid recipients, except for some long-term and government operated hospitals, are affected by this regulation. For FY '97, DMAS has allocated \$484,971,000 for inpatient hospital services. No budget impact is forecast. Hospitals have been consulted and the VHHA is in support of the methodology that these regulations will implement. There are no localities which are uniquely affected by these regulations as they apply statewide.

Forms: Forms used in connection with reimbursement of hospitals are Medicaid cost report forms and billing forms. There will be changes to the cost report to accommodate these regulatory changes, and there will be changes to how certain data elements are reported on the billing form. However, there are no new forms needed to implement this 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 § 9-6.14:7.1 G of the Administrative Process Act and Executive Order Number 13 (94). Section 9-6.14:7.1 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic effects.

Summary of the Proposed Regulation. The proposed regulation replaces an emergency regulation that became effective on July 9, 1996. This regulation is in fulfillment of a directive by the 1996 General Assembly to implement a prospective payment system for inpatient hospital services using a Diagnosis Related Group (DRG) method (Chapter 912, Item 322.J.), and the settlement terms of a case brought under the federal Boren Amendment which required DMAS and the then Virginia Hospital Association to jointly develop a replacement reimbursement method.

DRG prospective payment systems are not new. Following the federal Tax Equity and Fiscal Responsibility Act of 1982, Medicare shifted its method for reimbursing hospitals to a DRG system. The primary feature of a DRG system is that hospitals are reimbursed, not according to the number of

days that a patient is treated, but rather the average cost associated with a patient's diagnosis related group.

Under the current per diem system used by DMAS to reimburse hospitals for Medicaid patients, hospitals face a disincentive regarding efficiency related reductions in medical costs. Efficiency generated reductions in the average length of patient stays are more likely to eliminate "low cost" patient days than "high cost" patient days. Because hospitals are reimbursed according to a flat per diem, however, such efficiency enhancements will tend to reduce Medicaid reimbursements by a greater proportion than Medicaid related costs. As a result, hospitals are actually penalized for efficiency enhancements that reduce the number of "low cost" patient days. Moreover, hospitals face a perverse incentive to increase Medicaid patient lengths of stay if doing so increases the number of "low cost" days associated with the stay.

The intention of DRG prospective payment systems is to correct these problems by providing a more rational incentive structure. Under a DRG system hospitals can keep any difference between the DRG rate and actual costs. This allows hospitals to profit from efficiency enhancing efforts and creates a strong incentive for cost containment. The specific DRG system put forward in the proposed regulation contains one provision which alters this general incentive structure in ways that will be discussed more fully in the next section. That provision is a mechanism for providing hospitals additional reimbursement in the case of "outliers" (*i.e.*, individuals whose cost of care significantly exceeds the average cost of care for their diagnosis related group).

Estimated Economic Impact. As mentioned above DRG prospective payment systems are not new. As a result, there has been a substantial amount of experience regarding the general effects of such systems. This makes it possible to clearly assess the direction of the economic effects that such an alteration in incentives is likely to induce, if not always the magnitude.

Distributional Equity. One of the primary economic benefits of the proposed regulation is that it will enhance distributional equity in hospital reimbursements for Medicaid patients. DMAS's current per diem ceilings were calculated in 1981 and have only been adjusted for inflationary increases since. This implies that hospitals that have had a significant change in case mix are currently being compensated at rates that no longer reflect their actual costs. Depending on the circumstances, some hospitals may be advantaged by this inaccuracy and some may be disadvantaged. Because the proposed DRG rate reimbursement system specifically recognizes that not all cases cost the same to treat, and because it controls for the case mix of individual hospitals by disaggregating reimbursements according to case category, it will more accurately compensate hospitals for the true costs of their Medicaid patient loads. This more accurate method of compensation will serve to eliminate any distributional inequities that may be present in the current system.

Dumping. One widely cited disadvantage of DRG prospective payment systems is that they create an incentive for hospitals to "dump" --- either refuse to treat or transfer --- patients with relatively high costs of care. Because hospitals are reimbursed according to the average cost for each

diagnosis related group, they have an incentive to avoid treating patients whose cost of care significantly exceeds the average. There are two reasons to believe that the proposed regulation is unlikely to engender such adverse effects however. First, it is very unlikely that a hospital would be able to accurately identify patients in advance who would have a high cost of treatment relative to their DRG category, even if the hospital had a policy that encouraged such identification.

The second reason that the proposed regulation is unlikely to engender dumping is that it provides a mechanism that allows hospitals to receive additional compensation in the case of "outliers." Allowing hospitals to recoup the additional costs imposed by outliers mitigates the incentive for hospitals to dump these patients.

Enhanced Efficiency. The primary goal of DRG prospective payment systems is to create an incentive for hospitals to engage in cost containment. The empirical evidence to date indicates that DRG systems have been largely successful in achieving this goal. Hospitals subject to DRG systems have been shown to exhibit lower increases in total expenses and greater decreases in average length of patient stay than hospitals subject to other payment systems.¹

Generally in a DRG system, hospitals whose existing costs fall below the system-wide average for specific DRGs receive a positive economic incentive (*i.e.*, they are reimbursed at the system-wide average even though their current costs are below that average). Reciprocally, hospitals whose existing costs exceed the system-wide average for specific DRGs receive a negative economic incentive (*i.e.*, they are reimbursed at the system-wide average even though their costs are above that average). This negative economic incentive provides a strong inducement for hospitals with high costs of treatment for certain DRGs, relative to their peers, to substantially reduce those costs or, if that option is not achievable, specialize away from the treatment of that particular diagnosis (*i.e.*, quit providing those services). The desirable effect of such specialization is that it reduces overall medical costs by encouraging hospitals to produce only those services that they are able to provide efficiently. The undesirable effect of such specialization is that it means patients may have to travel outside of their communities to acquire treatment.

An additional efficiency enhancing implication of DRG systems is that they have been shown to promote vertical integration and other forms of industrial organization intended to reduce service disruptions and contract costs.² The DRG system contained in the proposed regulation is likely to encourage similar efficiency enhancing consolidations.

¹See Judy Feder, Jack Hadley, and Stephen Zuckerman, "How Did Medicare's Prospective Payment System Affect Hospitals?," *New England Journal of Medicine*, vol. 317 (October 1 1987) pp. 867-73; or Stuart Guterman and Allen Dobson, "Impact of the Medicare Prospective Payment System for Hospitals," *Health Care Financing Review*, vol. 7 (Spring 1987) pp. 97-114; for examples of empirical studies that demonstrate this point.

²For empirical support of this implication see James C. Robinson, "Administered Pricing and Vertical Integration in the Hospital Industry," *Journal of Law and Economics*, vol. XXXIX (April 1996) pp. 357-78.

Incentive to Undertreat. Another common criticism of DRG prospective payment systems is that they create an incentive for hospitals to undertreat patients and release them "quicker and sicker" in order to reduce costs. Given the strong incentives for cost reduction in DRG systems, this is not an invalid concern. Some empirical studies have demonstrated, however, that even though DRG systems are generally associated with reduced lengths of stay, they are also associated with increased levels of hospital and doctor service intensity.³ One implication of this finding is that observed reduced lengths of stay in hospitals subject to DRG payment systems are reflective of increased levels of service intensity rather than undertreatment. In addition, competitive and liability concerns will also serve to mitigate incentives to reduce costs at the expense of patient well being.

Businesses and Entities Particularly Affected. The proposed regulation particularly affects Virginia hospitals, their patients, and their employees.

Localities Particularly Affected. No localities are particularly affected by the proposed regulation.

Projected Impact on Employment. The proposed regulation is not anticipated to have a significant effect on employment.

Effects on the Use and Value of Private Property. The proposed regulation is not anticipated to have a significant effect on the use and value of private property.

Summary of Analysis. The proposed regulation implements a prospective payment system for inpatient hospital services using a Diagnosis Related Group (DRG) method. DPB anticipates that the primary economic impact of the proposed regulation will be to enhance economic efficiency in the provision of inpatient hospital services. This enhancement of efficiency will likely have a dampening effect on medical costs over time. The exact magnitude of that effect is difficult to predict however. In addition, the proposed regulation will likely encourage vertical integration and other forms of consolidation designed to reduce transaction costs and service disruptions. Finally, the proposed regulation should also enhance distributional equity by eliminating disparities in the current system between current Medicaid cost of treatment and Medicaid reimbursements that may be attributable to changes over time in hospital specific case mixes.

Agency's Response to Department of Planning and Budget's Economic Impact Analysis: The Agency concurs with the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning Methods and Standards for Establishing Payment Rates--Inpatient Hospital Care (Diagnosis Related Groupings (DRGs)).

Summary:

The proposed regulation replaces an emergency regulation that became effective on July 9, 1996. This regulation is in fulfillment of a directive by the 1996

³See Richard J. Willke, William S. Cusler, James S. Moser, and Robert A. Musacchio, *Collaborative Production and Resource Allocation: The Consequences of Prospective Payment for Hospital Care*, Quarterly Review of Economics and Business, vol. 31, no. 1 (Spring 1991) pp. 28-47.

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General Assembly to implement a prospective payment system for inpatient hospital services using a Diagnosis Related Group (DRG) method (Chapter 912, Item 322.J.), and the settlement terms of a case brought under the federal Boren Amendment which required DMAS and the then Virginia Hospital Association to jointly develop a replacement reimbursement method.

DRG prospective payment systems are not new. Following the federal Tax Equity and Fiscal Responsibility Act of 1982, Medicare shifted its method for reimbursing hospitals to a DRG system. The primary feature of a DRG system is that hospitals are reimbursed, not according to the number of days that a patient is treated, but rather the average cost associated with a patient's diagnosis related group.

Under the current per diem system used by DMAS to reimburse hospitals for Medicaid patients, hospitals face a disincentive regarding efficiency related reductions in medical costs. Efficiency generated reductions in the average length of patient stays are more likely to eliminate "low cost" patient days than "high cost" patient days. Because hospitals are reimbursed according to a flat per diem, however, such efficiency enhancements will tend to reduce Medicaid reimbursements by a greater proportion than Medicaid related costs. As a result, hospitals are actually penalized for efficiency enhancements that reduce the number of "low cost" patient days. Moreover, hospitals face a perverse incentive to increase Medicaid patient lengths of stay if doing so increases the number of "low cost" days associated with the stay.

The intention of DRG prospective payment systems is to correct these problems by providing a more rational incentive structure. Under a DRG system hospitals can keep any difference between the DRG rate and actual costs. This allows hospitals to profit from efficiency enhancing efforts and creates a strong incentive for cost containment. The specific DRG system put forward in the proposed regulation contains one provision which alters this general incentive structure. That provision is a mechanism for providing hospitals additional reimbursement in the case of "outliers" (i.e., individuals whose cost of care significantly exceeds the average cost of care for their diagnosis related group).

CHAPTER 70.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES; IN-PATIENT HOSPITAL CARE.

PART I. PER DIEM METHODOLOGY.

12 VAC 30-70-10. Effect of participation in Health Insurance for the Aged program.

For each hospital also participating in the Health Insurance for the Aged program under Title XVIII of the Social Security Act, the state agency will apply the standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the inpatient routine service costs for medical assistance

recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII inpatient routine service charges or patient days as well as Title XVIII inpatient routine service cost.

12 VAC 30-70-20. Standards applied to nonparticipants in Title XVIII programs.

For each hospital not participating in the Program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital inpatient charges; the resulting percentage is applied to the bill of each inpatient under the Medical Assistance Program.

12 VAC 30-70-30. Limitations of Medical Assistance Program payment; Medicare reimbursement principles.

For either participating or nonparticipating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services that the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lesser of reasonable cost or customary charges in 42 CFR 447.250.

12 VAC 30-70-40. Payment of reasonable costs based on other methods.

The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary, HHS on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in 12 VAC 30-70-10 and 12 VAC 30-70-20.

12 VAC 30-70-50. Hospital reimbursement system.

The reimbursement system for hospitals includes the following components:

A. Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural - 0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban - 0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.

B. Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982 were subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, based on available, allowable cost data for hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were re-adjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each

SMSA area. The wage index is based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986 and until June 30, 1988, providers subject to the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This method uses an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

The prospective operating cost rate is based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The allowance for inflation percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the base for computing the next prospective year ceiling.

Effective on and after July 1, 1988, and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the moving average of the Data Resources, Incorporated Health Care Cost HCFA-Type Hospital Market Basket (updated quarterly) determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988, for all such hospitals shall be adjusted to reflect this change.

Effective on or after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia, as developed by Data Resources, Incorporated, determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989, for all such hospitals shall be adjusted to reflect this change.

Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described above, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points, (200 basis points) to the then current allowance for inflation. The escalation factor shall be applied in accordance with the inpatient hospital reimbursement methodology in effect on June 30, 1992. On July 1, 1992, the conversion to the new escalation factor shall be

accomplished by a transition methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992, and their next fiscal year ending on or before May 31, 1993.

The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

C. Subsequent to June 30, 1992, the group ceilings shall not be recalculated on allowable costs, but shall be updated by the escalator factor.

D. Prospective rates for each hospital shall be based upon the hospital's allowable costs plus the escalator factor, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment shall be made to prospective rates.

Depreciation, capital interest, and education costs approved pursuant to PRM-15 (\$ 400), shall be considered as pass throughs and not part of the calculation.

E. An incentive plan should be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive should be calculated based on the annual cost report.

The table below presents three examples under the new plan:

Group Ceiling	Hospital's Allowable Cost Per Day	Difference \$	% of Ceiling	Sliding Scale Incentive \$	% of Difference
\$230.00	\$230.00	-0-	-0-	-0-	-0-
230.00	207.00	23.00	10%	2.30	10%
230.00	172.00	57.50	25%	14.38	25%
230.00	143.00	76.00	33%	19.00	25%

F. There will be special consideration for exception to the median operating cost limits in those instances where extensive neonatal care is provided.

G. Hospitals which have a disproportionately higher level of Medicaid patients and which exceed the ceiling shall be allowed a higher ceiling based on the individual hospital's Medicaid utilization. This shall be measured by the percent of Medicaid patient days to total hospital patient days. Each hospital with a Medicaid utilization of over 8.0% shall receive an adjustment to its ceiling. The adjustment shall be set at a percent added to the ceiling for each percent of utilization up to 30%.

Disproportionate share hospitals defined.

Effective July 1, 1988, the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

1. Criteria

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a. A Medicaid inpatient utilization rate in excess of 8.0% for hospitals receiving Medicaid payments in the Commonwealth, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

b. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

c. Subdivision A 2 does not apply to a hospital:

(1) At which the inpatients are predominantly individuals under 18 years of age; or

(2) Which does not offer nonemergency obstetric services as of December 21, 1987.

2. Payment adjustment.

a. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the type of hospital and on the individual hospital's Medicaid utilization. There shall be two types of hospitals: (i) Type One, consisting of state-owned teaching hospitals, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization shall be determined by dividing the number of utilization Medicaid inpatient days by the total number of inpatient days. Each hospital with a Medicaid utilization of over 8.0% shall receive a disproportionate share payment adjustment.

b. For Type One hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8.0%, times 11, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8.0%, times (ii) the lower of the prospective operating cost rate or ceiling.

c. No payments made under items 1 or 2 above shall exceed any applicable limitations upon such payments established by federal law or regulations.

H. Outlier adjustments.

1. DMAS shall pay to all enrolled hospitals an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under one year of age.

2. DMAS shall pay to disproportionate share hospitals (as defined in paragraph G above) an outlier adjustment in payment amounts for medically necessary inpatient

hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

3. The outlier adjustment calculation.

a. Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals identified in H 1 or 2 above. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

b. Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals identified in H 1 or 2 above. Any hospital which qualifies for the extensive neonatal care provision (as governed by paragraph F, above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals identified in H 1 or 2 above.

c. Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in H 3 (ii) above.

d. DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital. Pursuant to 12 VAC 30-50-100, there is no limit on length of time for medically necessary stays for individuals under six years of age. This section provides that consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities 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. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

12 VAC 30-70-60. Establishment of reasonable and adequate payment rates; cost reporting.

In accordance with 42 CFR 447.250 through 447.272 which implements § 1902(a)(13)(A) of the Social Security Act, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide

services in conformity with state and federal laws, regulations, and quality and safety standards. To establish these rates Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's prospective payment system. Allowable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);
2. The provider's trial balance showing adjusting journal entries;
3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of charges in financial position, and footnotes to the financial statements;
4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;
5. Home office cost report, if applicable; and
6. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

Although utilizing the cost apportionment and cost finding methods of the Medicare Program, Virginia does not adopt the prospective payment system of the Medicare Program enacted October 1, 1983.

12 VAC 30-70-70. Revaluation of assets.

A. Effective October 1, 1984, the valuation of an asset of a hospital or long-term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984, or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the first owner of record, or the acquisition cost to the new owner.

C. In establishing appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986) the base to be used for such computations shall be limited to A or B above.

D. Costs (including legal fees, accounting and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. The recapture of depreciation up to the full value of the asset is required.

F. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest and (if applicable prior to July 1, 1986) return on equity based on cost of ownership as determined in accordance with A. and B. above.

12 VAC 30-70-80. Refund of overpayments.

A. Lump sum payment. When the provider files a cost report indicated that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

B. Offset. If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

D. Extension request documentation. In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved

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repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

E. Interest charge on extended repayment. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

12 VAC 30-70-90. Reimbursement of certified hospitals exempt from Medicare Prospective Payment system.

Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the 12 VAC 30-70-10 through 12 VAC 30-70-80, excluding 12 VAC 30-70-50 (6). Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports annually utilizing the applicable Medicare cost reporting forms (HCFA 2552 series) and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by the DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating cost or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph.

12 VAC 30-70-100. Reimbursement of return on equity capital to proprietary providers.

Item 398D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

12 VAC 30-70-110. Group ceiling for state-owned university teaching hospitals.

A. Pursuant to Item 389 E4 of the 1988 Appropriation Act (as amended), effective July 1, 1988, a separate group ceiling for allowable operating cost shall be established for state-owned university teaching hospitals.

B. Effective July 1, 1994, the separate group ceiling for allowable operating costs for state-owned university teaching hospitals shall be calculated using cost report and other applicable data pertaining to facility fiscal year ending June 30, 1993.

12 VAC 30-70-120. Nonenrolled providers.

A. Hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the lesser of:

1. The DMAS average reimbursable inpatient cost-to-charge ratio, updated annually on September 30 of each year based on the most recent settled cost report, for enrolled hospitals less five percent. (The 5.0% is for the cost of additional manual processing of the claims.)

2. The DMAS average per diem, updated annually on September 30 of each year based on the most recent settled cost report, of enrolled hospitals excluding the state-owned teaching hospitals and disproportionate share adjustments.

B. Hospitals that are not enrolled shall submit claims using the required DMAS invoice formats. Such claims must be submitted within twelve months from date of services. A hospital is determined to regularly treat Virginia Medicaid recipients and shall be required by DMAS to enroll if it provides more than 500 days of care to Virginia Medicaid recipients during the hospitals' financial fiscal year. A hospital which is required by DMAS to enroll shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in 12 VAC 30-70-10 through 12 VAC 30-70-100. The hospital shall be placed in one of the DMAS peer groupings which most nearly reflects its licensed bed size and location (12 VAC 30-70-50 (1)). These hospitals shall be required to maintain separate cost accounting records, and to file separate cost reports annually, utilizing the applicable Medicare cost reporting forms, (HCFA 2552 Series) and the Medicaid forms (MAP-783 Series).

C. A newly enrolled facility shall have an interim rate determined using the provider's most recent filed Medicare cost report or a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider shall be limited to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates

shall be determined in accordance with the current Medicaid Prospective Payment System as noted in subsection A.

D. Once a hospital has obtained the enrolled status, 500 days of care, the hospital must agree to become enrolled as required by DMAS to receive reimbursement. This status shall continue during the entire term of the provider's current Medicare certification and subsequent recertification or until mutually terminated with 30 days written notice by either party. The provider must maintain this enrolled status to receive reimbursement. If an enrolled provider elects to terminate the enrolled agreement, the non-enrolled reimbursement status will not be available to the hospital for future reimbursement, except for emergency care.

E. Prior approval must be received from the DMAS Health Services Review Division when a referral has been made for treatment to be received from a non-enrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

F. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for the services on an individually, negotiated rate basis.

12 VAC 30-70-130. Payment Adjustment Fund.

A. A Payment Adjustment Fund shall be created in each of the Commonwealth's fiscal years during the period July 1, 1992, to June 30, 1996. The Payment Adjustment Fund shall consist of the Commonwealth's cumulative addition of five million dollars in General funds and its corresponding federal financial participation for reimbursement to non-state owned hospitals in each of the Commonwealth's fiscal years during this period. Each July 1, or as soon thereafter as is reasonably possible, the Commonwealth shall, through a single payment to each non-state owned hospital, equitably and fully disburse the Payment Adjustment Fund for that year.

B. In the absence of any amendment to this section, for the Commonwealth's fiscal year after 1996, the Payment Adjustment Fund shall be continued at the level established in 1996 and shall be disbursed in accordance with the methodology described below.

C. The Payment Adjustment Fund shall be disbursed in accordance with the following methodology:

1. Identify each non-state owned hospital provider (acute, neonatal and rehabilitation) receiving payment based upon its peer group operating ceiling in May of each year.
2. For each such hospital identified in Paragraph 1, identify its Medicaid paid days for the 12 months ending each May 31.
3. Multiply each such hospital's days under Paragraph 2 by such hospital's May individual peer group ceiling (i.e., disregarding such hospital's actual fiscal year end ceiling) as adjusted by its then current disproportionate share factor.

4. Sum all hospital amounts determined in Paragraph 3.

5. For each such hospital, divide its amount determined in Paragraph 3 by the total of such amounts determined in Paragraph 4. This then becomes the hospital adjustment factor ("HAF") for each such hospital.

6. Multiply each such hospital's HAF times the amount of the Payment Adjustment Fund ("PAF") to determine its potential PAF share.

7. Determine the unreimbursed Medicaid allowable operating cost per day for each such hospital in Paragraph 1 for the most recent fiscal year on file at DMAS as of May 31, inflate such costs by DRI-V+2 from the mid-point of such cost report to May 31 and multiply such inflated costs per day by the days identified for that hospital in Paragraph 2 above, creating the "unreimbursed amount."

8. Compare each such hospital's potential PAF share to its unreimbursed amount.

9. Allocate to all hospitals, where the potential PAF share exceeds the unreimbursed amount, such hospital's unreimbursed amount as its actual PAF share.

10. If the PAF is not exhausted, for those hospitals with an unreimbursed amount balance, recalculate a new HAF for each such hospital by dividing the hospital's HAF by the total of the HAFs for all hospitals with an unreimbursed amount balance.

11. Recompute each hospital's new potential share of the undisbursed PAF by multiplying such finds by each hospital's new HAF.

12. Compare each hospital's new potential PAF share to its unreimbursed amount. If the unreimbursed amounts exceed the PAF shares at all hospitals, each hospital's new PAF share becomes its actual PAF share. If some hospitals' unreimbursed amounts are less than the new potential PAF shares, allocate to such hospitals their unreimbursed amount as their actual PAF share. Then, for those hospitals with an unreimbursed amount balance, repeat steps 10, 11, and 12 until each hospital's actual PAF share is determined and the PAF is exhausted.

13. The annual payment to be made to each non-state owned hospital from the PAF shall be equal to their actual PAF share as determined and allocated above. Each hospital's actual PAF share payment shall be made on July 1, or as soon thereafter as is reasonable feasible.

PART II.

HOSPITAL APPEALS OF REIMBURSEMENT RATES.

12 VAC 30-70-140. Hospital appeals of reimbursement rates.

§ 1. Right to appeal and initial agency decision.

A. Right to Appeal: Any hospital seeking to appeal its prospective payment rate for operating costs related to inpatient care or other allowable costs shall submit a written request to the Department of Medical Assistance Services

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within 30 days of the date of the letter notifying the hospital of its prospective rate unless permitted to do otherwise under § 5 E. The written request for appeal must contain the information specified in § 1 B. The Department shall respond to the hospital's request for additional reimbursement within 30 days or after receipt of any additional documentation requested by the Department, whichever is later. Such agency response shall be considered the initial agency determination.

B. Required Information: Any request to appeal the prospective payment rate must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) current and prospective cost containment efforts, if appropriate.

C. Non-Appealable Issues: The following issues will not be subject to appeal: (i) the organization of participating hospitals into peer groups according to location and bed size and the use of bed size and the urban/rural distinction as a generally adequate proxy for case mix and wage variations between hospitals in determining reimbursement for inpatient care; (ii) the use of Medicaid and applicable Medicare Principles of Reimbursement to determine reimbursement of costs other than operating costs relating to the provision of inpatient care; (iii) the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982; (iv) the use of the inflation factor identified in the State Plan as the prospective escalator; and (v) durational limitations set forth in the State Plan (the "21 day rule").

D. The rate which may be appealed shall include costs which are for a single cost reporting period only.

E. The hospital shall bear the burden of proof throughout the administrative process.

§ 2. Administrative appeal of adverse initial agency determination.

A. General. The administrative appeal of an adverse initial agency determination shall be made in accordance with the Virginia Administrative Process Act, § 9-6.14:11 through § 9-6.14:14 of the Code of Virginia, as set forth below.

B. The informal proceeding:

1. The hospital shall submit a written request to appeal an adverse initial agency determination in accordance with § 9-6.14:11 of the Code of Virginia within 15 days of the date of the letter transmitting the initial agency determination.

2. The request for an informal conference in accordance with § 9-6.14:11 of the Code of Virginia shall include the following information:

- a. The adverse agency action appealed from;
- b. A detailed description of the factual data, argument or information the hospital will rely on to challenge the adverse agency decision.

3. The agency shall afford the hospital an opportunity for an informal conference in accordance with § 9-6.14:11 of the Code of Virginia within 45 days of the request.

4. The Director of the Division of Provider Reimbursement of the Department of Medical Assistance Services, or his designee, shall preside over the informal conference. As hearing officer, the director, or his designee, may request such additional documentation or information from the hospital or agency staff as may be necessary in order to render an opinion.

5. After the informal conference, the Director of the Division of Provider Reimbursement, having considered the criteria for relief set forth in §§ 4 and 5, shall take any of the following actions:

- a. Notify the provider that its request for relief is denied setting forth the reasons for such denial;
- b. Notify the provider that its appeal has merit and advise it of the agency action which will be taken; or
- c. Notify the provider that its request for relief will be granted in part and denied in part, setting forth the reasons for the denial in part and the agency action which will be taken to grant relief in part.

6. The decision of the informal hearing officer shall be rendered within 30 days of the conclusion of the informal conference.

§ 3. The formal administrative hearing: procedures.

A. The hospital shall submit its written request for a formal administrative hearing under § 9-6.14:12 of the Code of Virginia within 15 days of the date of the letter transmitting the adverse informal agency decision.

B. At least 21 days prior to the date scheduled for the formal hearing, the hospital shall provide the agency with:

1. Identification of the adverse agency action appealed from, and
2. A summary of the factual data, argument and proof the provider will rely on in connection with its case.

C. The agency shall afford the provider an opportunity for a formal administrative hearing within 45 days of the receipt of the request.

D. The Director of the Department of Medical Assistance Services, or his designee, shall preside over the hearing. Where a designee presides, he shall make recommended findings and a recommended decision to the director. In such instance, the provider shall have an opportunity to file exceptions to the proposed findings and conclusions. In no case shall the designee presiding over the formal administrative hearing be the same individual who presided over the informal appeal.

E. The Director of the Department of Medical Assistance Services shall make the final administrative decision in each case.

F. The decision of the agency shall be rendered within 60 days of the conclusion of the administrative hearing.

§ 4. The formal administrative hearing: necessary demonstration of proof.

A. The hospital shall bear the burden of proof in seeking relief from its prospective payment rate.

B. A hospital seeking additional reimbursement for operating costs relating to the provision of inpatient care shall demonstrate that its operating costs exceed the limitation on operating costs established for its peer group and set forth the reasons for such excess.

C. In determining whether to award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, the Director of the Department of Medical Assistance Services shall consider the following:

1. Whether the hospital has demonstrated that its operating costs are generated by factors generally not shared by other hospitals in its peer group. Such factors may include, but are not limited to, the addition of new and necessary services, changes in case mix, extraordinary circumstances beyond the control of the hospital, and improvements imposed by licensing or accrediting standards.

2. Whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis.

a. In making such a determination, the director or his designee may require that an appellant hospital provide quantitative data, which may be compared to similar data from other hospitals within that hospital's peer group or from other hospitals deemed by the director to be comparable. In making such comparisons, the director may develop operating or financial ratios which are indicators of performance quality in particular areas of hospital operation. A finding that the data or ratios or both of the appellant hospital fall within a range exhibited by the majority of comparable hospitals, may be construed by the director to be evidence that the hospital has taken every reasonable action to contain costs in that particular area. Where applicable, the director may require the hospital to submit to the agency the data it has developed for the *Virginia Department of Health (formerly Virginia Health Services Cost Review Commission Council)*. The director may use other data, standards or operating screens acceptable to him. The appellant hospital shall be afforded an opportunity to rebut ratios, standards or comparisons utilized by the director or his designee in accordance with this section.

b. Factors to be considered in determining effective cost containment may include the following:

- Average daily occupancy
- Average hourly wage
- FTE's per adjusted occupied bed
- Nursing salaries per adjusted patient day
- Average length of stay
- Average cost per surgical case
- Cost (salary/nonsalary) per ancillary procedure

- Average cost (food/nonfood) per meal served
- Average cost per pound of laundry
- Cost (salary/nonsalary) per pharmacy prescription
- Housekeeping cost per square foot
- Maintenance cost per square foot
- Medical records cost per admission
- Current ratio (current assets to current liabilities)
- Age of receivables
- Bad debt percentage
- Inventory turnover
- Measures of case mix

c. In addition, the director may consider the presence or absence of the following systems and procedures in determining effective cost containment in the hospital's operation.

- Flexible budgeting system
- Case mix management systems
- Cost accounting systems
- Materials management system
- Participation in group purchasing arrangements
- Productivity management systems
- Cash management programs and procedures
- Strategic planning and marketing
- Medical records systems
- Utilization/Peer review systems

d. Nothing in this provision shall be construed to require a hospital to demonstrate every factor set forth above or to preclude a hospital from demonstrating effective cost containment by using other factors.

The director or his designee may require that an onsite operational review of the hospital be conducted by the department or its designee.

3. Whether the hospital has demonstrated that the Medicaid prospective payment rate it receives to cover operating costs related to inpatient care is insufficient to provide care and service to conforms to applicable state and federal laws, regulations and quality and safety standards.¹

¹ See 42 USC § 1396a(a)(13)(A). This provision reflects the Commonwealth's concern that she reimburse only those excess operating costs which are incurred because they are needed to provide adequate care. The Commonwealth recognizes that hospitals may choose to provide more than "just adequate" care and, as a consequence, incur higher costs. In this regard, the Commonwealth notes that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services ... that package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit

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D. In no event shall the Director of the Department of Medical Assistance Services award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, unless the hospital demonstrates to the satisfaction of the director that the Medicaid rate it receives under the Medicaid prospective payment system is insufficient to ensure Medicaid recipients reasonable access to sufficient inpatient hospital services of adequate quality.²

In making such demonstration, the hospital shall show that:

1. The current Medicaid prospective payment rate jeopardizes the long-term financial viability of the hospital. Financial jeopardy is presumed to exist if, by providing care to Medicaid recipients at the current Medicaid rate, the hospital can demonstrate that it is, in the aggregate, incurring a marginal loss.³

For purposes of this section, marginal loss is the amount by which total variable costs for each patient day exceed the Medicaid payment rate. In calculating marginal loss, the hospital shall compute variable costs at 60% of total inpatient operating costs and fixed costs at 40% of total inpatient operating costs; however, the director may accept a different ratio of fixed and variable operating costs if a hospital is able to demonstrate that a different ratio is appropriate for its particular institution.

Financial jeopardy may also exist if the hospital is incurring a marginal gain but can demonstrate that it has unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospital's long-term financial viability and,

2. The population served by the hospital seeking additional financial relief has no reasonable access to

other inpatient hospitals. Reasonable access exists if most individuals served by the hospital seeking financial relief can receive inpatient hospital care within a 30 minutes travel time at a total per diem rate which is less to Department of Medical Assistance Services than the costs which would be incurred by DMAS per patient day were the appellant hospital granted relief.⁴

E. In determining whether to award additional reimbursement to a hospital for reimbursable costs which are other than operating costs related to the provision of inpatient care, the director shall consider Medicaid and applicable Medicare rules of reimbursement.

§ 5. Available relief.

A. Any relief granted under §§ 1-4 shall be for one cost reporting period only.

B. Relief for hospitals seeking additional reimbursement for operating costs incurred in the provision of inpatient care shall not exceed the difference between:

1. The cost per allowable Medicaid day arising specifically as a result of circumstances identified in accordance with § 4 (excluding plant and education costs and return on equity capital) and

2. The prospective operating costs per diem, identified in the Medicaid Cost Report and calculated by DMAS.⁵

C. Relief for hospitals seeking additional reimbursement for (i) costs considered as "pass-throughs" under the prospective payment system or (ii) costs incurred in providing care to a disproportionate number of Medicaid recipients or (iii) costs incurred in providing extensive neonatal care shall not exceed the difference between the payment made and the actual allowable cost incurred.

D. Any relief awarded under §§ 1-4 shall be effective from the first day of the cost period for which the challenged rate was set. Cost periods for which relief will be afforded are those which begin on or after January 4, 1985. In no case shall this limitation apply to a hospital which noted an appeal of its prospective payment rate for a cost period prior to January 4, 1985.

E. All hospitals for which a cost period began or after January 4, 1985, but prior to the effective date of these regulations, shall be afforded an opportunity to be heard in accordance with these regulations if the request for appeal set forth in § 1A is filed within 90 days of the effective date of these regulations.

provided remains the individual services offered -- not 'adequate health care.'" *Alexander v. Choate*, - U.S. - decided January 9, 1985, 53 L.W., 4072, 4075.

² In *Mary Washington Hospital v. Fisher*, the court ruled that the Medicaid rate "must be adequate to ensure reasonable access". *Mary Washington Hospital v. Fisher*, at p. 18. The need to demonstrate that the Medicaid rate is inadequate to ensure recipients reasonable access derives directly from federal law and regulation. In its response to comments on the NPRM published September 30, 1981, HCFA points out Congressional intent regarding the access issue:

The report on H.R. 3982 states the expectation that payment levels for inpatient services will be adequate to assure that a sufficient number of facilities providing a sufficient level of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to obtain quality inpatient services. This report further states that payments should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals in the state. 46 FR 47970.

³ The Commonwealth believes that Congressional intent is threatened in situations in which a hospital is incrementally harmed for each additional day a Medicaid patient is treated -- and therefore has good cause to consider withdrawal from the program -- and where no alternative is readily available to the patient, should withdrawal occur. Otherwise, although the rate being paid a hospital may be less than that paid by other payors -- indeed, less than average cost per day for all patients -- it nonetheless equals or exceeds the variable cost per day, and therefore benefits the hospital by offsetting some amount of fixed costs, which it would incur even if the bed occupied by the Medicaid patient were left empty.

It should be emphasized that application of this marginal loss or "incremental harm" concept is a device to assess the potential harm to a hospital continuing to treat Medicaid recipients, and not a mechanism for determining the additional payment due to a successful appellant. As discussed below, once a threat to access has been demonstrated, the Commonwealth may participate in the full average costs associated with the circumstances underlying the appeal.

⁴ With regard to the thirty minute travel standard, this requirement is consistent with general health planning criteria regarding acceptable travel time for hospital care.

⁵ The Commonwealth recognizes that in cases where circumstances warrant relief beyond the existing payment rate, she may share in the cost associated with those circumstances. This is consistent with the existing policy, whereby payment is made on an average per diem basis. The Commonwealth will not reimburse more than her share of fixed costs. Any relief to an appellant hospital will be computed using patient days adjusted for the level of occupancy during the period under appeal. In no case will any additional payments made under this rule reflect lengths of stay which exceed the twenty-one day limit currently in effect.

§ 6. Catastrophic occurrence.

A. Nothing in §§ 1 through 5 shall be construed to prevent a hospital from seeking additional reimbursement for allowable costs incurred as a consequence of a natural or other catastrophe. Such reimbursement will be paid for the cost period in which such costs were incurred and for cost periods beginning on or after July 1, 1982.

B. In order to receive relief under this section, a hospital shall demonstrate that the catastrophe met the following criteria:

1. One time occurrence;
2. Less than 12 months duration;
3. Could not have been reasonably predicted;
4. Not of an insurable nature;
5. Not covered by federal or state disaster relief;
6. Not a result of malpractice or negligence.

C. Any relief sought under this section must be calculable and auditable.

D. The agency shall pay any relief afforded under this section in a lump sum.

PART III.
DISPUTE RESOLUTION FOR STATE-OPERATED FACILITIES.

12 VAC 30-70-150. Dispute resolution for state-operated providers.

A. Definitions.

"DMAS" means the Department of Medical Assistance Services.

"Division director" means the director of a division of DMAS.

"State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

The appropriate DMAS division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

C. Informal review. The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The division director or his designee shall review

this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

D. Division director action. The division director shall consider any recommendation of his designee and shall render a decision.

E. DMAS director review. A state-operated provider may, within 30 days after receiving the informal review decision of the division director, request that the DMAS director or his designee review the decision of the division director. The DMAS director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

F. Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other cabinet secretary as appropriate. Any determination by such secretary or secretaries shall be final.

PART IV.
[Reserved.]

12 VAC 30-70-160 through 12 VAC 30-70-190. [Reserved.]

PART V.
INPATIENT HOSPITAL PAYMENT SYSTEM.

Article 1.
Application of Payment Methodologies.

12 VAC 30-70-200. Application of payment methodologies.

The state agency will pay for inpatient hospital services under the methodologies and during the time periods specified in this part. During state fiscal years (SFY) 1997 and 1998, the state agency's methodology for inpatient hospital services in general acute care hospitals will transition from a per diem methodology to a DRG-based methodology. Article 2 (12 VAC 30-70-210) describes the special rules that apply during the transition period. Article 3 (12 VAC 30-70-220 et seq.) describes the DRG methodology that will apply (at a specified transition percentage) during the transition period and that will remain after the transition is over. Article 4 (12 VAC 30-70-400 et seq.) describes the revised per diem methodology that will apply in part during the transition, but that will cease to apply after the transition is over.

For inpatient hospital services in general acute care hospitals and rehabilitation hospitals occurring before July 1, 1996, reimbursement shall be based on the methodology described in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130), which language, until July 1, 1996, was Attachment 4.19-A of the State Plan for Medical Assistance Services. The provisions contained in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130) shall not be effective after June 30, 1996, except as otherwise provided in this part.

For inpatient hospital services that are psychiatric or rehabilitation services and that are provided in general acute

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care hospitals, distinct part units of general acute care hospitals, licensed freestanding psychiatric hospitals, or rehabilitation hospitals on and after July 1, 1996, reimbursement shall be based on a methodology described in Articles 2, 3 and 4 of this part. This methodology implements a transition from revised per diem rates taken from the previous methodology (12 VAC 30-70-10 through 12 VAC 30-70-130) to different per diem rates that will be used in the context of the DRG methodology. These services shall not be reimbursed by means of DRG per case rates. For licensed freestanding psychiatric hospitals there shall be no transition period, but the new per diem rates are to be implemented effective July 1, 1996. Also effective for those services rendered on or after July 1, 1996, the professional component for the care rendered in such licensed freestanding psychiatric hospitals may be billed separately by the attending professional who is enrolled in Medicaid. Inpatient hospital services that are provided in long stay hospitals and state-owned rehabilitation hospitals shall be subject to the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, which until July 1, 1996, was Attachment 4.19-A of the State Plan for Medical Assistance Services.

Transplant services shall not be subject to the provisions of this part. They shall continue to be subject to 12 VAC 30-50-95 through 12 VAC 30-50-310.

Article 2. Transition Period.

12 VAC 30-70-210. Transition period reimbursement rules.

A. Effective July 1, 1996, the state agency's reimbursement methodology for inpatient hospital services shall begin a transition from a prospective per diem to a prospective diagnosis related groupings (DRG) methodology. During the transition period, reimbursement of operating costs shall be a blend of a prospective DRG methodology (described in Article 3 of this part) and a revised prospective per diem methodology (described in Article 4 of this part). The transition period shall be SFY1997 and 1998, after which a DRG methodology alone shall be used.

B. Tentative payment during the transition period. During the transition period claims will be tentatively paid on the basis of the revised per diem methodology only. Payment of claims based on DRG rates shall begin July 1, 1998.

C. Final operating reimbursement during the transition period. During the transition period settlement of each hospital fiscal year will be carried out as provided in 12 VAC 30-70-460. Each hospital's final reimbursement for services that accrue to each state fiscal year of the transition shall be based on a blend of the prospective DRG methodology and the revised per diem methodology. For services to patients admitted and discharged in SFY1997 the blend shall be 1/3 DRG and 2/3 revised per diem. For services to patients admitted after June 30, 1996, and discharged during SFY1998 the blend shall be 2/3 DRG and 1/3 revised per diem. Settlements shall be completed according to hospital fiscal years, but after June 30, 1996, changes in rates and in the percentage of reimbursement that is based on DRGs vs. per diem rates, shall be according to state fiscal year. Services in freestanding psychiatric facilities licensed as

hospitals shall not be subject to the transition period phase-in of new rates, or to settlement at year end; the new system rates for these providers shall be fully effective on July 1, 1996. In hospital fiscal years that straddle the implementation date (years starting before and ending after July 1, 1996) operating costs must be settled partly under the old and partly under the new methodology:

1. Days related to discharges occurring before July 1, 1996, shall be settled under the previous reimbursement methodology (see 12 VAC 30-70-10 through 12 VAC 30-70-130).

2. Stays with admission date before July 1, 1996, and discharge date after June 30, 1996, shall be settled in two parts, with days before July 1, 1996, settled on the basis of the previous reimbursement methodology (see 12 VAC 30-70-10 through 12 VAC 30-70-130), and days after June 30, 1996, settled at 100% of the hospital's revised per diem rate as described in Article 4 (12 VAC 30-70-400 et seq.) of this part. The DRG reimbursement methodology shall not be used in the settlement of any days related to a stay with an admission date before July 1, 1996.

3. Stays with admission dates on and after July 1, 1996, shall be settled under the transition methodology. All cases admitted from July 1, 1996, onward shall be settled based on the rates and transition rules in effect in the state fiscal year in which the discharge falls. The only exception shall be claims for rehabilitation cases with length of stay sufficient that one or more interim claims are submitted. Such claims for rehabilitation cases shall be settled based on rates and rules in effect at the time of the end date ("through" date) of the claim, whether or not it is the final or discharge claim.

D. Capital cost reimbursement. During the transition period capital cost shall be reimbursed as a pass-through as described in 12 VAC 30-70-10 through 12 VAC 30-70-130, except that paid days and charges used to determine Medicaid allowable cost in a fiscal period for purposes of capital cost reimbursement shall be the same as those accrued to the fiscal period for operating cost reimbursement. Effective July 1, 1998, capital cost shall be reimbursed as described in Article 4 (12 VAC 30-70-400 et seq.) of this part. Until capital costs are fully included in prospective rates the provisions of 12 VAC 30-70-70 regarding recapture of depreciation shall remain in effect. Reimbursement of capital cost for freestanding psychiatric facilities licensed as hospitals shall be included in their per diem rates as provided in Article 4 (12 VAC 30-70-400 et seq.) of this part, and shall not be treated as a pass-through during the transition period or afterward.

E. Disproportionate Share Hospital (DSH) payments during the transition. Effective July 1, 1996, DSH payments shall be fully prospective amounts determined in advance of the state fiscal year to which they apply, and shall not be subject to settlement or revision based on changes in utilization during the year to which they apply. Payments prospectively determined for each state fiscal year shall be considered payment for that year, and not for the year from which data used in the calculation was taken. Payment of

DSH amounts determined under this methodology shall be made on a quarterly basis.

For patient days occurring before July 1, 1996, DSH reimbursement shall be determined under the previous methodology and settled accordingly (12 VAC 30-70-10 through 12 VAC 30-70-130). Effective for days occurring July 1, 1996, and after, DSH reimbursement made through prospective lump sum amounts as described in this section shall be final and not subject to settlement except when necessary due to the limit in subdivision 2 e of this subsection. After July 1, 1998, DSH reimbursement shall be as provided in Article 4 (12 VAC 30-70-400 et seq.) of this part.

1. **Definition.** A disproportionate share hospital shall be a hospital that meets the following criteria:

a. A Medicaid utilization rate in excess of 15%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

b. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

c. Subdivision 1 b of this subsection does not apply to a hospital:

(1) At which the inpatients are predominantly individuals under 18 years of age; or

(2) Which does not offer nonemergency obstetric services as of December 21, 1987.

2. **Payment adjustment.**

a. A disproportionate share hospital's additional payment shall be based on the type of hospital and on the hospital's Medicaid utilization percentage. There shall be two types of hospitals: (i) Type One, consisting of hospitals that were state-owned teaching hospitals on January 1, 1996, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization percentage is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days. Each eligible hospital with a Medicaid utilization percentage above 15% shall receive a disproportionate share payment.

b. For Type One hospitals, the disproportionate share payment shall be equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 15%, times 11, times the hospital's Medicaid operating reimbursement, times 1.3186 in SFY1997, and 1.3782 in SFY1998 and (ii) the hospital's Medicaid utilization percentage in excess of 30%, times 11, times the

hospital's Medicaid operating reimbursement, times 1.3186 in SFY1997, and 1.3782 in SFY1998.

c. For Type Two hospitals, the disproportionate share payment shall be equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 15%, times the hospital's Medicaid operating reimbursement, times 1.0964 in SFY1997, and 1.1476 in SFY1998 and (ii) the hospital's Medicaid utilization percentage in excess of 30%, times the hospital's Medicaid operating reimbursement, times 1.0964 in SFY1997, and 1.1476 in SFY1998.

d. For hospitals which do not qualify under the 15% inpatient Medicaid utilization rate, but do qualify under the low-income patient utilization rate, exceeding 25% in subdivision 1 a of this subsection, the disproportionate share payment amount for Type One hospitals shall be equal to the product of the hospital's low-income utilization in excess of 25%, times 11, times the hospital's Medicaid operating reimbursement. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.

e. OBRA 1993 § 13621 Disproportionate Share Adjustment Limit.

(1) **Limit on amount of payment.** No payments made under subdivision E 2 of this section shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 § 13621. A payment adjustment during a fiscal year shall not exceed the sum of:

(a) Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year, and

(b) Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

(2) During state fiscal year 1995, the limit in this section shall apply only to hospitals which are owned or operated by a state or an instrumentality or unit of government within the state. During this year such a hospital, if it is one whose Medicaid inpatient utilization rate is at least one standard deviation above the mean inpatient utilization rate in the state or if it has the largest number of Medicaid days of any such hospital in the Commonwealth for the previous state fiscal year, shall be allowed a limit that is 200% of the limit described above which the Governor certifies to the Secretary of the U. S. Department of Health and Human Services that such amount (the amount by which the hospital's

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payment exceeds the limit described above) shall be used for health services during the year.

3. Source data for calculation of eligibility and payment adjustment. Each hospital's eligibility for DSH payment, and the amount of the DSH payment in state fiscal year 1997, shall be based upon Medicaid utilization in hospital fiscal years ending in calendar year 1994, and on projected operating reimbursement in state fiscal year 1997, estimated on the basis of 1994 utilization. After state fiscal year 1997, each new year's DSH payments shall be calculated using the most recent reliable utilization and projection data available. For the purpose of calculating DSH payments, each hospital with a Medicaid-recognized Neonatal Intensive Care Unit (NICU) (a unit having had a unique NICU operating cost limit under subdivision 6 of 12 VAC 30-70-60), shall have its DSH payment calculated separately for the NICU and for the remainder of the hospital as if the two were separate and distinct providers.

For licensed freestanding psychiatric hospitals, DSH payment shall be based on the most recent filed Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.

F. Direct medical education (DMedEd). During the transition period (July 1996 through June 1998), DMedEd costs shall be reimbursed in the same way as under the previous methodology (12 VAC 30-70-10 through 12 VAC 30-70-130). This methodology does not and shall not include the DME reimbursement limitation enacted for the Medicare program effective July 1, 1985. Reimbursement of DMedEd shall include an amount to reflect DMedEd associated with services to Medicaid patients provided in hospitals but reimbursed by capitated managed care providers. This amount shall be estimated based on the number of days of care provided by the hospital that are reimbursed by capitated managed care providers. Direct medical education shall not be a reimbursable cost in licensed freestanding psychiatric hospitals. DMedEd will be paid in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end settlement.

G. Final payment adjustment fund (PAF) payment for certain hospitals. Hospitals receiving payments for Medicaid patients from managed care providers enrolled in Medallion II shall be paid a separate lump sum amount, based on the continuation of capitation rates during July 1, 1996, through December 31, 1996, that do not reflect adjustments made to hospital per diem and DRG payments on July 1, 1996. Each of these hospitals shall be paid a final PAF amount. It shall be equal to a hospital specific PAF per diem times the number of Medallion II days that occur in the hospital in July 1, 1996, through December 31, 1996. The PAF per diem shall be based on a revision of the PAF calculation that was carried out for the SFY1996 PAF payment that was made in August 1995. The revision shall be the hospital ceiling, DSH per diem, and cost report data used in the calculation from the cost reports that would be used under the PAF methodology if a SFY1997 PAF calculation were to be done. The "paid days" data used in this calculation shall be the same as that used in the SFY1996 calculation. Pending the

calculation of the final PAF payment in the settlement of the relevant time period for the affected hospitals, an interim payment shall be made. The interim payment shall be equal to 1/2 the PAF payment made to the same hospitals for SFY1996.

H. Adjusting DRG rates for length of stay (LOS) reductions from 1995 Appropriations Act. If it is demonstrated that there are savings directly attributable to LOS reductions resulting from utilization initiatives directed by the 1995 Appropriations Act as agreed to and evaluated by the Medicaid Hospital Payment Policy Advisory Council, these savings, up to a maximum of \$16.9 million in SFY1997, shall be applied as a reduction to SFY1997 and 1998 DRG rates used for settlement purposes.

I. Service limits during the transition period. The limit of coverage for adults of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply in the processing of claims and in the per diem portion of settlement during the transition period. This limit shall not apply in the DRG portion of reimbursement, except for covered psychiatric cases. Psychiatric cases are cases with a principal diagnosis that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see 12 VAC 30-50-95 through 12 VAC 30-50-310.

Article 3.

Diagnosis Related Groups (DRG) Reimbursement Methodology.

12 VAC 30-70-220. General.

A. Reimbursement of operating costs for cases which are subject to DRG rates shall be equal to the relative weight of the DRG in which the patient falls, times the hospital specific operating rate per case. Reimbursement of outliers, transfer cases, cases still subject to per diem reimbursement, capital costs, and medical education costs shall be as provided in this article.

B. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG reimbursement methodology. Effective July 1, 1996, and until notification of a change is given, Version 12 of this grouper shall be used. DMAS shall notify hospitals by means of a Medicaid memo when updating the system to later grouper versions.

12 VAC 30-70-230. Calculation of DRG weights and hospital case mix indices.

A. The relative weight measures the cost and, therefore, the reimbursement level of each DRG relative to all other DRGs. The hospital case mix index measures the hospital's average case mix complexity (costliness) relative to all other hospitals.

B. The relative weight for each DRG was determined by calculating the average standardized cost for cases assigned to that DRG, divided by the average standardized cost for cases assigned to all DRGs. For the purpose of calculating relative weights, groupable cases (cases having coding data of sufficient quality to support DRG assignment) and transfer cases (groupable cases where the patient was transferred to another hospital) were used. Ungroupable cases and

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rehabilitation, psychiatric, and transplant cases were not used. DMAS' hospital computerized claims history file for discharges in hospital fiscal years ending in calendar year 1993 was used. All available data from all enrolled, cost-reporting general acute care hospitals were used, including data from state-owned teaching hospitals. Cost report data from hospital fiscal years ending in calendar year 1993 were also used.

C. Before relative weights were calculated for each DRG, each hospital's total charges were disaggregated into operating charges and capital charges, based on the ratio of operating and capital cost to total cost. Operating charges and capital charges were standardized for regional variation, and then both operating charges and capital charges were reduced to costs using ratios of costs-to-charges (RCCs) obtained from the Medicaid cost report database. Direct medical education costs were eliminated from the relative weight calculations since such costs will be addressed outside the DRG rates. These steps, detailed in subsection D of this section, were completed on a case-by-case basis using the data elements identified in the following table.

Data Elements for Relative Weight and Case Mix Index Calculations

Data Elements	Source
Total charges for each groupable case	Claims Database
Total charges for each transfer case	Claims Database
Ratio of operating costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of capital costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of durable medical equipment costs to total costs for each hospital	Medicaid Cost Report Database
Statewide average labor portion of operating costs	Virginia Health Services Cost Review Council
Medicare wage index for each hospital	Federal Register
Medicare Geographic Adj. Factor (GAF) for each hospital	Federal Register
RCC for each hospital	Medicaid Cost Report Database

D. Steps in calculation of relative weights.

1. The total charges for each case were split into operating charges, capital charges, and durable medical equipment charges using hospital specific ratios obtained from the cost report database.

2. The operating charges obtained in Step 1 were standardized for regional variations in wages. This involved three substeps.

a. The operating charges were multiplied by 59.77% yielding the labor portion of operating charges.

b. The labor portion of operating charges was divided by the hospital specific Medicare wage index yielding the standardized labor portion of operating charges.

c. The standardized labor portion of operating charges was added to the nonlabor portion of operating charges (40.23%) yielding standardized operating charges.

3. The standardized operating charges were multiplied by the hospital specific RCC yielding standardized operating costs.

4. The capital charges obtained in Step 1 were divided by the hospital specific Medicare geographic adjustment factor (GAF) yielding standardized capital charges.

5. The standardized capital charges were multiplied by the hospital specific cost-to-charge ratio yielding standardized capital costs.

These five steps were repeated for all groupable cases and transfer cases. Once this was done, the cases were sorted by DRG category resulting in the total cases and the total standardized cost of each DRG. Total cost divided by total cases yielded the average standardized cost of each DRG. The average standardized cost of each DRG was divided by the average standardized cost across all DRGs yielding the relative weight for each DRG. To address the unavailability of charge data related to adult hospital days beyond 21 days, an adjustment was estimated for certain DRGs and added to the weights as calculated above. This adjustment for adult days over 21 is necessary only until the first recalibration of weights becomes effective in July 1998 (see 12 VAC 30-70-380).

The relative weights were then used to calculate a case-mix index for each hospital. The case-mix index for a hospital was determined by summing for all DRGs the product of the number of groupable cases and transfer cases in each DRG and the relative weight for each DRG. This sum was then divided by the total number of cases yielding the case-mix index. This process was repeated on a hospital-by-hospital basis.

12 VAC 30-70-240. Calculation of standardized costs per case.

A. Standardized costs per case were calculated using all DRG cases (groupable, ungroupable, and transfer cases). Cases entirely subject to per diem rather than DRG reimbursement and cases from state-owned teaching hospitals were not used. Using the data elements identified in the following table, the seven steps outlined in subsection B of this section were completed on a case-by-case basis.

Data Elements for Standardized Costs Per Case Calculations

Data Elements	Source
Total charges for each groupable case	Claims Database
Total charges for each ungroupable case	Claims Database
Total charges for each transfer case	Claims Database
Ratio of operating costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of capital costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of durable medical equipment costs to total costs for each hospital	Medicaid Cost Report Database

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Statewide average labor portion of operating costs	Virginia Health Services Cost Review Council
Medicare wage index for each hospital	Federal Register
Medicare GAF for each hospital	Federal Register
RCC for each hospital	Medicaid Cost Report Database
Case-mix index for each hospital	Calculated
Total number of groupable cases	Claims Database
Total number of ungroupable cases	Claims Database
Total number of transfer cases	Claims Database

B. Steps in calculation of standardized cost per case.

1. The total charges for each case were split into operating charges, capital charges, and durable medical equipment charges using hospital specific ratios obtained from the cost report database.
2. The operating charges obtained in Step 1 were standardized for regional variations in wages. This involved three substeps.
 - a. The operating charges were multiplied by 59.77% yielding the labor portion of operating charges.
 - b. The labor portion of operating charges was divided by the hospital specific Medicare wage index yielding the standardized labor portion of operating charges.
 - c. The standardized labor portion of operating charges was added to the nonlabor portion of operating charges (40.23%) yielding standardized operating charges.
3. The standardized operating charges were multiplied by the hospital specific RCC yielding standardized operating costs.
4. The capital charges obtained in Step 1 were divided by the hospital specific Medicare geographic adjustment factor (GAF) yielding standardized capital charges.
5. The standardized capital charges were multiplied by the hospital specific cost-to-charge ratio yielding standardized capital costs.
6. The standardized operating costs obtained in Step 3 were divided by the hospital specific case-mix index yielding case-mix neutral standardized operating costs.
7. The standardized capital costs obtained in Step 5 were divided by the hospital specific case-mix index yielding case-mix neutral standardized capital costs.

These seven steps were repeated for all DRG cases. Once this was done, the case-mix neutral standardized operating costs for all DRG cases were summed and an average was calculated. This yielded what is referred to as standardized operating costs per case. A similar average was computed for capital yielding standardized capital costs per case.

12 VAC 30-70-250. Calculation of statewide operating rate per case for SFY1997.

The statewide operating rate per case that shall be used to calculate the DRG portion of operating reimbursement for cases admitted and discharged in state fiscal year 1997 is equal to the standardized operating cost per case, updated to the midpoint of SFY1997 and multiplied by an additional factor. The update shall be done by multiplying the standardized operating cost per case by the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS. The additional factor is equal to 0.6247. This factor is the ratio of two numbers:

1. The numerator of the factor is the aggregate amount of operating reimbursement for hospitals included in the data base used for the calculations described above that DMAS and the Virginia Hospital and Healthcare Association (VHHA) jointly determined would be made by Medicaid in state fiscal year 1997 if the rate methodology in effect on June 30, 1996, were to continue. This amount was further adjusted by agreement between DMAS and the VHHA to carry out specific policy agreements with respect to various elements of reimbursement.
2. The denominator of the factor is the estimated aggregate operating amount for the same hospitals identified in subdivision 1 of this section, calculated using the standardized operating cost per case and standardized operating cost per day as calculated in 12 VAC 30-70-230 and 12 VAC 30-70-320, and adjusted for inflation as in subdivision 1.

12 VAC 30-70-260. Calculation of statewide capital rate per case. (Reserved)

12 VAC 30-70-270. Hospital specific operating rate per case.

Each hospital specific operating rate per case shall be the labor portion of the statewide operating rate per case multiplied by the Medicare wage index applicable to the hospital's geographic location plus the nonlabor portion of the statewide operating rate per case. The Medicare wage index shall be the one in effect for Medicare in the base period used in the calculation of the standardized costs per case (1993 for the calculation of 1997 rates).

12 VAC 30-70-280. Hospital specific capital rate per case (geographic adjustment). (Reserved)

12 VAC 30-70-290. Outliers.

A. An outlier case shall be one whose estimated cost exceeds the applicable DRG payment plus the applicable fixed loss threshold.

B. Total payment for an outlier case shall be calculated according to the following methodology (an example of the application of this methodology is found in 12 VAC 30-70-500):

1. The operating cost for the case shall be estimated. Operating cost for the case shall be the charges for the case times the hospital's operating cost-to-charge ratio based on the hospital's cost report data in the base

period used to establish the rates in effect in the period for which outlier payment is being calculated.

2. The hospital specific operating cost amount for the DRG shall be calculated. This shall be equal to the sum of the labor portion of the standardized operating cost per case times the Medicare wage index, and the nonlabor portion of the standardized operating cost per case, multiplied by the relative weight applicable to the case.

3. The hospital specific operating cost outlier threshold is calculated as follows:

a. An outlier fixed loss threshold times the statewide average labor portion of operating cost times the Medicare wage index for the hospital, plus

b. The nonlabor portion of the fixed loss threshold, plus

c. The DRG operating cost amount for the case (subdivision 2 above).

4. The case specific excess over the hospital specific operating outlier threshold is calculated. This shall be equal to the difference between the estimated operating cost for the case (subdivision 1 above) and the hospital specific operating cost outlier threshold (subdivision 3 above), multiplied by the cost adjustment factor for outliers.

5. The total payment for the case is calculated. This shall be equal to the sum of the DRG operating cost amount for the case (subdivision 2 above) and the case specific excess over the hospital specific operating threshold (subdivision 4 above), multiplied by the factor that is used to adjust the standardized operating cost per case in 12 VAC 30-70-250.

C. Data element definitions. Factors and variables used in the above calculation and not already defined are defined as follows:

1. The "outlier fixed loss threshold" is a fixed dollar amount in SFY1997, applicable to all hospitals, that shall be adjusted each year. It shall be calculated each year, based on the most recent available estimates so as to result in a total operating expenditure for outliers equal to 5.1% of total operating expenditures, including outliers. In SFY1997, this amount shall be \$15,483. If in any year revised estimates are unavailable the previous year's value shall be used updated for inflation using the same factor applied to hospital rates.

2. The "statewide average labor proportion of operating cost" is a fixed percentage, equal to .5977. This figure may be updated with revised data when rates are rebased/recalibrated.

3. The "adjustment factor for outliers" is a fixed factor, published by Medicare in the Federal Register, and equal to 0.80. This figure shall be updated based on changes to the Medicare factor, upon the next rebasing of the system described in this part.

4. The "Medicare wage index applicable to the hospital" is as published by the Health Care Financing Administration in the year used as the base period.

12 VAC 30-70-300. Transfers and readmissions.

A. Transfer cases shall be defined as (i) patients transferred from one general acute care hospital to another and (ii) patients discharged from one general acute care hospital and admitted to another for the same or similar diagnosis (similar diagnoses shall be defined as ones with the first three digits the same) within five days of that discharge.

B. Readmissions shall be defined as cases readmitted to the same hospital for the same or similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as a new admission or case (a separate DRG payment shall not be made).

C. Exceptions.

1. Cases falling into DRGs 456, 639, or 640 shall not be treated as transfer cases, but the full DRG rate shall be paid to the transferring hospital. These DRGs are designed to be populated entirely with transfer patients.

2. Cases transferred to or from a distinct part psychiatric or rehabilitation units of a general acute care hospital shall not be treated as transfer cases.

D. Transfer methodology. When two general acute care hospitals provide inpatient services to a patient defined as a transfer case:

1. The transferring hospital shall receive the lesser of (i) a per diem payment equal to the DRG payment for the transferring hospital, divided by the arithmetic mean length of stay for the DRG in all hospitals for which data are available, times the patient's length of stay at the transferring hospital or (ii) the full DRG payment for the transferring hospital. The transferring hospital shall be eligible for outlier payments if the applicable criteria are met.

2. The receiving hospital, if it is the final discharging hospital, shall receive DRG payment. A receiving hospital that later transfers the patient to another hospital, including the first transferring hospital, shall be reimbursed as a transferring hospital. Only the final discharging hospital shall receive DRG payment. The receiving hospital shall be eligible for outlier payments if the applicable criteria are met.

12 VAC 30-70-310. Per diem reimbursement in the DRG methodology.

Cases that will continue to be reimbursed on a per diem basis are (i) covered psychiatric cases in general acute care hospitals and psychiatric units of general acute care hospitals, (ii) covered psychiatric cases in licensed freestanding psychiatric hospitals, and (iii) rehabilitation cases in both general acute care and rehabilitation hospitals. Psychiatric cases are cases with a principal diagnosis that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see

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the Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1A&B (12 VAC 30-50-95 through 12 VAC 30-50-310).

12 VAC 30-70-320. Calculation of standardized costs per day.

A. Standardized operating costs per day and standardized capital costs per day were calculated separately, but using the same calculation methodology, for psychiatric cases in general acute care hospitals, psychiatric acute care in licensed freestanding psychiatric hospitals, and rehabilitation cases (per diem cases). Using the data elements identified in the following table, the first five steps outlined below were completed on a case-by-case basis.

Data Elements for Calculating Total Costs for Per Diem Cases

Data Elements	Source
Total charges for each acute care psychiatric case	Claims Database
Total charges for each freestanding acute care psychiatric case	Claims Database
Total charges for each rehabilitation case	Claims Database
Ratio of operating costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of capital costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of durable medical equipment costs to total costs for each hospital	Medicaid Cost Report Database
Statewide average labor portion of operating costs	Virginia Health Services Cost Review Council
Medicare wage index for each hospital	Federal Register
Medicare GAF for each hospital	Federal Register
RCC for psychiatric distinct part unit for each hospital	Medicare Cost Report
RCC for each hospital	Medicaid Cost Report Database
Number of acute care psychiatric days at each hospital	Claims Database
Number of freestanding acute care psychiatric days at each freestanding psychiatric facilities licensed as a hospital	Claims Database
Number of rehabilitation days at each acute care hospital and freestanding rehabilitation hospital	Claims Database

B. Steps in calculation of standardized cost per day.

1. The total charges for the case were split into operating charges, capital charges, and durable medical equipment charges using hospital specific ratios obtained from the cost report database.

2. The operating charges obtained in Step 1 were standardized for regional variations in wages. This involved three substeps.

a. The operating charges were multiplied by 59.77% yielding the labor portion of operating charges.

b. The labor portion of operating charges was divided by the hospital specific Medicare wage index yielding the standardized labor portion of operating charges.

c. The standardized labor portion of operating charges was added to the nonlabor portion of operating charges (40.23%) yielding standardized operating charges.

3. The standardized operating charges were multiplied by the hospital specific RCCs yielding standardized operating costs.

4. The capital charges obtained in Step 1 were divided by the hospital specific Medicare geographic adjustment factor (GAF) yielding standardized capital charges.

5. The standardized capital charges were multiplied by the hospital specific RCCs yielding standardized capital costs.

These five steps were repeated for all per diem cases. The standardized operating costs for per diem cases were then summed and divided by the total number of per diem days yielding the standardized operating costs per day for per diem cases. Similarly, the standardized capital costs for per diem cases were summed and divided by the total number of per diem days yielding the standardized capital costs per day for per diem cases. These two calculations were done separately for psychiatric cases in freestanding psychiatric facilities licensed as hospitals, for psychiatric cases in general acute care hospitals (including distinct part units) and for rehabilitation cases.

C. Where general acute care hospitals had psychiatric distinct-part units (DPUs) reported on their cost reports, separate RCCs were calculated for the DPUs and used in lieu of the hospital specific RCCs. Since DPU-specific RCCs are generally higher than hospital specific RCCs, this had the effect of increasing the estimated costs of acute care psychiatric cases. Overall hospital RCCs were used for freestanding acute care psychiatric cases and rehabilitation cases, as well as for psychiatric cases at general acute care hospitals without a psychiatric DPU.

12 VAC 30-70-330. Calculation of statewide operating rate per day.

The statewide hospital operating rate per day that shall be used to calculate the DRG system portion of operating reimbursement for psychiatric and rehabilitation cases admitted and discharged in SFY1997 is equal to the standardized operating cost per day updated to the midpoint of SFY1997 and multiplied by an additional factor. The update shall be done by multiplying the standardized operating cost per day by the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS. The additional factor for per diem cases in general acute care hospitals and rehabilitation hospitals is equal to 0.6290, and 0.6690 for freestanding psychiatric facilities licensed as hospitals. These factors were calculated so that per diem cases will be reimbursed the same percentage of cost as DRG cases based on the data used for rate calculation.

Per diem rates used for acute care hospitals during the transition shall be operating rates only and capital shall be reimbursed on a pass-through basis. Per diem rates used for freestanding psychiatric facilities licensed as hospitals shall be inclusive of capital. The capital-inclusive statewide per diem rate for freestanding psychiatric facilities licensed as hospitals shall be the standardized cost per day calculated for such hospitals adjusted for the wage index and the geographic adjustment factor (GAF) and multiplied by the factor above.

12 VAC 30-70-340. Calculation of hospital specific operating rate per day.

Each hospital specific operating rate per day shall be the labor portion of the statewide operating rate per day multiplied by the Medicare wage index applicable to the hospital's geographic location plus the nonlabor portion of the statewide operating rate per day. The Medicare wage index shall be the one in effect for Medicare in the base period used in the calculation of the standardized costs per case (1993 for the calculation of 1997 rates).

The hospital specific rate per day for freestanding psychiatric facilities licensed as hospitals shall be inclusive of capital cost, and shall have a capital portion which shall be adjusted by the GAF and added to the labor and nonlabor operating elements calculated as described above. The geographic adjustment factor shall be taken from the same time period as the Medicare wage index.

12 VAC 30-70-350. Prospective per case reimbursement of capital after transition period (1998). (Reserved)

12 VAC 30-70-360. Indirect medical education (IME).

Hospitals with programs in graduate medical education shall receive a rate adjustment for associated indirect costs. This reimbursement for IME costs recognizes the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The IME adjustment shall employ the equation shown below.

$$\text{IME percentage} = 1.89 \times ((1 + r)^{0.405} - 1)$$

In this equation, *r* is the ratio of interns and residents to staffed beds. The IME adjustment shall be the IME percentage, times 0.4043, times operating reimbursement for DRG cases and per diem cases.

12 VAC 30-70-370. Updating rates for inflation.

DRG system rates in SFY1997 shall be as provided in 12 VAC 30-70-270 and 12 VAC 30-70-340. Rates for state fiscal years after SFY1997 shall be updated for inflation as follows:

1. The statewide operating rate per case as calculated in 12 VAC 30-70-250 and the statewide rates per day as calculated in 12 VAC 30-70-310 shall be converted to a price level at the midpoint of state fiscal year 1993, using the same inflation values as were used to establish the amounts used in subdivision 1 of 12 VAC 30-70-250. The resulting rates are the base period operating rates per case and the base period rates per day.

2. Rates shall be updated each July first by increasing the 1993 base period rates to the midpoint of the upcoming state fiscal year using the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS. The most current table available prior to the effective date of the new rates shall be used. By means of this method, each year, corrections made by DRI/McGraw-Hill in the moving averages that were used to update rates for previous years shall automatically be incorporated as adjustments to the update calculation used for the upcoming year. For each new year's rate calculation that uses a base year prior to 1997, the inflation values shall be the DRI/McGraw-Hill values plus two percentage points for each year through SFY1997.

12 VAC 30-70-380. Recalibration/rebasing policy.

DMAS recognizes that claims experience during the transition period or modifications in federal policies may require adjustment to the DRG system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the weights assigned to cases) and rebase (review and update as appropriate the cost basis on which the rate is developed) the DRG system at least every other year. The first such recalibration and rebasing shall be done prior to full implementation of the DRG methodology in SFY1999. Recalibration and rebasing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12 VAC 30-70-490.

12 VAC 30-70-390. Disproportionate Share Hospital (DSH) payments after transition period (1998). (Reserved)

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Revised Per Diem Methodology.

12 VAC 30-70-400. Determination of per diem rates.

Each hospital's revised per diem rates to be used during the transition period shall be based on the hospital's previous peer group ceiling or ceilings that were established under the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, with the following adjustments:

1. All operating ceilings will be increased by the same proportion to effect an aggregate increase in reimbursement of \$40 million in SFY1997. This adjustment incorporates in per diem rates the systemwide aggregate value of payment that otherwise would be made through the payment adjustment fund. This adjustment will be calculated using estimated 1997 rates and 1994 days.

2. Starting July 1, 1996, operating ceilings will be increased for inflation to the midpoint of the state fiscal year, not the hospital fiscal year. Inflation shall be based on the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS, increased by two percentage points per year. The most current table available prior to the effective date of the new rates shall be used.

For services to be paid at SFY1998 rates, per diem rates shall be adjusted consistent with the methodology for

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updating rates under the DRG methodology (12 VAC 30-70-370).

3. There will be no disproportionate share hospital (DSH) per diem.

4. To pay capital cost through claims, a hospital specific adjustment to the per diem rate will be made. At settlement of each hospital fiscal year, this per diem adjustment will be eliminated and capital shall be paid as a pass-through.

12 VAC 30-70-410. State university teaching hospitals.

For hospitals that were state owned teaching hospitals on January 1, 1996, all the calculations which support the determination of hospital specific rate per case and rate per day amounts under the DRG reimbursement methodology shall be carried out separately from other hospitals, using cost data taken only from state university teaching hospitals. Rates to be used effective July 1, 1996, shall be determined on the basis of cost report and other applicable data pertaining to the facility fiscal year ending June 30, 1993. For these hospitals the factors used to establish rates shall be as listed below according to the section in Article 3 (12 VAC 30-70-220 et seq.) of this part where corresponding factors for other hospitals are set forth:

1. 12 VAC 30-70-250. 0.8432
2. 12 VAC 30-70-330. 0.8470

12 VAC 30-70-420. Reimbursement of nonenrolled general acute care hospital providers.

During the transition period, nonenrolled general acute care hospitals (general acute care hospitals that are not required to file cost reports) shall be reimbursed according to the previous methodology for such hospitals (12 VAC 30-70-120 A). Effective with discharges after June 30, 1998, these hospitals shall be paid based on DRG rates unadjusted for geographic variation. General acute care hospitals shall not file cost reports if they have less than 1000 days per year (in the most recent provider fiscal year) of inpatient utilization by Virginia Medicaid recipients, inclusive of patients in managed care capitation programs.

Prior approval must be received from DMAS when a referral has been made for treatment to be received from a nonenrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

12 VAC 30-70-430. Medicare upper limit.

For participating and nonparticipating facilities, the state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2) or the lesser of reasonable cost or customary charges in 42 CFR 447.250.

12 VAC 30-70-440. Determination of reasonable and adequate rates.

In accordance with 42 CFR 447.250 through 42 CFR 447.272 which implements §1902(a)(13)(A) of the Social Security Act, the state agency establishes payment rates for services that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards. To establish these rates Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's reimbursement system. Allowable costs will be determined from the filing of a uniform cost report by participating providers.

12 VAC 30-70-450. Cost reporting requirements.

Except for nonenrolled general acute care hospitals and freestanding psychiatric facilities licensed as hospitals, all hospitals shall submit cost reports. All cost reports shall be submitted on uniform reporting forms provided by the state agency and by Medicare. Such cost reports shall cover a 12-month period. Any exceptions must be approved by the state agency. The cost reports are due not later than 150 days after the provider's fiscal year end. All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the program shall take action in accordance with its policies to ensure that an overpayment is not being made. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. The reductions shall start on the first day of the following month when the cost report is due. After the delinquent cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to the state agency. The cost report will be judged complete when the state agency has all of the following:

1. Completed cost reporting form or forms provided by DMAS, with signed certification or certifications.
2. The provider's trial balance showing adjusting journal entries.
3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of charges in financial position, and footnotes to the financial statements. Multi-level facilities shall be governed by VII5.
4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report.
5. Hospitals which are part of a chain organization must also file:
 - a. Home office cost report;
 - b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances

require, disclaims an opinion based on generally accepted auditing standards, the management report, and footnotes to the financial statements;

c. The hospital's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value.

6. Such other analytical information or supporting documents requested by the state agency when the cost reporting forms are sent to the provider.

12 VAC 30-70-460. Hospital settlement.

A. During the transition period claims will be processed and tentative payment made using per diem rates. Settlements will be carried out to ensure that the correct blend of DRG and per diem-based payment is received by each general acute care and rehabilitation hospital and to settle reimbursement of pass-through costs. There shall be no settlement of freestanding psychiatric facilities licensed as hospitals except with respect to disproportionate share hospital (DSH) payment, if necessary (see 12 VAC 30-70-210 E 3).

B. The transition blend percentages which determine the share of DRG system and of revised per diem system reimbursement that is applicable in a given period shall change with the change of the state fiscal year, not the hospital fiscal year.

C. If a hospital's fiscal year does not end June 30, its first year ending after June 30, 1996, contains one or more months under the previous methodology, a "split" settlement shall be done of that hospital's fiscal year. Services rendered through June 30, 1996, shall be reimbursed under the previous reimbursement methodology and services rendered after June 30, 1996, will be reimbursed as described in subsection G of this section.

D. For cases subject to settlement under the blend of DRG and per diem methodologies (cases with an admission date after June 30, 1996), the date of discharge determines the year in which any inpatient service or claim related to the case shall be settled. This shall be true for both the DRG and the per diem portions of settlement. Interim claims tentatively paid in one hospital fiscal year that relate to a discharge in a later hospital fiscal year, shall be voided and reprocessed in the latter year so that the interim claim shall not be included in the settlement of the first year, but in the settlement of the year of discharge. An exception to this shall be rehabilitation cases, the claims for which shall be settled in the year of the "through" date of the claim.

E. A single group of cases with discharges in the appropriate time period shall be the basis of both the DRG and the per diem portion of settlement. These cases shall be based on claims submitted or corrected by 120 days after the providers FYE. Cases which are based on claims that lack

sufficient information to support grouping to a DRG category, and which the hospital cannot correct, shall be settled for purposes of the DRG portion of settlement based on the lowest of the DRG weights.

F. Reimbursement for services in freestanding psychiatric facilities licensed as hospitals shall not be subject to settlement.

G. During the transition period settlements shall be carried out according to the following formulas.

1. Settlement of a hospital's first fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Paid days occurring in the hospital's fiscal year before July 1, 1996, times the per diem in effect before July 1, 1996.

(2) Paid days occurring after June 30, 1996, but in the hospital fiscal year, that are related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective on July 1, 1996.

(3) DRG system payment for DRG and psychiatric cases admitted after June 30, 1996, and discharged within the hospital fiscal year times 1/3.

(4) DRG system payment for rehabilitation claims having a "from" date of July 1, 1996, or later and a "through" date within the hospital fiscal year times 1/3.

(5) Paid days from the cases and claims in subdivisions 1 a (3) and (4) of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

b. DSH reimbursement shall be equal to paid days from the start of the hospital fiscal year through June 30, 1996, times the DSH per diem effective before July 1, 1996. There shall be no settlement of DSH after July 1, 1996, as the lump sum amount shall be final.

c. Pass-throughs shall be settled as previously based on allowable cost related to days paid in subdivisions 1 a (1), (2), and (5) of this subsection.

2. Settlement of a hospital's second fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Days occurring in the hospital fiscal year related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective at the time.

(2) DRG system payment for DRG and psychiatric cases discharged in the hospital fiscal year, but before July 1, 1997, times 1/3.

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(3) DRG system payment for rehabilitation claims having a "through" date within the hospital fiscal year but before July 1, 1997, times 1/3.

(4) Covered days from the cases and claims and in subdivisions 2 b and c of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

(5) DRG system payment for DRG and psychiatric cases discharged from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(6) DRG system payment for rehabilitation claims having a "through" date from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(7) Covered days from the cases and claims and in subdivisions 2 a (5) and (6), times the revised system per diem that is effective on July 1, 1997, times 1/3.

b. DSH reimbursement shall be the predetermined lump sum amount.

c. Pass-throughs shall be settled as previously, based on allowable cost related to days paid in subdivisions 2 a (1), (4), and (7).

12 VAC 30-70-470. Underpayments.

When the settlement of a hospital fiscal year indicates that an underpayment has occurred, the state agency shall pay the additional amount to the hospital within 60 days of completion of the settlement.

12 VAC 30-70-480. Refund of overpayments.

A. Lump sum payment. When the settlement of a hospital fiscal year indicates that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where the state agency discovers an overpayment during desk review, field audit, or final settlement, the state agency shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken unless the hospital disputes the state agency's determination of the overpayment. If the hospital disputes the state agency's determination, recovery, if any, shall be undertaken after the issue date of any administrative decision issued by the state agency after an informal fact finding conference.

B. Offset. If the hospital has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the hospital has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule. If the hospital cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the hospital shall request an extended repayment schedule at the time of filing or (ii) within 30 days after receiving the DMAS demand letter, the hospital shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a hospital demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the director) may approve a repayment schedule of up to 36 months.

A hospital shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the hospital submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the hospital withdraws from the program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the hospital or by lump sum payments.

D. Extension request documentation. In the request for an extended repayment schedule, the hospital shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the hospital written notification of the approved repayment schedule, which shall be effective retroactive to the date the hospital submitted the proposal.

E. Interest charge on extended repayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the hospital indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the hospital does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, regardless of whether the hospital files a further appeal. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the hospital shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the hospital paid to DMAS.

12 VAC 30-70-490. Medicaid Hospital Payment Policy Advisory Council.

In order to ensure the ongoing relevance and fairness of the prospective payment system for hospital services, the Director of the Department of Medical Assistance Services shall appoint a Medicaid Hospital Payment Policy Advisory Council. The council shall be composed of four hospital or health system representatives nominated by the Virginia Hospital and Healthcare Association, two senior department staff and one representative each from the Department of

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Planning and Budget and the Joint Commission on Healthcare. This council will be charged with evaluating and developing recommendations on payment policy changes in areas that include, but are not limited to, the following: (i) utilization reductions directly attributable to the 1995 Appropriations Act utilization initiative and any necessary adjustments to SFY1997 and 1998 DRG rates; (ii) the update and inflation factors to apply to the various components of the delivery system; (iii) the treatment of capital and medical education costs; (iv) the mechanisms and budget implications of recalibration and rebasing approaches; (v) the disproportionate share payment fund and allocation mechanisms; and (vi) the timing and final design of an outpatient payment methodology.

12 VAC 30-70-500. Outlier methodology illustration.

OUTLIER METHODOLOGY ILLUSTRATION

(dollar amounts and other values are for illustration purposes only)

Assume the Following:

Medicare: Fixed Loss Cost Outlier Threshold for Fiscal Year 1996	\$15,150.00
Medicare: Marginal Cost Factor for Cost Outliers for Fiscal Year 1996	0.8000
Hospital X Operating Cost-to-Charge Ratio	0.7200
Hospital X Capital Cost-to-Charge Ratio	0.0600
Medicare Wage Index for Hospital X	0.9413
Statewide Average Labor Portion of Operating Costs	0.5977
Hospital X Billed Charges for Case Y	\$100,000.00
Total Adjusted Costs per Case for Hospital X	\$3,115.00
Relative Weight for Case Y	3.1790
Adjustment Factor for DRG Cases	0.6197

Step 1	Calculate Hospital X Operating Costs for Case Y:	
	Hospital X Billed Charges for Case Y	\$100,000.00
	Hospital X Operating Cost-to-Charge Ratio	x .7200
	Hospital X Operating Costs for Case Y	\$72,000

Step 2	Calculate Hospital X DRG Operating Amount for Case Y:	
	Total Adjusted Operating Costs per Case for Hospital X	\$3,115.00
	Relative Weight for Case Y	x 3.1790
	Hospital X DRG Operating Amount for Case Y	\$9,902.59

Step 3 Calculate Hospital X Cost Outlier Threshold for Case Y:

Fixed Loss Cost Outlier Threshold	\$15,150.00
Statewide Average Labor Portion of Operating Costs	x 0.5977
Labor Portion of Fixed Loss Cost Outlier Threshold	\$9,055.16
Wage Index for Hospital X	x 0.9413
Wage Adjusted Labor Portion of Fixed Loss Cost Outlier Threshold	\$8,523.62
Non-Labor Portion of Fixed Loss Cost Outlier Threshold	+ \$6,094.85
Wage Adjusted Fixed Loss Cost Outlier Threshold	\$14,618.46
Hospital X DRG Operating Amount for Case Y	+ \$9,902.59
Hospital X Cost Outlier Threshold for Case Y	\$24,521.05

Step 4	Calculate Hospital X Operating Outlier Amount for Case Y:	
	Hospital X Operating Costs for Case Y	\$72,000.00
	Hospital X Cost Outlier Threshold for Case Y	- \$24,521.05
	Hospital X Operating Outlier Costs for Case Y	\$47,478.95
	Marginal Cost Factor for Cost Outliers	x 0.8000
	Hospital X Operating Outlier Amount for Case Y	\$37,983.16

Step 5	Calculate Hospital X Total Payment for Case Y:	
	Hospital X DRG Operating Amount for Case Y	\$9,902.59
	Hospital X Operating Outlier Amount for Case Y	+ \$37,983.16
	Hospital X Total Amount for Case Y	\$47,885.75
	Adjustment Factor for DRG Cases	x 0.6197
	Hospital X Total Payment for Case Y	\$29,674.80

12 VAC 30-80-140. EPSDT. (Repealed.)

A. ~~Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, reimbursement shall be provided for services resulting from early and periodic screening, diagnostic, and treatment services. Reimbursement shall be provided for such other measures described in Social Security Act § 1905(a) required to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan.~~

B. ~~Payments to fee for service providers shall be in accordance with 12 VAC 30-80-30 the lower of (i) state agency fee schedule or (ii) actual charge (charge to the general public).~~

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VA.R. Doc. No. R97-176; Filed December 4, 1996, 11:29 a.m.

~~C. Payments to outpatient cost-based providers shall be in accordance with 12 VAC 30-80-20.~~

~~D. Psychiatric services delivered in a psychiatric hospital for individuals under age 21 shall be reimbursed at a uniform all-inclusive per diem fee and shall apply to all service providers. The fee shall be all-inclusive to include physician and pharmacy services. The methodology to be used to determine the per diem fee shall be as follows. The base period uniform per diem fee for psychiatric services resulting from an EPSDT screening shall be the median (weighted by children's admissions in state-operated psychiatric hospitals) variable per day cost of state-operated psychiatric hospitals in the fiscal year ending June 30, 1990. The base period per diem fee shall be updated each year using the hospital market basket factor utilized in the reimbursement of acute care hospitals in the Commonwealth.~~

NOTICE: The forms used in administering 12 VAC 30-70-10 et seq., Methods and Standards for Establishing Payment Rates for Long-Term Care, are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

Cost Reporting Forms for Hospitals (Map 783 Series), eff. 10/15/93

- Certification by Officer or Administrator of Provider
- Analysis of Interim Payments for Title XIX Services
- Computation of Title XIX Ratio of Cost to Charges
- Computation of Inpatient and Outpatient Ancillary Service Costs
- Computation of Outpatient Capital Reduction
- Computation of Title XIX Outpatient Costs
- Computation of Charges for Lower of Cost or Charge Comparison
- Computation of Title XIX Reimbursement Settlement
- Computation of Net Medicaid Inpatient Operating Cost Adjustment
- Calculation of Medicaid Inpatient Profit Incentive for Hospitals
- Plant Costs
- Education Costs
- Obstetrical Care Requirements Certification
- Computation for Separating the Allowable Plant and Education Cost (pass-throughs) from the Inpatient Medicaid Hospital Costs

Computation of Inpatient Operating Cost, HCFA-2552-92 D-1 (12/92).

Apportionment of Cost of Services Rendered by Interns and Residents, HCFA-2552-92 D-2 (12/92).

DOCUMENTS INCORPORATED BY REFERENCE

All Patient Diagnosis Related Groups (AP-DRG) Grouper, DRG and MDC Code Listings, Version 12, January 1995.

Data Resources, Incorporated: Health Care Cost HCFA-Type Hospital Market Basket, DRI/McGraw Hill.

Title of Regulation: 12 VAC 30-100-250 et seq. Part III: HIV Premium Assistance Program.

Statutory Authority: §§ 32.1-325 and 32.1-330.1 of the Code of Virginia.

Public Hearing Date: N/A - Public comments may be submitted until February 21, 1997.

(See Calendar of Events section for additional information)

Basis and Authority: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code also provides, in the Administrative Process Act (APA) §§ 9-6.14:7.1 and 9-6.14:9.1, for this agency's promulgation of proposed regulations subject to the Governor's review.

Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA. The emergency regulation became effective on July 1, 1996. The Code, at § 9-6.14:4.1(C) requires the agency to publish the Notice of Intended Regulatory Action within 60 days of the effective date of the emergency regulation if it intends to promulgate a permanent replacement regulation. The Notice of Intended Regulatory Action for this regulation was published in the Virginia Register on August 19, 1996.

Section 32.1-330.1 of the Code of Virginia requires DMAS to implement a premium assistance program for HIV-positive individuals and permits the promulgation of any regulations necessary. The Code also specifies the minimum characteristics the program is to have. With the elimination, by the 1996 General Assembly, of this program's sunset provision, DMAS has determined that its previous BMAS approved operating policies were no longer sufficient and that duly promulgated regulations were indicated.

Purpose: The purpose of this proposal is to promulgate permanent regulations which provide for the administration of the agency's HIV Premium Assistance Program. Without these regulations, the agency will lack the eligibility criteria, which are necessary to determine applicants' eligibility for the services, by which to operate the program once the emergency regulation expires in June 1997.

Summary and Analysis: The purpose of this action is to promulgate regulations pursuant to § 32.1-330.1 of the Code of Virginia consistent with actions taken by the 1996 General Assembly. Without these regulations, DMAS has no authority to administer this program and determine which

individuals will be assisted and which will be denied assistance.

These regulations provide the policies for the administration of the HIV Premium Assistance Program. The program was mandated by legislation passed by the 1994 General Assembly and was originally set to expire on July 1, 1996. Because of this temporary nature of the program, the Board of Medical Assistance Services (BMAS) approved operating policies by which the daily administrative decisions could be made. When the 1996 General Assembly removed the expiration date from the law, thereby making this program a permanent administrative responsibility of this agency, DMAS determined that its BMAS policies were no longer adequate.

The program uses Ryan White CARE Act federal grant funds or other funds which may be appropriated or made available for this program. The authorizing statute requires that DMAS administer the program, which provides premium payments for group health insurance obtained pursuant to insurance continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985). Eligibility criteria including income and assets limits are specified in the statute. These regulations define how eligibility will be determined and address other programmatic issues including appeal rights and responsibilities of the applicants and program participants and of DMAS.

The HIV Premium Assistance Program, funded through the federal Ryan White CARE Act, has served slightly more than 90 individuals in the Commonwealth who suffered with HIV/AIDS related conditions. Lengths of enrollment typically range from six months to one year due to the nature of these individuals' illnesses. The program has allowed these individuals to retain the private insurance they had through their employers. Considering the nature of their illnesses and their qualifying incomes, the clients would very likely have become Medicaid eligible if it were not for the intervention of the HIV Premium Assistance Program.

These proposed permanent regulations are necessary to ensure DMAS' long-term compliance with the statutory requirements. Action by the 1996 General Assembly (House Bill 1148) eliminated the sunset provision for this program thereby eliminating the pilot program status. Consequently, DMAS requires duly promulgated regulations under which to operate this program to replace the temporary Board of Medical Assistance Services' policies. The difference in this proposed regulation over the previously approved emergency regulation is the incorporation of the reference to the new federal welfare reform law (Public Law 104-193) as affecting the eligibility for these services of some aliens.

Issues: Some citizens may object to an assistance program which has been targeted to a disease-specific population. In the past, a few employers have been able to drop HIV positive former employees from their group health coverage due to such employees inability to meet total COBRA premium payments. The Ryan White Premium Assistance Program may enable some of these former employees to make their COBRA premium payments and therefore retain their health insurance coverage through their former employers. Such affected employers, who may have an incomplete understanding of COBRA law, may object to this

program. Otherwise, the agency projects no negative issues involved in implementing this proposed change.

Fiscal/Budget Impact: No providers will be affected by this regulation. Program recipients will be a small number (less than 100) of low income Virginia residents who meet financial and other eligibility criteria.

To date, program funds have been derived solely from federal Ryan White CARE Act grant funds awarded to the Commonwealth and limited to HIV/AIDS-related uses. The average monthly Virginia Medicaid cost for an HIV/AIDS patient (not eligible for these Ryan White funds) in FY 95 was approximately \$2,136*. (*Medicaid HIV/AIDS cost figures come from the 1994 HCFA AIDS Waiver renewal, Department of Medical Assistance Services claims analysis, patients in mid stage of AIDS.) The referenced 1996 legislation permits funds from other sources to be used for this programmatic purpose but no appropriations were specified.

In the HIV Premium Assistance Program, the average premium assistance payment was \$196 per month (Oct. 95) or \$2,352 per person per year. For each case diverted from Medicaid, the Commonwealth is saving approximately \$970 (GF and NGF) per month or \$23,280 GF per year. The total amount of premium assistance paid between October 1994 and October 1995 was \$71,360. Several applicants for this assistance voluntarily submitted verification of medical expenses ranging from \$35,000 to about \$90,000. Payment of the small average premium amounts represents considerable savings over the low end of this range of potential medical expenses. There are no localities which are uniquely affected by these regulations as they apply statewide.

Forms: This program requires that persons use an application package and that their attending physicians certify the applicants' disease states.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 9-6.14:7.1 G of the Administrative Process Act and Executive Order Number 13 (94). Section 9-6.14:7.1 G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic effects.

Summary of the Proposed Regulation. The proposed regulation replaces an emergency regulation that became effective on July 1, 1996. This regulation establishes eligibility requirements and general procedures for the HIV Premium Assistance Program. The purpose of this program is to assist low income HIV positive individuals by paying post-employment insurance premiums necessary for continuation of group health insurance coverage pursuant to

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the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The pilot for this program was mandated by the 1994 General Assembly. By deleting the program expiration date from the Code, the 1996 General Assembly effectively made the pilot an ongoing program. The key provisions contained in the proposed regulation are as follows:

- eligibility is restricted to individuals who are ineligible for Medicaid;
- the number of enrollees is limited to the number that can be covered with available funding; and
- payments under the program are limited to the cost of the insurance premium and do not include copayments, deductibles, or any other costs.

Estimated Economic Impact. The proposed regulation is likely to have at least three economic consequences. The first is that it will ensure that some number of qualified low income HIV positive individuals are able to continue their group health insurance coverage after they are unable to work and, therefore, continue to have uninterrupted access to medical care. Although it would be difficult to quantify the exact magnitude of the positive health benefit derived from continued access to medical care, it is nonetheless nontrivial.

The second economic consequence of the proposed regulation is that it will likely preclude some program participants from becoming Medicaid patients during the 18 months that they would be eligible for continued health care coverage under COBRA. Although one of the eligibility criteria for the HIV Premium Assistance Program is ineligibility for Medicaid, it is reasonable to assume that some number of program participants would have become eligible for Medicaid if the program did not exist. According to information provided by DMAS, the current premium payments for program participants are approximately \$2,352 per person per year. This compares to average Medicaid costs for HIV/AIDS patients of approximately \$25,632 per person per year. This implies a cost savings to the Commonwealth of approximately \$23,280 annually for each individual that the HIV Premium Assistance Program keeps off the Medicaid rolls.

The third economic consequence of the proposed regulation is the premium payment costs associated with the program. As mentioned above, information provided by DMAS indicates that premium payments for program participants average approximately \$2,352 per person per year. DMAS further indicates that the likely number of program participants will remain under 100. This implies total premium costs of somewhere between \$71,360 (the amount of premiums paid out over the most recent twelve month period) and \$235,200 (\$2,352 x 100) per year. To date, premium payment costs have been derived solely from federal Ryan White CARE Act grant funds and no state appropriations have been specified.

Businesses and Entities Particularly Affected. The proposed regulation particularly affects eligible low income HIV positive individuals, their insurance providers, and their medical service providers.

Localities Particularly Affected. No localities are particularly affected by the proposed regulation.

Projected Impact on Employment. The proposed regulation is not anticipated to have a significant effect on employment.

Effects on the Use and Value of Private Property. The proposed regulation is not anticipated to have a significant effect on the use and value of private property.

Summary of Analysis. The proposed regulation replaces an emergency regulation that became effective on July 1, 1996. This regulation establishes eligibility requirements and general procedures for the HIV Premium Assistance Program. It is anticipated that the proposed regulation will have three primary economic consequences: (i) it will facilitate uninterrupted medical care for eligible low income HIV positive individuals; (ii) it will likely afford savings in Medicaid expenditures by keeping some number of program participants off the Medicaid rolls; and (iii) it will entail program costs of between \$71,360 and \$235,200 for premium payments, most, if not all, of which will be derived from federal sources.

Agency's Response to Department of Planning and Budget's Economic Impact Analysis: The agency concurs with the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning the HIV Premium Assistance Program.

Summary:

The purpose of this action is to promulgate regulations pursuant to § 32.1-330.1 of the Code of Virginia consistent with actions taken by the 1996 General Assembly. Without these regulations, DMAS has no authority to administer this program and determine which individuals will be assisted and which will be denied assistance.

These regulations provide the policies for the administration of the HIV Premium Assistance Program. The program was mandated by legislation passed by the 1994 General Assembly and was originally set to expire on July 1, 1996. The program uses Ryan White CARE Act federal grant funds or other funds which may be appropriated or made available for this program. The authorizing statute requires that DMAS administer the program, which provides premium payments for group health insurance obtained pursuant to insurance continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985). Eligibility criteria including income and assets limits are specified in the statute. These regulations define how eligibility will be determined and address other programmatic issues including appeal rights and responsibilities of the applicants and program participants and of DMAS.

The HIV Premium Assistance Program, funded through the federal Ryan White CARE Act, has served slightly more than 90 individuals in the Commonwealth who suffered with HIV/AIDS related conditions. Lengths of enrollment typically range from six months to one year due to the nature of these individuals' illnesses. The program has allowed these individuals to retain the private insurance they had through their employers. Considering the nature of their illnesses and their qualifying incomes, the clients would very likely have

become Medicaid eligible if it were not for the intervention of the HIV Premium Assistance Program.

Some citizens may object to an assistance program which has been targeted to a disease-specific population. In the past, a few employers have been able to drop HIV positive former employees from their group health coverage due to such employees inability to meet total COBRA premium payments. The Ryan White Premium Assistance Program may enable some of these former employees to make their COBRA premium payments and therefore retain their health insurance coverage through their former employers. Such affected employers, who may have an incomplete understanding of COBRA law, may object to this program. Otherwise, the agency projects no negative issues involved in implementing this proposed change.

No providers will be affected by this regulation. Program recipients will be a small number (less than 100) of low income Virginia residents who meet financial and other eligibility criteria.

To date, program funds have been derived solely from federal Ryan White CARE Act grant funds awarded to the Commonwealth and limited to HIV/AIDS-related uses. The average monthly Virginia Medicaid cost for an HIV/AIDS patient (not eligible for these Ryan White funds) in FY 95 was approximately \$2,136. In the HIV Premium Assistance Program, the average premium assistance payment was \$196 per month (October 1995) or \$2,352 per person per year. For each case diverted from Medicaid, the Commonwealth is saving approximately \$970 (GF and NGF) per month or \$23,280 GF per year. The total amount of premium assistance paid between October 1994 and October 1995 was \$71,360. Payment of the small average premium amounts represents considerable savings over the low end of this range of potential medical expenses. There are no localities which are uniquely affected by these regulations as they apply statewide.

PART III.

HIV PREMIUM ASSISTANCE PROGRAM.

12 VAC 30-100-250. Definitions.

"Appeal" means the process by which an applicant or enrollee in the HIV Premium Assistance Program can obtain a review of a decision, action, or failure to act on the part of the program.

"Applicant" means an individual who has applied for or is in the process of applying for HIV Premium Assistance Program benefits.

"Applicant's representative" means a person who, because of the applicant's or enrollee's mental or physical incapacity or standing as a child, is permitted to act, complete, sign, or withdraw an application for the benefits of the program; activate the appeal process; and otherwise supply any information requested by the program on behalf of the applicant or enrollee.

"Child" means an unmarried person younger than 18 years of age and who lives with a parent or legal guardian.

"Date of application" means the date that an application is officially received by the program.

"Department" or "DMAS" means the Virginia Department of Medical Assistance Services which has administrative authority and responsibility for the program.

"Enrollee" means an individual who has been determined to be eligible for and is receiving assistance from the program.

"Family" means:

1. The applicant or enrollee,
2. The applicant or enrollee's spouse,
3. The applicant's or enrollee's children who are under 21 years if the children live with the applicant,
4. When the applicant or enrollee is a child:
 - a. The applicant's parent or parents,
 - b. The minor applicant's unmarried siblings under 21 years, at the option of the applicant's or enrollee's parents.

"Group health insurance plan" means a plan which meets § 5000(b)(1) of the Internal Revenue Code of 1986, as amended, includes continuation coverage pursuant to Title XXII of the Public Health Services Act, § 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974, and is consistent with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272 and any subsequent modifications to the Act. Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees.

"Health insurance premiums" or "premiums" means the health insurance premiums paid by or on behalf of an individual in order to obtain or maintain health insurance plan benefits.

"HIV positive" means a positive diagnosis of infection with the human immune deficiency virus (HIV) as determined by the enzyme-linked immunosorbent assay (ELISA) and confirmed by the Western Blot, or another generally accepted diagnostic test for HIV infection.

"HIV Premium Assistance Program" or "the program" means the Virginia program that provides payment of health insurance premiums under certain circumstances to individuals who are HIV positive, in accordance with the provision of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272 and any subsequent modifications to the Act and as authorized by § 32.1-330.1 of the Code of Virginia.

"Medicaid" means the state-federal medical assistance program of comprehensive medical and other health-related care for indigent and medically indigent persons authorized by Title XIX of the Social Security Act and administered by the Virginia Department of Medical Assistance Services.

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"Nongroup health insurance plan" means a health insurance plan that is offered to an individual or an individual family unit without being tied to an employer.

"Physician verification" means certification by a licensed physician of medical information regarding an applicant's or enrollee's HIV positive status and inability to work due to the disease or the substantial likelihood that within three months the individual will be too ill to continue working.

"Poverty level" means the official federal poverty income level, as revised annually.

12 VAC 30-100-260. Eligibility requirements.

An applicant will be determined to be eligible for the HIV Premium Assistance Program if the individual:

1. Is a Virginia resident at the time of application and is:
 - a. A citizen of the United States;
 - b. An alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, including an alien who is lawfully present in the United States pursuant to 8 USC § 1101 et seq.; or
 - c. An alien lawfully admitted under authority of the Indochina Migration and Refugee Assistance Act of 1975, 22 USC § 2601 et seq.;
2. Is certified by a licensed physician to be HIV positive;
3. Is certified by a licensed physician to be unable to work or to have a substantial likelihood of being unable to work within three months of the date of the physician's certification due to the HIV infection;
4. Is eligible for continuation of group health insurance plan benefits through the employer and the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, or for continuation of benefits under any type of health insurance plan unless DMAS has reason to believe it is not cost effective;
5. Has family income no greater than 200% of the poverty level;
6. Has countable liquid assets no more than \$10,000 in value; and
7. Is not eligible for Medicaid.

12 VAC 30-100-270. Determination of countable income and liquid assets.

When determining eligibility for the HIV Premium Assistance Program, the countable income and assets of each applicant shall be determined as follows:

1. Income shall include total projected family income for the year beginning with the month of application to the program, including but not limited to:
 - a. Wages;
 - b. Commissions and fees;
 - c. Salaries and tips;

- d. Profit from self-employment;
- e. Dividends or interest income;
- f. Disability benefits;
- g. Unemployment;
- h. Pension or retirement.

2. Countable liquid assets shall include assets available as of the date of the application which are convertible to cash. The following liquid assets shall be counted when determining eligibility:

- a. Savings accounts;
- b. Checking accounts;
- c. Money market certificates;
- d. Certificates of deposit;
- e. Mutual funds;
- f. Stocks and bonds.

12 VAC 30-100-280. Program application and enrollment.

A. Any person requesting participation in the program shall be given the opportunity to file an application and, if determined eligible by the program, shall be enrolled in accordance with the provisions of this part within established funding constraints.

B. An applicant or applicant's representative shall complete an application on the form designated by the program. The program may request additional documentation for eligibility determination purposes as it deems necessary.

C. An unmarried child younger than 18 years old shall have a representative complete and sign the application.

D. Applications shall conform with the requirements of this part and those set forth by the program. Applicants shall be determined ineligible without prejudice when they fail to provide information sufficient for the determination of eligibility.

E. An applicant or applicant's representative shall sign a statement authorizing the program to verify from any source, including banks and public or private agencies providing monetary benefits, qualifying information submitted to the program as part of the application process. Refusal to sign an authorization shall be considered failure to provide sufficient information, and applicants shall be determined ineligible in accordance with the provisions of this policy.

F. Eligibility determination shall be made promptly, not later than 30 days from the date of receipt of the completed application by the program.

G. An applicant or applicant's representative may voluntarily withdraw the application at any time without prejudice.

H. An individual previously determined ineligible for program benefits may submit a new application at any time.

1. Program enrollment shall be effective on the day eligibility is approved. Premium payments for health insurance coverage beginning on the first day of the month following eligibility shall start as long as there is available funding.

12 VAC 30-100-290. Changes in eligibility.

A. The program will promptly redetermine eligibility when it receives information concerning an enrollee's circumstances that may affect eligibility.

B. The enrollee or representative shall notify the program within 10 working days of any changes in circumstances which would affect continuing eligibility, including but not limited to:

1. Sale, transfer or change of the value of assets;
2. Change in income;
3. Change in name or address;
4. Change in COBRA eligibility.

C. If any changes in status result in an enrollee no longer qualifying for the program, the enrollee shall be considered ineligible for program benefits and enrollment shall be canceled. The cancellation shall be effective on the last day of the month in which notice has been given consistent with 12 VAC 30-100-320. The program shall notify the enrollee of its determination in writing, and inform the enrollee of any legal rights to appeal the decision pursuant to the notification requirements of this policy.

D. Failure to make such required notification may be considered to be fraudulent and may be addressed pursuant to the department's fraud prevention and control policies (12 VAC 30-100-360).

12 VAC 30-100-300. Enrollee openings.

A. The number of enrollees in the program shall be limited to the number that can be covered by the program's available funding as reflected in available openings. DMAS shall project the expenditures for the current and expected enrollees and funding levels for the program to determine the number of available enrollee openings.

B. Initial available openings in the program shall be filled based on the applicant's date of completed application. In the event that more than one application is received on any one day, applicants shall be considered based on the order of the day and month of the applicant's birth, with January being month one.

C. Should the number of applications exceed available funding at any time, a waiting list shall be maintained by the program of applicants who are determined to be eligible for the program but for whom openings are not available when the eligibility determinations are made.

1. Available openings shall be filled from the waiting list on a first come, first served basis, using the same criteria defined in 12 VAC 30-100-300.
2. If an opening becomes available, the applicant shall be notified in writing by the program. The applicant must

provide any necessary information to the program to verify that he is still eligible within 10 days of receiving such notification. The 10-day period may be extended by the program for just cause. If determined to be still eligible, the applicant shall be enrolled.

3. At the end of three months from the date of application, and every three months thereafter, if an opening has not yet become available, each applicant may be contacted by DMAS to verify the applicant's interest in remaining on the waiting list. At these contacts, applicants may be requested to inform the program of changes in the contents of their applications. At such time as funding becomes available for waiting list applicants, DMAS shall reexamine the applications for program qualifications.

12 VAC 30-100-310. Authorization for benefits.

Authorization for benefits under this program shall be granted until program termination, unless the recipient's status changes so that he no longer meets the eligibility criteria.

12 VAC 30-100-320. Notification.

The program shall inform an applicant, enrollee or the representative of the individual's legal rights and obligations and give written notice of the following:

1. The final determination on an application, which shall include the reason or reasons if an applicant is found ineligible;
2. The imminent expiration of program authority and funding;
3. A notice of action to deny, cancel, or suspend program benefits which shall:
 - a. Include a statement of the proposed action, the reason for the action, and the regulatory authority for the action;
 - b. Include notification of the right to appeal the action;
 - c. Be mailed at least 15 calendar days before the effective date of the action.

12 VAC 30-100-330. Appeals.

A. An applicant, enrollee, or representative who is dissatisfied with a decision, action, or inaction of the program may request and shall be granted an opportunity to appeal, as provided for under the department's Client Appeals Regulations (12 VAC 30-110-10 through 12 VAC 30-110-380).

B. The applicant or enrollee shall request in writing reconsideration from the HIV Premium Assistance Program within 15 days of the denial notice. DMAS will respond within five days to this request for reconsideration. If the applicant or enrollee still disagrees with DMAS' decision, he shall have the right to file an appeal in accordance with the department's Client Appeals Regulations.

C. An enrollee shall be notified in writing by the program that the program shall be responsible for the payment of

Proposed Regulations

health insurance premiums until the appeal process is concluded. If the appeal results in the enrollee being found ineligible for the program, the program shall seek recovery in accordance with the department's recovery policies.

D. If an applicant is found eligible for the program as a result of an appeal, the program shall reimburse the applicant directly for premiums which were paid, beginning with a premium payment for the month following the decision that was the subject of appeal. The applicant shall provide proof of payment of premiums.

E. Cases on appeal which are in current payment status shall be considered filled enrollee openings until the appeal process has been completed.

12 VAC 30-100-340. Health insurance premium payments.

A. Premium payments shall be made to the employer, the insurer, or the enrollee, according to procedures established by the program.

B. Applicants and enrollees shall provide information as may be necessary for the payment of health insurance premiums by the program, including but not limited to the name and address of the employer or health insurance company, the last day of employment, the type of policy, the amount of the premium, and the date by which the premium must be paid.

C. Payments under this program are limited to the cost of the health insurance premium currently in effect and shall not include copayments, deductibles, or any other costs incurred by the enrollees.

12 VAC 30-200-350. Recovery.

In all cases in which program benefits have been incorrectly paid or paid during an appeal in which the program action was upheld, the program shall seek recovery from the payee, according to the department's recovery policies.

12 VAC 30-100-360. Fraud.

Cases of suspected misrepresentation or fraud shall be investigated according to the department's fraud prevention and control policies and any other applicable statutory provision.

12 VAC 30-100-370. Confidentiality.

All information maintained by the program containing personal data including name, address, employer, insurance company, HIV status, application to or enrollment in the program, and any other information which could identify or reasonably be used to identify any applicant or enrollee in the program shall be maintained in confidence according to all applicable DMAS policies and procedures and any other applicable laws or regulations. Such information shall not be disclosed to any individual or organization without the written and dated consent of the applicant, enrollee, or representative.



Department of Medical Assistance Services
 HIPP Unit, Division of Client Services
 600 E. Broad Street, Suite 1300
 Richmond, VA 23219
 (804) 225-4236

**HIV PREMIUM ASSISTANCE PROGRAM
 APPLICATION**

The information on this form will be used in determining eligibility for the HIV Health Insurance Premium Assistance Program. All questions must be completed, and the form must be signed by the applicant or the applicant's representative.

All information on this form will be maintained in the strictest confidence. It will not be disclosed without written consent from you or your representative.

To help us process the application as quickly as possible and avoid a break in coverage under your insurance plan, the following information *must* be submitted with the completed application form:

- Physician's Verification Form
- a copy of your insurance card
- a copy of your most recent pay stub or tax return

If you wish to enroll or are currently enrolled in a COBRA plan, you are responsible for any premium payments until eligibility is determined.

PART A - APPLICANT				
Last Name		First Name		MI
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.				
Your Address		City	State	ZIP
Telephone Number	Date of Birth	Sex	Currently Enrolled in Medicaid	
Home: ()		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Work: ()				
Number of Dependents in Household		Virginia Resident		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

PART B - INSURANCE			
Name of Insurance Company		Policyholder Name	
Address of Insurance Company		City	State ZIP
Effective Date of policy	Type of Coverage	Copy of insurance card attached?	
	<input type="checkbox"/> Employee Only <input type="checkbox"/> Family <input type="checkbox"/> Other (explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Monthly Premiums under COBRA	Date COBRA eligibility began, or will become effective: _____		
\$	Date COBRA eligibility will end (should be 18 or 29 months after above date): _____		

Proposed Regulations

PART C - EMPLOYER INFORMATION	
Employer providing coverage:	Contact (Group Administrator):
Address:	Phone #:
	()

PART D - INCOME AND ASSET STATEMENT	
INCOME	ASSETS
Please list the following family sources of income on an annual basis:	Total family assets
Wages	Savings accounts
Commissions and fees	Checking accounts
Salaries and tips	Money market certificates
Profit from self-employment	Certificates of deposit
Dividends or interest income	Mutual funds
Disability benefits	Stocks and bonds
Unemployment	
Pension or retirement	
Other (describe)	
Total: (cannot exceed 200% of federal poverty guidelines)	Total: (cannot exceed \$10,000)

Please note: all income and asset information is subject to further verification.

PART E - PAYMENT INFORMATION			
Please indicate the address to which your COBRA payments should be mailed. If there is a particular account number or person involved, please indicate that:			
Name of Company			
Address	City	State	ZIP
Telephone Number ()	Account #		
Attention to: (person and department)			

READ CAREFULLY BEFORE SIGNING

- I assume full responsibility for the accuracy of the statements on this form. I understand that the Department of Medical Assistance Services will use these statements to determine my eligibility for the HIV Health Insurance Premium Assistance Program.
- I understand that I am to reimburse the Department for any money received by me or paid on my behalf to which I was not entitled.
- I understand that if available funding is obligated, my name will be placed on a waiting list for three months. If I am still interested in the program after that time, it is my responsibility to reapply to the program.
- I agree to report any changes in my circumstances to the HIV Health Insurance Premium Assistance Program within 10 days, including changes in income, resources, employment, coverage, premium amount, and my address.
- I am aware that Virginia Laws provide that anyone who obtains or tries to obtain or who helps any person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the State of Virginia, including the Code of Virginia Sections 32.1-321.2 through 321.4 and 63.1-124.
- A copy of the HIV Health Insurance Premium Assistance Program policies has been provided to me. By my signature below, I certify I have read and understand these policies and agree to be bound by them for purposes of my application for and/or receipt of benefits under this program.

SIGNATURES	
Under penalty of perjury, I certify that the statements I have made are true and correct to the best of my knowledge and belief.	
Signature of the Applicant: _____	Date: _____
If the Applicant was assisted in filling out this application, name of preparer _____	
Relationship to Applicant: _____	Organization: _____



Department of Medical Assistance Services
 HIPP Unit, Division of Client Services
 600 E. Broad Street
 Richmond, VA 23219
 (804) 225-4236

**HIV PREMIUM PAYMENT PROGRAM
 PHYSICIAN'S VERIFICATION FORM**

Please complete this section and give this form to your physician. Once the form is completed you should then mail it, along with your application, to the address below. If the form must be left with your physician, either you or your physician must submit it within ten days to the address below:

**HIPP UNIT
 DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
 600 E. BROAD STREET, SUITE 1300
 RICHMOND, VA 23219
 (804) 225-4236**

To Be Completed by the Applicant			
Patient Last Name:	First Name:	MI	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.			
Address:	City:	State:	Zip:
Social Security Number:	Date of Birth:		

Authorization for Release of Information

I hereby authorize my physician named below to furnish the Virginia Department of Medical Assistance confidential medical information for the purpose of determining my eligibility for the HIV Health Insurance Premium Payment Program.

Patient's Name: _____ Date: _____

To Be Completed by the Applicant's Physician			
The applicant has tested positive for Human Immunodeficiency Virus (HIV):		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the applicant still working: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If the applicant is still working, it is my judgment that there is a substantial likelihood that within approximately three months this patient will be unable to work because of HIV-related disease.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician's Name:		Telephone Number:	
Office Address:	City:	State:	Zip:
Signature:		Date:	

J:\HIPPHIV\CORR\HIV\VERIF.DOT

FINAL REGULATIONS

BOARD FOR COSMETOLOGY

REGISTRAR'S NOTICE: The following fee reductions filed by the Board for Cosmetology are exempt from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 9 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 which are limited to reducing fees charged to regulants and applicants.

Title of Regulation: 18 VAC 55-22-10 et seq. Board for Cosmetology Regulations (amending 18 VAC 55-22-170, 18 VAC 55-22-270, 18 VAC 55-22-300, and 18 VAC 55-22-310).

Statutory Authority: §§ 54.1-201 and 54.1-1202 of the Code of Virginia.

Effective Date: February 1, 1997.

Summary:

The amendments reduce the fees charged to applicants for licensure and certification and for renewal of licenses and certifications.

Agency Contact: Copies of the regulation may be obtained from Karen W. O'Neal, Assistant Director, Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-8552.

18 VAC 55-22-170. Application fees.

All fees are nonrefundable and shall not be prorated. Application fees are valid for a period of one year from the date of receipt. Application fees shall be as follows:

Cosmetology license by endorsement	\$50	<u>\$30</u>
Cosmetology salon	\$420	<u>\$100</u>
Cosmetology instructor license by endorsement	\$75	<u>\$55</u>
Nail technician license by endorsement	\$50	<u>\$30</u>
Nail salon	\$420	<u>\$100</u>
Nail technician instructor license by endorsement	\$75	<u>\$55</u>
Bad check penalty	\$25	

18 VAC 55-22-270. Application fees.

Application fees shall be as follows:

Nail technician school	\$445	<u>\$125</u>
Cosmetology school without a nail technician program	\$445	<u>\$125</u>

Cosmetology school offering a nail technician program	\$190	<u>\$150</u>
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Licensed cosmetology school adding a nail technician program	\$45	<u>\$25</u>
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18 VAC 55-22-300. Renewal fees.

A. All fees are nonrefundable.

B. Renewal fees shall be as follows:

Cosmetology license	\$45	<u>\$25</u>
Cosmetology license with instructor certificate	\$60	<u>\$40</u>
Cosmetology salon license	\$105	<u>\$85</u>
Cosmetology school license	\$140	<u>\$120</u>
Nail technician license	\$45	<u>\$25</u>
Nail technician license with instructor certificate	\$60	<u>\$40</u>
Nail salon license	\$105	<u>\$85</u>
Nail school license	\$140	<u>\$120</u>

18 VAC 55-22-310. Failure to renew; reinstatement required.

A. When a licensed or certified individual or entity fails to renew its license or certificate within 30 days following its expiration date, the licensee or certificate holder shall apply for reinstatement of the license or certificate by submitting to the Department of Professional and Occupational Regulation a reinstatement application and reinstatement fee as follows:

Cosmetology license	\$150	<u>\$75</u>
Cosmetology license with instructor certificate	\$180	<u>\$140</u>
Cosmetology salon license	\$250	<u>\$185</u>
Cosmetology school license	\$300	<u>\$220</u>
Nail technician license	\$150	<u>\$75</u>
Nail technician license with instructor certificate	\$180	<u>\$140</u>
Nail salon license	\$250	<u>\$185</u>
Nail school license	\$300	<u>\$220</u>

B. The application for reinstatement for a school shall provide the reasons for failing to renew prior to the expiration date, a notarized statement that all students currently enrolled or seeking to enroll at the school have been notified in writing that the school's license expired on December 31 of the last even numbered year. All of these materials shall be called the application package. Reinstatement will be considered by the board if the school consents to and satisfactorily passes an inspection of the school and its records maintained in accordance with 18 VAC 55-22-250 of this chapter by the Department of Professional and Occupational Regulation. Pursuant to 18 VAC 55-22-320, upon receipt of the reinstatement fee, application package,

and inspection results, the board may reinstate the school's license or require requalification or both. If the reinstatement application package and reinstatement fee are not received by the board within six months following the expiration date of the school's license, the board will notify the testing service that prospective graduates of the unlicensed school are not acceptable candidates for the exam.

C. When a cosmetologist or nail technician fails to renew his license within two years following the expiration date, the licensee may be required to submit the reinstatement fee outlined in subsection A of this section and may be required to pass the appropriate examination(s) in order to be reinstated.

D. When a cosmetology instructor or nail technician instructor fails to renew his certificate within two years following the expiration date, the certificate holder may be required to requalify for licensure as outlined in 18 VAC 55-22-110 and 18 VAC 55-22-120.

E. The date a renewal fee is received by the Department of Professional and Occupational Regulation, or its agent, will be used to determine whether a penalty fee or the requirement for reinstatement of a license or certificate is applicable.

F. When a license or certificate is reinstated, the licensee or certificate holder shall be assigned an expiration date two years from the date of reinstatement.

G. A licensee or certificate holder who reinstates his license or certificate shall be regarded as having been continuously licensed or certified without interruption. Therefore, a licensee or certificate holder shall remain under the disciplinary authority of the board during this entire period and may be held accountable for its activities during this period. A licensee or certificate holder who fails to reinstate his license or certificate shall be regarded as unlicensed or uncertified from the expiration date of the license or certificate forward. Nothing in this chapter shall divest the board of its authority to discipline a licensee or certificate holder for a violation of the law or regulations during the period of time for which the individual was licensed or certified.

H. Five years after the expiration date on the license or certificate, reinstatement is no longer possible. To resume practice, the former licensee or certificate holder shall reapply for licensure or certification as a new applicant, meeting current application requirements.

VA.R. Doc. No. R97-172; Filed December 3, 1996, 11:57 a.m.

DEPARTMENT OF HEALTH (STATE BOARD OF)

Title of Regulation: 12 VAC 5-220-10 et seq. Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations (amending 12 VAC 5-220-10, 12 VAC 5-220-20, 12 VAC 5-220-40, 12 VAC 5-220-70, 12 VAC 5-220-110, 12 VAC 5-220-140, 12 VAC 5-220-150, 12 VAC 5-220-200, 12 VAC 5-220-210, 12 VAC 5-220-230, 12 VAC 5-220-250, 12 VAC 5-220-270, and 12 VAC 5-220-320 through 12 VAC 5-220-390; adding 12 VAC 5-220-325 through 12 VAC

5-220-500; and repealing 12 VAC 5-220-320 through 12 VAC 5-220-400).

Statutory Authority: §§ 32.1-12 and 32.1-102.1 of the Code of Virginia.

Effective Date: January 24, 1997.

Summary:

The changes are in response to amendments to the Certificate of Public Need (COPN) Law that became effective on July 1, 1996, through the passage of HB 1302 from the 1996 Session of Virginia's General Assembly. The regulations establish a distinct process for acceptance and consideration of requests for COPNs which involve the establishment of nursing home facilities or an increase in the total number of nursing home facility beds at an existing medical care facility.

No substantial changes were made after the regulation was published in the proposed version. The two chief nonsubstantive changes were expansion of the number of review cycles for non-Request for Application nursing home projects from two per year to six per year (12 VAC 5-220-200), and revision of the conditioning authority language in both the standard review process (12 VAC 5-220-270) and new nursing home bed review process (12 VAC 5-220-420).

Summary of Public Comment and Agency 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.

Agency Contact: Paul Parker, Director, Division of Certificate of Public Need, Office of Health Facilities Regulation, Department of Health, 3600 West Broad Street, Suite 216, Richmond, VA 23230, telephone (804) 367-2126.

12 VAC 5-220-10. Definitions.

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

"Acquisition" means an expenditure of \$600,000 or more that changes the ownership of a medical care facility. It shall also include the donation or lease of a medical care facility. An acquisition of a medical care facility shall not include a capital expenditure involving the purchase of stock.

"Amendment" means any modification to an application which is made following the public hearing and prior to the issuance of a certificate and includes those factors that constitute a significant change as defined in this chapter. An amendment shall not include a modification to an application which serves to reduce the scope of a project.

"Applicant" means the owner of an existing medical care facility or the sponsor of a proposed medical care facility project submitting an application for a certificate of public need.

"Application" means a prescribed format for the presentation of data and information deemed necessary by the board to determine a public need for a medical care facility project.

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"Application fees" means fees required for a project application and application for a significant change. Fees shall not exceed the lesser of 1.0% of the proposed capital expenditure or cost increase for the project or \$10,000.

"Board" means the State Board of Health.

"Capital expenditure" means any expenditure by or in behalf of a medical care facility which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance. Such expenditure shall also include a series of related expenditures during a 12-month period or a financial obligation or a series of related financial obligations made during a 12-month period by or in behalf of a medical care facility. Capital expenditures need not be made by a medical care facility so long as they are made in behalf of a medical care facility by any person. See definition of "person."

"Certificate of public need" means a document which legally authorizes a medical care facility project as defined herein and which is issued by the commissioner to the owner of such project.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Commissioner" means the State Health Commissioner who has authority to make a determination respecting the issuance or revocation of a certificate.

"Competing applications" means applications for the same or similar services and facilities which are proposed for the same planning district or medical service area and which are in the same review cycle. See 12 VAC 5-220-220.

"Completion" means conclusion of construction activities necessary for substantial performance of the contract.

"Construction" means the building of a new medical facility or the expansion, remodeling, or alteration of an existing medical care facility.

"Construction, initiation of" means that a project shall be considered under construction for the purpose of certificate extension determinations upon the presentation of evidence by the owner of: (i) a signed construction contract; (ii) the completion of short term financing and a commitment for long term (permanent) financing when applicable; (iii) the completion of predevelopment site work; and (iv) the completion of building foundations.

"Date of issuance" means the date of the commissioner's decision awarding a certificate of public need.

"Department" means the State Department of Health.

"Designated medically underserved areas" means (i) areas designated as medically underserved areas pursuant to § 32.1- 122.5 of the Code of Virginia; (ii) federally designated Medically Underserved Areas (MUA); or (iii) federally designated Health Professional Shortage Areas (HPSA).

"Ex parte" means any meeting which takes place between (i) any person acting in behalf of the applicant or holder of a certificate of public need or any person opposed to the

issuance or in favor of the revocation of a certificate of public need and (ii) any person who has authority in the department to make a decision respecting the issuance or revocation of a certificate of public need for which the department has not provided 10 days written notification to opposing parties of the time and place of such meeting. An ex parte contact shall not include a meeting between the persons identified in (i) and staff of the department.

"Gamma knife surgery" means stereotactic radiosurgery, where stereotactic radiosurgery is the noninvasive therapeutic procedure performed by directing radiant energy beams from any source at a treatment target in the head to produce tissue destruction. See definition of "project."

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Informal fact-finding conference" means a conference held pursuant to § 9-6.14:11 of the Code of Virginia.

"Inpatient beds" means accommodations within a medical care facility with continuous support services (such as food, laundry, housekeeping) and staff to provide health or health-related services to patients who generally remain in the medical care facility in excess of 24 hours. Such accommodations are known by varying nomenclatures including but not limited to: nursing beds, intensive care beds, minimal or self care beds, isolation beds, hospice beds, observation beds equipped and staffed for overnight use, and obstetric, medical, surgical, psychiatric, substance abuse, medical rehabilitation and pediatric beds, including pediatric bassinets and incubators. Bassinets and incubators in a maternity department and beds located in labor or birthing rooms, recovery rooms, emergency rooms, preparation or anesthesia inductor rooms, diagnostic or treatment procedures rooms, or on-call staff rooms are excluded from this definition.

"Medical care facility" means any institution, place, building, or agency, at a single site, whether or not licensed or required to be licensed by the board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or operated or owned or operated by a local governmental unit, (i) by or in which facilities are maintained, furnished, conducted, operated, or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical, or nursing attention or services as acute, chronic, convalescent, aged, physically disabled, or crippled or (ii) which is the recipient of reimbursements from third party health insurance programs or prepaid medical service plans. For purposes of this chapter, only the following medical care facility classifications shall be subject to review:

1. General hospitals.
2. Sanitariums.

3. Nursing homes.
4. Intermediate care facilities.
5. Extended care facilities.
6. Mental hospitals.
7. Mental retardation facilities.
8. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.
9. Specialized centers or clinics or that portion of a physician's office developed for the provision of out-patient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, single photon emission computed tomography (SPECT) scanning, or such other specialty services as may be designated by the board by chapter.
10. Rehabilitation hospitals.

For purposes of this chapter, the following medical care facility classifications shall not be subject to review:

1. Any facility of the Department of Mental Health, Mental Retardation and Substance Abuse Services.
2. Any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services Comprehensive Plan.
3. Any physician's office, except that portion of the physician's office which is described in subdivision 9 of the definition of "medical care facility."

"*Medical service area*" means the geographic territory from which at least 75% of patients come or are expected to come to existing or proposed medical care facilities, the delineation of which is based on such factors as population characteristics, natural geographic boundaries, and transportation and trade patterns, and all parts of which are reasonably accessible to existing or proposed medical care facilities.

"*Modernization*" means the alteration, repair, remodeling, replacement or renovation of an existing medical care facility or any part thereto, including that which is incident to the initial and subsequent installation of equipment in a medical care facility. See definition of "construction."

"*Operating expenditure*" means any expenditure by or in behalf of a medical care facility which, under generally accepted accounting principles, is properly chargeable as an expense of operation and maintenance and is not a capital expenditure.

"*Operator*" means any person having designated responsibility and legal authority from the owner to administer and manage a medical care facility. See definition of "owner."

"*Other plans*" means any plan(s) which is formally adopted by an official state agency or regional health planning agency and which provides for the orderly planning and development of medical care facilities and services and which is not otherwise defined in this chapter.

"*Owner*" means any person who has legal responsibility and authority to construct, renovate or equip or otherwise control a medical care facility as defined herein.

"*Person*" means an individual, corporation, partnership, association or any other legal entity, whether governmental or private. Such person may also include the following:

1. The applicant for a certificate of public need;
2. The regional health planning agency for the health planning region in which the proposed project is to be located;
3. Any resident of the geographic area served or to be served by the applicant;
4. Any person who regularly uses health care facilities within the geographic area served or to be served by the applicant;
5. Any facility or health maintenance organization (HMO) established under § 38.2-4300 et seq. of the Code of Virginia which is located in the health planning region in which the project is proposed and which provides services similar to the services of the medical care facility project under review;
6. Third party payors who provide health care insurance or prepaid coverage to 5.0% or more patients in the health planning region in which the project is proposed to be located; and
7. Any agency which reviews or establishes rates for health care facilities.

"*Physician's office*" means a place, owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever, which is designed and equipped solely for the provision of fundamental medical care whether diagnostic, therapeutic, rehabilitative, preventive or palliative to ambulatory patients and which does not participate in cost-based or facility reimbursement from third party health insurance programs or prepaid medical service plans excluding pharmaceuticals and other supplies administered in the office. See definition of "medical care facility."

"*Planning district*" means a contiguous area within the boundaries established by the Department of Planning and Budget as set forth in § 15.1-1402 of the Code of Virginia.

"*Predevelopment site work*" means any preliminary activity directed towards preparation of the site prior to the completion of the building foundations. This includes, but is not limited to, soil testing, clearing, grading, extension of utilities and power lines to the site.

"*Primary medical care services*" means first-contact, whole-person medical and health services delivered by broadly trained, generalist physicians, nurses and other professionals, intended to include, without limitation,

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obstetrics/gynecology, family practice, internal medicine and pediatrics.

"Progress" means actions which are required in a given period of time to complete a project for which a certificate of public need has been issued. See ~~12 VAC 5-220-340~~ or ~~12 VAC 5-220-450~~, *Demonstration of Progress*.

"Project" means:

1. The establishment of a medical care facility. See definition of "medical care facility."
2. An increase in the total number of beds or operating rooms in an existing or authorized medical care facility.
3. Relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of 10% of its beds as nursing home beds as provided in § 32.1-132 of the Code of Virginia.
4. The introduction into any existing medical care facility of any new nursing home service such as intermediate care facility services, extended care facility services or skilled nursing facility services except when such medical care facility is an existing nursing home as defined in § [~~§ 32.1-12~~ and] 32.1-123 of the Code of Virginia.
5. The introduction into an existing medical care facility of any new cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), medical rehabilitation, neonatal special care services, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, organ or tissue transplant service, radiation therapy, single photon emission computed tomography (SPECT), psychiatric, substance abuse treatment, or such other specialty clinical services as may be designated by the board by regulation, which the facility has never provided or has not provided in the previous 12 months.
6. The conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds.
7. The addition or replacement by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, single photon emission computed tomography (SPECT), or other specialized service designated by the board by regulation, except for the replacement of any medical equipment identified in this part which the commissioner has determined to be an emergency in accordance with 12 VAC 5-220-150.
8. [~~Any capital expenditure of \$1 million or more by or on behalf of a medical care facility which is not defined as reviewable under subdivisions 1 through 7 of this definition, except capital expenditures registered with the commissioner of less than \$2 million that do not involve the expansion of any space in which patient care~~

~~services are provided, including, but not limited to, expenditures for nurse call systems, materials handling and management information systems, parking lots and garages, child care centers, and laundry services. See definition of "capital expenditure." Any capital expenditure of \$5 million or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between \$1 million and \$5 million shall be registered with the commissioner.]~~

"Public hearing" means a proceeding conducted by a regional health planning agency at which an applicant for a certificate of public need and members of the public may present oral or written testimony in support or opposition to the application which is the subject of the proceeding and for which a verbatim record is made. See subsection A of 12 VAC 5-220-230.

"Regional health plan" means the regional plan adopted by the regional health planning agency board.

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform health planning activities within a health planning region.

"Schedule for completion" means a timetable which identifies the major activities required to complete a project as identified by the applicant and which is set forth on the certificate of public need. The timetable is used by the commissioner to evaluate the applicant's progress in completing an approved project.

"Significant change" means any alteration, modification or adjustment to a reviewable project for which a certificate of public need has been issued or requested following the public hearing which:

1. Changes the site;
2. Increases the capital expenditure amount authorized by the commissioner on the certificate of public need issued for the project by 10% or more;
3. Changes the service(s) proposed to be offered;
4. Extends the schedule for completion of the project beyond three years (36 months) from the date of certificate issuance or beyond the time period approved by the commissioner at the date of certificate issuance, whichever is greater. See ~~12 VAC 5-220-330~~ 12 VAC 5-220-440 and ~~12 VAC 5-220-340~~ 12 VAC 5-220-450.

"Standard review process" means the process utilized in the review of all certificate of public need requests with the exception of:

1. Certain bed relocation, equipment replacement, and new service introduction projects as specified in 12 VAC 5-220-280;
2. Certain projects which involve an increase in the number of beds in which nursing facility or extended care services are provided as specified in 12 VAC 5-220-325.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to (i) methodologies for projecting need for medical care facility beds and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services. The most recent applicable State Medical Facilities Plan shall remain in force until any such chapter is amended, modified or repealed by the Board of Health.

"Virginia Health Planning Board" means the statewide health planning body established pursuant to § 32.1-122.02 of the Code of Virginia which serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.

12 VAC 5-220-20. Authority for regulations.

The Virginia Medical Care Facilities Certificate of Public Need Law, which is codified as §§ 32.1-102.1 through 32.1-102.11 of the Code of Virginia, requires the owners or sponsors of medical care facility projects to secure a certificate of public need from the State Health Commissioner prior to initiating such projects. Sections 32.1-102.2 and 32.1-12 and 32.1-145 of the Code of Virginia direct the Board of Health to promulgate and prescribe such rules and ~~chapters~~ regulations as are deemed necessary to effectuate the purposes of this statute.

12 VAC 5-220-40. Administration of [~~chapters~~ chapter].

This chapter is administered by the following:

1. The Board of Health is the governing body of the State Virginia Department of Health. The Board of Health has the authority to promulgate and prescribe such rules and regulations as it deems necessary to effectuate the purposes of the Act.
2. The State Health Commissioner is the executive officer of the State Virginia Department of Health. The commissioner is the designated decision maker in the process of determining public need under the Act.

12 VAC 5-220-70. Application of chapter.

~~These rules and chapters have~~ This chapter has general applicability throughout the Commonwealth. The requirements of the Virginia Administrative Process Act (§ 9-6.14:1 et seq.) of the Code of Virginia apply to their promulgation.

12 VAC 5-220-110. Requirements for registration of certain capital expenditures of \$1 million or more but less than [\$2 \$5] million.

At least 30 days before any person contracts to make or is otherwise legally obligated to make a capital expenditure by or on behalf of a medical care facility that is \$1 million or more but is less than [\$2 \$5] million [~~and does not involve the expansion of any space in which patient care services are provided, including, but not limited to, expenditures for nurse call systems, materials handling and management information systems, parking lots and garages, child care centers, and laundry services,~~] and has not been previously authorized by the commissioner, the owner of any medical

care facility as defined in ~~these chapters~~ this chapter [~~, physician's office or specialized center or clinic~~] shall register in writing such expenditure with the commissioner. The format for registration shall include information concerning the purpose of such expenditure and projected impact that the expenditure will have upon the charges for services. For purposes of registration, the owner shall include any person making the affected capital expenditure. See definition of "project."

12 VAC 5-220-140. Requirements for health maintenance organizations (HMO).

An HMO must obtain a certificate of public need prior to initiating a project. Such HMO must also adhere to the requirements for the acquisition of medical care facilities if appropriate. See definition of "project" and ~~12 VAC 5-220-120~~ [~~12 VAC 5-220-110~~ 12 VAC 5-220-10].

12 VAC 5-220-150. Requirements for emergency replacement of equipment; notification of decision.

The commissioner shall consider requests for emergency replacement of medical equipment as identified in Part I of this chapter. Such an emergency replacement is not a "project" of a medical care facility requiring a certificate of public need. To request authorization for such replacement, the owner of such equipment shall submit information to the commissioner to demonstrate that (i) the equipment is inoperable as a result of a mechanical failure, Act of God, or other reason which may not be attributed to the owner and the repair of such equipment is not practical or feasible; or (ii) the immediate replacement of the medical equipment is necessary to maintain an essential clinical health service or to assure the safety of patients or staff.

For purposes of this section, "inoperable" means that the equipment cannot be put into use, operation, or practice to perform the diagnostic or therapeutic clinical health service for which it was intended.

Within 15 days of the receipt of such requests the commissioner will notify the owner in the form of a letter of the decision to deny or authorize the emergency replacement of equipment.

PART IV. DETERMINATION OF PUBLIC NEED (REQUIRED CONSIDERATIONS).

PART V. STANDARD REVIEW PROCESS.

12 VAC 5-220-200. One hundred twenty-day review cycle.

The department shall review the following groups of completed applications in accordance with the following 120-day scheduled review cycles and the following descriptions of projects within each group, except as provided for in 12 VAC 5-220-220.

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BATCH GROUP	GENERAL DESCRIPTION	REVIEW CYCLE	
		Begins	Ends
A	General Hospitals/ Obstetrical Services/ Neonatal Special Care Services	Feb 10 Aug 10	Jun 10 Dec 8
B	Open Heart Surgery/Cardiac Catheterization/Ambulatory Surgery Centers/ Operating Room Additions/Transplant Services	Mar 10 Sep 10	Jul 8 Jan 8
C	Psychiatric Facilities/ Substance Abuse Treatment/ Mental Retardation Facilities	Apr 10 Oct 10	Aug 8 Feb 7
D	Diagnostic Imaging Facilities/ Services	May 10 Nov 10	Sep 7 Mar 10
E	Medical Rehabilitation Beds/ Services	Jun 10 Dec 10	Oct 8 Apr 9
F	Selected Therapeutic Facilities/ Services	Jul 10 Jan 10	Nov 7 May 10
G	Nursing Home Beds/Services	Jan. 10 Mar. 10 May 10 July 10 Sep. 10 Nov. 10	May 10 July 8 Sep. 7 Nov. 7 Jan. 8 Mar. 10
	<i>Nursing Home Beds at Retirement Communities/ Bed Relocations/Miscellaneous Expenditures by Nursing Homes</i>	<i>Jan 10 [Mar. 10 May 10 [Sep. 10 Nov. 10</i>	<i>May 10 July 8] Sep. 7] Nov. 7] Jan. 8] Mar. 10]</i>

Batch Group A includes:

1. The establishment of a general hospital.
2. An increase in the total number of general acute care beds in an existing or authorized general hospital.
3. The relocation at the same site of 10 general hospital beds or 10% of the general hospital beds of a medical care facility, whichever is less, from one existing physical facility to any other in any two-year period.
4. The introduction into an existing medical care facility of any new neonatal special care or obstetrical services which the facility has not provided in the previous 12 months.
5. Any capital expenditure of [\$4 \$5] million or more, not defined as a project category included in Batch Groups B through G, by or in behalf of a general hospital.

Batch Group B includes:

1. The establishment of a specialized center, clinic, or portion of a physician's office developed for the provision of outpatient or ambulatory surgery or cardiac catheterization services.

2. An increase in the total number of operating rooms in an existing medical care facility or establishment of operating rooms in a new facility.
3. The introduction into an existing medical care facility of any new cardiac catheterization, open heart surgery, or organ or tissue transplant services which the facility has not provided in the previous 12 months.
4. The addition or replacement by an existing medical care facility of any medical equipment for the provision of cardiac catheterization services.
5. Any capital expenditure of [\$4 \$5] million or more, not defined as a project category in Batch Group A or Batch Groups C through G, by or in behalf of a specialized center, clinic, or portion of a physician's office developed for the provision of outpatient or ambulatory surgery or cardiac catheterization services.
6. Any capital expenditure of [\$4 \$5] million or more, not defined as a project category in Batch Group A or Batch Groups C through G, by or in behalf of a medical care facility, which is primarily related to the provision of surgery, cardiac catheterization, open heart surgery, or organ or tissue transplant services.

Batch Group C includes:

1. The establishment of a mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.
2. A increase in the total number of beds in an existing or authorized mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.
3. An increase in the total number of mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds in an existing or authorized medical care facility which is not a dedicated mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.
4. The relocation at the same site of 10 mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds or 10% of the mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period.
5. The introduction into an existing medical care facility of any new psychiatric or substance abuse treatment service which the facility has not provided in the previous 12 months.
6. Any capital expenditure of [\$4 \$5] million or more, not defined as a project category in Batch Groups A and B or

Batch Groups D through G, by or in behalf of a mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.

7. Any capital expenditure of [\$4 \$5] million or more, not defined as a project category in Batch Groups A and B or Batch Groups D through G, by or in behalf of a medical care facility, which is primarily related to the provision of mental health, psychiatric, substance abuse treatment or rehabilitation, or mental retardation services.

Batch Group D includes:

1. The establishment of a specialized center, clinic, or that portion of a physician's office developed for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT).

2. The introduction into an existing medical care facility of any new computed tomography (CT), magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT) services which the facility has not provided in the previous 12 months.

3. The addition or replacement by an existing medical care facility of any equipment for the provision of computed tomography (CT), magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT).

4. Any capital expenditure of [\$4 \$5] million or more, not defined as a project category in Batch Groups A through C or Batch Groups E through G, by or in behalf of a specialized center, clinic, or that portion of a physician's office developed for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT).

5. Any capital expenditure of [\$4 \$5] million or more, not defined as a project category in Batch Groups A through C or Batch Groups E through G, by or in behalf of a medical care facility, which is primarily related to the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT).

Batch Group E includes:

1. The establishment of a medical rehabilitation hospital.
2. An increase in the total number of beds in an existing or authorized medical rehabilitation hospital.
3. An increase in the total number of medical rehabilitation beds in an existing or authorized medical

care facility which is not a dedicated medical rehabilitation hospital.

4. The relocation at the same site of 10 medical rehabilitation beds or 10% of the medical rehabilitation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period.

5. The introduction into an existing medical care facility of any new medical rehabilitation service which the facility has not provided in the previous 12 months.

6. Any capital expenditure of [\$4 \$5] million or more, not defined as a project category in Batch Groups A through D or Batch Groups F and G, by or in behalf of a medical rehabilitation hospital.

7. Any capital expenditure of [\$4 \$5] million or more, not defined as a project category in Batch Groups A through D or Batch Groups F and G, by or in behalf of a medical care facility, which is primarily related to the provision of medical rehabilitation services.

Batch Group F includes:

1. The establishment of a specialized center, clinic, or that portion of a physician's office developed for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

2. Introduction into an existing medical care facility of any new gamma knife surgery, lithotripsy, or radiation therapy services which the facility has never provided or has not provided in the previous 12 months.

3. The addition or replacement by an existing medical care facility of any medical equipment for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

4. Any capital expenditure of [\$4 \$5] million or more, not defined as a project in Batch Groups A through E or Batch Group G, by or in behalf of a specialized center, clinic, or that portion of a physician's office developed for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

5. Any capital expenditure of [\$4 \$5] million or more, not defined as a project in Batch Groups A through E or Batch Group G, by or in behalf of a medical care facility, which is primarily related to the provision of gamma knife surgery, lithotripsy, or radiation therapy.

Batch Group G includes:

1. The establishment of a nursing home, intermediate care facility, or extended care facility [*at of*] a continuing care retirement community by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.

[2. The establishment of a nursing home, intermediate care facility, or extended care facility that does not involve an increase in the number of nursing home facility beds in Virginia when the capital expenditure for such establishment is \$5 million or more.]

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[2. §3.] An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility [*af of*] a *continuing care retirement community by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.*

~~3. An increase in the total number of nursing home beds, intermediate care facility beds, or extended care facility beds in an existing or authorized medical care facility which is not a dedicated nursing home, intermediate care facility, or extended care facility.~~

[4. *An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility that does not involve an increase in the number of nursing home facility beds in Virginia when the capital expenditure for such an increase is \$5 million or more.*]

4. [~~3. 5.~~] The relocation at the same site of 10 nursing home, intermediate care facility, or extended care facility beds or 10% of the nursing home, intermediate care facility, or extended care facility beds of a medical care facility, whichever is less, from one physical facility to another in any two-year period, *when the capital expenditure for such relocation is \$1 million or more.*

~~5. The introduction into any existing medical care facility of any new nursing home service such as intermediate care facility services, extended care facility services or skilled nursing facility services except when such medical care facility is an existing nursing home as defined in § 32.1-12 and 32.1-1453 of the Code of Virginia.~~

6. [4. 6.] Any capital expenditure of [\$1 \$5] million or more, not defined as a project category in Batch Groups A through F, by or in behalf of a nursing home, intermediate care facility, or extended care facility, *which does not increase the total number of beds of the facility.*

7. [5. 7.] Any capital expenditure of [\$4 \$5] million or more, not defined as a project category in Batch Groups A through F, by or in behalf of a medical care facility, which is primarily related to the provision of nursing home, intermediate care, or extended care services, *and does not increase the number of beds of the facility.*

12 VAC 5-220-210. Requests for application (RFA).

The commissioner may request the submission of applications for his consideration which address a specific need for services and facilities as identified in the State Medical Facilities Plan. The department shall give notice of such RFA in a newspaper of general circulation in the locality or the planning district where the specific services or facility is requested. Such notice shall be published at least 120 days prior to the first day of the appropriate review cycle for the type of project being requested. A written copy of an RFA shall also be available upon request from the department and the regional health planning agency in the appropriate geographic area. The process for adoption of an RFA by the commissioner *for projects other than nursing home bed*

projects (see 12 VAC 5-220-325) shall be set forth in the State Medical Facilities Plan.

12 VAC 5-220-230. Review of complete application.

A. Review cycle. At the close of the work day on the 10th day of the month, the department shall provide written notification to applicants specifying the acceptance date and review schedule of completed applications including a proposed date for any informal fact-finding conference that may be held. The regional health planning agency shall conduct no more than two meetings, one of which must be a public hearing conducted by the regional health planning agency board or a subcommittee of the board and provide applicants with an opportunity, prior to the vote, to respond to any comments made about the project by the regional health planning agency staff, any information in a staff report, or comments by those voting in completing its review and recommendation by the 60th day of the cycle. By the 70th day of the review cycle, the department shall complete its review and recommendation of an application and transmit the same to the applicant(s) and other appropriate persons. Such notification shall also include the proposed date, time and place of any informal fact-finding conference.

An informal fact-finding conference shall be held when (i) determined necessary by the department or (ii) requested by any person opposed to a project seeking to demonstrate good cause at the conference. Any person seeking to demonstrate good cause shall file, no later than seven days prior to the conference, written notification with the commissioner, applicant(s) and other competing applicants, and regional health planning agency stating the grounds for good cause.

For purposes of this section, "good cause" means that (i) there is significant, relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing or (iii) there is a substantial material mistake of fact or law in the department staff's report on the application or in the report submitted by the regional health planning agency. See § 9-6.14:11 of the Code of Virginia.

The commissioner shall render a final determination by the 120th day of the review cycle. Unless agreed to by the applicant and, when applicable, the parties to any informal fact-finding conference held, the review schedule shall not be extended.

B. Regional health planning agency required notifications. Upon notification of the acceptance date of a complete application as set forth in subsection A of this section, the regional health planning agency shall provide written notification of its review schedule to the applicant. The regional health planning agency shall notify health care providers and specifically identifiable consumer groups who may be affected by the proposed project directly by mail and shall also give notice of the public hearing in a newspaper of general circulation in such county or city wherein a project is proposed or a contiguous county or city at least nine days prior to such public hearing. Such notification by the regional health planning agency shall include: (i) the date and location of the public hearing which shall be conducted on the

application except as otherwise provided in ~~these rules and chapters~~ *this chapter*, in the county or city wherein a project is proposed or a contiguous county or city and (ii) the date, time and place the final recommendation of the regional health planning agency shall be made. The regional health planning agency shall maintain a verbatim record which may be a tape recording of the public hearing. Such public hearing record shall be maintained for at least a one-year time period following the final decision on a certificate of public need application. See definition of "public hearing."

C. Ex parte contact. After commencement of a public hearing and before a final decision is made, there shall be no ex parte contacts between the State Health Commissioner and any person acting on behalf of the applicant or holder of a certificate or any person opposed to the issuance or in favor of revocation of a certificate of public need, unless written notification has been provided. See definition of "ex parte."

12 VAC 5-220-250. Amendment to an application.

The applicant shall have the right to amend an application at any time. Any amendment which is made to an application following the public hearing and prior to the issuance of a certificate unless otherwise specified in ~~these chapters~~ *this chapter* shall constitute a new application and shall be subject to the review requirements set forth in Part V of the ~~chapters~~ *this chapter*. If such amendment is made subsequent to the issuance of a certificate of public need, it shall be reviewed in accordance with 12 VAC 5-220-130.

12 VAC 5-220-270. Action on an application.

A. Commissioner's responsibility. Decisions as to approval or disapproval of applications or a portion thereof for certificates of public need shall be rendered by the commissioner. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Medical Facilities Plan. However, if the commissioner finds, upon presentation of appropriate evidence, that the provisions of either such plan are inaccurate, outdated, inadequate or otherwise inapplicable, the commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan.

Conditions of approval. The commissioner may condition the approval of an application for a project (i) on the agreement by the applicant to provide an acceptable level of [~~free care or~~] care at a reduced rate to indigents, or (ii) on the agreement of the applicant to provide care to persons with special needs, or (iii) upon the agreement of the applicant to facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area. The terms of such agreements shall be specified in writing prior to the commissioner's decision to approve a project. Any person willfully refusing, failing or neglecting to honor such agreement shall be subject to a civil penalty of \$100 per violation per day from the date of receipt from the department of written notice of noncompliance until the date of compliance. Upon information and belief that a person has failed to honor such agreement in accordance with this provision, the department

shall notify the person in writing and 15 days shall be provided for response in writing including a plan for immediate correction. In the absence of an adequate response or necessary compliance or both, a judicial action shall be initiated in accordance with the provisions of § 32.1-27 of the Code of Virginia.

B. Notification process-extension of review time. The commissioner shall make a final determination on an application for a certificate of public need and provide written notification detailing the reasons for such determination to the applicant with a copy to the regional health planning agency by the 120th day of the review cycle unless an extension is agreed to by the applicant and an informal fact-finding conference described in 12 VAC 5-220-230 is held. When an informal fact-finding conference is held, the 120-day review cycle shall not be extended unless agreed to by the parties to the conference. Such written notification shall also reference the factors and bases considered in making a decision on the application and, if applicable, the remedies available for appeal of such decision and the progress reporting requirements. The commissioner may approve a portion of a project provided the portion to be approved is agreed to by the applicant following consultation, which may be subject to the ex parte provision of ~~these chapters~~ *this chapter*, between the commissioner and the applicant.

PART VII.

[NEW] NURSING HOME BED REVIEW PROCESS.

12 VAC 5-220-325. Applicability.

The following categories of projects as determined by the State Health Commissioner shall be subject to the nursing home bed review process [: when they involve an increase in the number of nursing home facility beds in Virginia. (For Continuing Care Retirement Community nursing home beds, see Part V (12 VAC 5-220-170 et seq.) of this chapter.)]

1. *The establishment of a nursing home, intermediate care facility, or extended care facility, except when such nursing home, intermediate care facility, or extended care facility is proposed by a continuing care retirement community and the project is sponsored by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.*

2. *An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility, except when the nursing home, intermediate care facility, or extended care facility is a component of a continuing care retirement community and the project is sponsored by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.*

3. *An increase in the total number of nursing home beds, intermediate care facility beds, or extended care facility beds in an existing or authorized medical care facility which is not a dedicated nursing home, intermediate care facility, or extended care facility.*

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4. The introduction into any existing medical care facility of any new nursing home service such as intermediate care facility services, extended care facility services or skilled nursing facility services except when such medical care facility is an existing nursing home as defined in § 32.1-123 of the Code of Virginia.

12 VAC 5-220-335. Request for Applications (RFA).

A. Frequency. The commissioner shall periodically issue, in consultation and cooperation with the Department of Medical Assistance Services, a Request for Applications (RFA) from project applicants proposing projects which would result in an increase in the number of beds in which nursing facility or extended care services are provided. An RFA shall be issued at least annually. (See [~~42 VAC 5-220-320~~ 12 VAC 5-220-325])

B. Issuance. At least 60 days prior to the issuance of a RFA, the board shall publish the proposed RFA in the Virginia Register for public comment together with an explanation of (i) the regulatory basis for the planning district bed needs set forth in the proposed RFA and (ii) the rationale for the RFA's planning district designations. Any person objecting to the contents of the proposed RFA may notify, within 14 days of the publication, the board and the commissioner of his objection and the objection's regulatory basis. The commissioner shall prepare, and deliver by registered mail, a written response to each such objection within two weeks of the date of receiving the objection. The objector may file a rebuttal to the commissioner's response in writing within five days of receiving the commissioner's response. If objections are received, the board shall, after considering the provisions of the RFA, any objections, the commissioner's responses, and if filed, any written rebuttals of the commissioner's responses, hold a public hearing to receive comments on the specific RFA. Prior to making a decision on the RFA, the commissioner shall consider any recommendations made by the board.

C. Content. A RFA from project applicants proposing projects which would result in an increase in the number of beds in which nursing facility or extended care services are provided shall be based on analyses of the need for increases in the nursing home bed supply in each of Virginia's planning districts in accordance with standards included in the State Medical Facilities Plan. Such RFAs shall also include a schedule for the review of applications submitted in response to the RFA which allows for at least 120 days between the day on which the RFA is issued and the first day of the review cycle for such applications.

12 VAC 5-220-345. Limitation on acceptance of nursing home bed applications.

Applications for projects which would result in an increase in the number of beds in which nursing facility or extended care services are provided (see 12 VAC 5-22-325) shall only be accepted for review when properly filed in response to a RFA. Furthermore, the commissioner shall only accept for review applications which propose projects located in the planning districts from which applications are requested in the RFA and propose authorization of a number of new beds in which nursing facility or extended care services are

provided which is less than or equal to the total number of beds identified as needed for the planning district in which the project will be located.

12 VAC 5-220-355. Application forms.

A. Letter of intent. A nursing home bed applicant shall file a letter of intent with the commissioner to request appropriate application forms, and submit a copy of that letter to the appropriate regional health planning agency by the letter of intent deadline specified in the RFA. The letter shall identify the owner, the type of project for which an application is requested, and the proposed scope (size) and location of the proposed project. The department shall transmit application forms to the applicant within seven days of the receipt of the letter of intent. A letter of intent filed with the department shall be considered void if an application is not filed for the project by the application deadline specified in the RFA.

B. Application fees. The department shall collect application fees for applications that request a nursing home bed certificate of public need. The fee required for an application is the lesser of 1.0% of the proposed capital expenditure for the project or \$10,000. No application will be deemed to be complete for review until the required application fee is paid.

C. Filing application forms. Applications must be submitted to the department and the appropriate regional health planning agency by the application filing deadline specified in the RFA. All applications including the required data and information shall be prepared in triplicate; two copies to be submitted to the department; and one copy to be submitted to the appropriate regional health planning agency. No application shall be deemed to have been submitted until required copies have been received by the department and the appropriate regional health planning agency.

12 VAC 5-220-365. Review for completeness.

The applicant shall be notified by the department within 15 days following receipt of the application if additional information is required to complete the application or the application is complete as submitted. No application shall be reviewed until the department has determined that it is complete. To be complete, all questions [and information items requested on the application] must be [~~answered to the satisfaction of the commissioner and all requested documents supplied, when applicable~~ completely addressed] and the application fee submitted. Additional information required to complete an application shall be submitted to the department and the appropriate regional health planning agency at least five days prior to the first day of the review cycle, as specified in the RFA, to be considered in the review cycle.

12 VAC 5-220-375. Consideration of applications.

Nursing home bed applications proposed for the same planning district shall be considered as competing applications by the commissioner. The commissioner shall determine whether an application is competing and provide written notification to the competing applicants and the regional health planning agency.

12 VAC 5-220-385. Review of complete application.

A. *Review cycle.* The department shall provide written notification to applicants specifying the acceptance date and review schedule of completed applications including a proposed date for any informal fact-finding conference that may be held. The regional health planning agency shall conduct no more than two meetings, one of which must be a public hearing conducted by the regional health planning agency board or a subcommittee of the board and provide applicants with an opportunity, prior to the vote, to respond to any comments made about the project by the regional health planning agency staff, any information in a staff report, or comments by those voting in completing its review and recommendation by the 60th day of the cycle. By the 70th day of the review cycle, the department shall complete its review and recommendation of an application and transmit the same to the applicant or applicants and other appropriate persons. Such notification shall also include the proposed date, time and place of any informal fact-finding conference.

An informal fact-finding conference shall be held when (i) determined necessary by the department or (ii) requested by any person opposed to a project seeking to demonstrate good cause at the conference. Any person seeking to demonstrate good cause shall file, no later than seven days prior to the conference, written notification with the commissioner, applicant or applicants and other competing applicants, and regional health planning agency stating the grounds for good cause.

For purposes of this section, "good cause" means that (i) there is significant, relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing, or (iii) there is a substantial material mistake of fact or law in the department staff's report on the application or in the report submitted by the regional health planning agency. (See § 9-6.14:11 of the Code of Virginia.)

The commissioner shall render a final determination by the 120th day of the review cycle. Unless agreed to by the applicant or applicants and, when applicable, the parties to any informal fact-finding conference held, the review schedule shall not be extended.

B. *Regional health planning agency required notifications.* Upon notification of the acceptance date of a complete application as set forth in subsection A of this section, the regional health planning agency shall provide written notification of its review schedule to the applicant. The regional health planning agency shall notify health care providers and specifically identifiable consumer groups who may be affected by the proposed project directly by mail and shall also give notice of the public hearing in a newspaper of general circulation in such county or city wherein a project is proposed or a contiguous county or city at least nine days prior to such public hearing. Such notification by the regional health planning agency shall include: (i) the date and location of the public hearing which shall be conducted on the application except as otherwise provided in this chapter, in the county or city wherein a project is proposed or a contiguous county or city; and (ii) the date, time and place the

final recommendation of the regional health planning agency shall be made. The regional health planning agency shall maintain a verbatim record which may be a tape recording of the public hearing. Such public hearing record shall be maintained for at least a one-year time period following the final decision on a certificate of public need application. See definition of "public hearing."

Ex parte contact. After commencement of a public hearing and before a final decision is made, there shall be no ex parte contacts between the State Health Commissioner and any person acting on behalf of the applicant or holder of a certificate or any person opposed to the issuance or in favor of revocation of a certificate of public need, unless written notification has been provided. See definition of "ex parte."

12 VAC 5-220-395. Participation by other persons.

Any person affected by a proposed project under review may directly submit written opinions, data and other information to the appropriate regional health planning agency and the commissioner for consideration prior to their final action.

12 VAC 5-220-405. Amendment to an application.

The applicant shall have the right to amend an application at any time. Any amendment which is made to an application following the public hearing and prior to the issuance of a certificate unless otherwise specified in this chapter shall constitute a new application and shall be subject to the review requirements set forth in this part of this chapter. If such amendment is made subsequent to the issuance of a certificate of public need, it shall be reviewed in accordance with 12 VAC 5-220-130.

12 VAC 5-220-410. Withdrawal of an application.

The applicant shall have the right to withdraw an application from consideration at any time without prejudice by written notification to the commissioner.

12 VAC 5-220-420. Action on an application.

A. *Commission's responsibility.* Decisions as to approval or disapproval of applications or a portion thereof for certificates of public need shall be rendered by the commissioner. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Medical Facilities Plan. However, if the commissioner finds, upon presentation of appropriate evidence, that the provisions of such plan are inaccurate, outdated, inadequate or otherwise inapplicable, the commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan.

The commissioner may condition the approval of an application for a project (i) on the agreement by the applicant to provide an acceptable level of [~~free care or~~] care at a reduced rate to indigents or, (ii) on the agreement of the applicant to provide care to persons with special needs, or (iii) upon the agreement of the applicant to facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area. The terms of such agreements shall be

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specified in writing prior to the commissioner's decision to approve a project. Any person willfully refusing, failing or neglecting to honor such agreements shall be subject to a civil penalty of \$100 per violation per day from the date of receipt from the department of written notice of noncompliance until the date of compliance. Upon information and belief that a person has failed to honor such agreement in accordance with this provision, the department shall notify the person in writing and 15 days shall be provided for a response in writing including a plan for immediate correction. In the absence of an adequate response or necessary compliance or both, a judicial action shall be initiated in accordance with the provisions of § 32.1-27 of the Code of Virginia.

B. Notification process - extension of review time. The commissioner shall make a final determination on an application for a certificate of public need and provide written notification detailing the reasons for such determination to the applicant with a copy to the regional health planning agency by the 120th day of the review cycle unless an extension is agreed to by the applicant and an informal fact-finding conference described in 12 VAC 5-220-380 is held. When an informal fact-finding conference is held, the 120-day review cycle shall not be extended unless agreed to by the parties to the conference. Such written notification shall also reference the factors and bases considered in making a decision on the application and, if applicable, the remedies available for appeal of such decision and the progress reporting requirements. The commissioner may approve a portion of a project provided the portion to be approved is agreed to by the applicant following consultation, which may be subject to the *ex parte* provision of this chapter, between the commissioner and the applicant.

PART VIII.

DURATION, EXTENSION, AND REVOCATION OF CERTIFICATES.

~~12 VAC 5-220-320.~~ 12 VAC 5-220-430. Duration.

A certificate of public need shall be valid for a period of 12 months and shall not be transferrable from the certificate holder to any other legal entity regardless of the relationship, under any circumstances.

~~12 VAC 5-220-330.~~ 12 VAC 5-220-440. Extension.

A certificate of public need is valid for a 12-month period and may be extended by the commissioner for additional time periods which shall be specified at the time of the extension.

A. Basis for certificate extension within 24 months. An extension of a certificate of public need beyond the expiration date may be granted by the commissioner by submission of evidence to demonstrate that progress is being made towards the completion of the authorized project as defined in ~~12 VAC 5-220-340~~ 12 VAC 5-220-450. Such request shall be submitted to the commissioner in writing with a copy to the appropriate regional health planning agency at least 30 days prior to the expiration date of the certificate or period of extension.

B. Basis for certificate extension beyond 24 months. An extension of a certificate of public need beyond the two years

following the date of issuance may be granted by the commissioner when substantial and continuing progress is being made towards the development of the authorized project. In making the determination, the commissioner shall consider whether: (i) any delays in development of the project have been caused by events beyond the control of the owner; (ii) substantial delays in development of the project may not be attributed to the owner; and (iii) a schedule of completion has been provided and determined to be reasonable. Such request shall be submitted in writing with a copy to the appropriate regional health planning agency at least 30 days prior to the expiration date of the certificate of period of extension. The commissioner shall not grant an extension to the schedule for completion of a project beyond three years (36 months) of the date of certificate issuance or beyond the time period approved at the date of certificate issuance, whichever is greater, unless such extension is authorized in accordance with the provisions for a significant change. See 12 VAC 5-220-130, *Significant change limitation*.

C. Basis for indefinite extension. A certificate shall be considered for an indefinite extension by the commissioner when satisfactory completion of a project has been demonstrated as set forth in subsection C of ~~42 VAC 5-220-340~~ 12 VAC 5-220-450.

D. Regional health planning agency review. All requests for an extension of a certificate of public need shall be reviewed by the appropriate regional health planning agency within 30 days of receipt by the department and the regional health planning agency. The recommendations on the request by that agency shall be forwarded to the commissioner who shall act upon the progress report within 35 days of receipt by the department and the regional health planning agency. Failure of the regional health planning agency to notify the commissioner within the time frame prescribed shall constitute a recommendation of approval by such regional health planning agency.

E. Notification of decision. Extension of a certificate of public need by the commissioner shall be made in the form of a letter from the commissioner with a copy to the appropriate regional health planning agency and shall become part of the official project file.

~~12 VAC 5-220-340.~~ 12 VAC 5-220-450. Demonstration of progress.

The applicant shall provide reports to demonstrate progress made towards the implementation of an authorized project in accordance with the schedule of development which shall be included in the application. Such progress reports shall be filed in accordance with the following intervals and contain such evidence as prescribed at each interval:

A. Twelve months following issuance. Documentation that shows: (i) proof of ownership or control of site; (ii) the site meets all zoning and land use requirements; (iii) architectural planning has been initiated; (iv) preliminary architectural drawings and working drawings have been submitted to appropriate state reviewing agencies and the State Fire Marshal; (v) construction financing has been completed or will be completed within two months and (vi) purchase orders

or lease agreements exist for equipment and new service projects.

B. Twenty-four months following issuance. Documentation that shows that (i) all required financing is completed; (ii) preconstruction site work has been initiated; (iii) construction bids have been advertised and the construction contractor has been selected; (iv) the construction contract has been awarded and (v) construction has been initiated.

C. Upon completion of a project. Any documentation not previously provided which: (i) shows the final costs of the project, including the method(s) of financing; and (ii) shows that the project has been completed as proposed in accordance with the application originally submitted, including any subsequent approved changes. See "completion" as defined in 12 VAC 5-220-10.

~~42 VAC 5-220-350. 12 VAC 5-220-460. Revocation of certificate.~~

A. Lack of progress. Failure of any project to meet the progress requirements stated in ~~42 VAC 5-220-340 12 VAC 5-220-450~~ shall be cause for certificate revocation, unless the commissioner determines sufficient justification exists to permit variance, considering factors enumerated in ~~42 VAC 5-220-340 12 VAC 5-220-450~~.

B. Failure to report progress. Failure of an applicant to file progress reports on an approved project in accordance with ~~42 VAC 5-220-340 12 VAC 5-220-450~~ shall be cause for revocation, unless, due to extenuating circumstances, the commissioner, in his sole discretion, extends the certificate, in accordance with subsection B of ~~42 VAC 5-220-330 12 VAC 5-220-440~~.

C. Unapproved changes. Exceeding a capital expenditure amount not authorized by the commissioner or not consistent with the schedule of completion shall be cause for revocation. See definition of "significant change" and "schedule of completion."

D. Failure to initiate construction. Failure to initiate construction of the project within two years following the date of issuance of the certificate of public need shall be cause for revocation, unless due to extenuating circumstances the commissioner extends the certificate, in accordance with subsection B of ~~42 VAC 5-220-330 12 VAC 5-220-440~~.

E. Misrepresentation. Upon determination that an applicant has knowingly misrepresented or knowingly withheld relevant data or information prior to issuance of a certificate of public need, the commissioner may revoke said certificate.

F. Noncompliance with assurances. Failure to comply with the assurances or intentions set forth in the application or written assurances provided at the time of issuance of a certificate of public need shall be cause for revocation.

PART VIII IX.
APPEALS.

~~42 VAC 5-220-360. 12 VAC 5-220-470. Court review.~~

A. Appeal to circuit court. Appeals to a circuit court shall be governed by applicable provisions of Virginia's Administrative Process Act, § 9-6.14:15 et seq. of the Code of Virginia.

Any applicant aggrieved by a final administrative decision on its application for a certificate, any third party payor providing health care insurance or prepaid coverage to 5.0% or more of the patients in the applicant's service area, a regional health planning agency operating in the applicant's service area or any person showing good cause or any person issued a certificate aggrieved by a final administrative decision to revoke said certificate, within 30 days after the decision, may obtain a review, as provided in § 9-6.14:17 of the Code of Virginia by the circuit court of the county or city where the project is intended to be or was constructed, located or undertaken. Notwithstanding the provisions of § 9-6.14:16 of the Administrative Process Act, no other person may obtain such review.

B. Designation of judge. The judge of the court referred to in subsection A of this section shall be designated by the Chief Justice of the Supreme Court from a circuit other than the circuit where the project is or will be under construction, located or undertaken.

C. Court review procedures. Within five days after the receipt of notice of appeal, the department shall transmit to the appropriate court all of the original papers pertaining to the matter to be reviewed. The matter shall thereupon be reviewed by the court as promptly as circumstances will reasonably permit. The court review shall be upon the record so transmitted. The court may request and receive such additional evidence as it deems necessary in order to make a proper disposition of the appeal. The court shall take due account of the presumption of official regularity and the experience and specialized competence of the commissioner. The court may enter such orders pending the completion of the proceedings as are deemed necessary or proper. Upon conclusion of review, the court may affirm, vacate or modify the final administrative decision.

D. Further appeal. Any party to the proceeding may appeal the decision of the circuit court in the same manner as appeals are taken and as provided by law.

PART IX X.
SANCTIONS.

~~42 VAC 5-220-370. 12 VAC 5-220-480. Violation of rules and chapters regulations.~~

Commencing any project without a certificate required by this chapter shall constitute grounds for refusing to issue a license for such project.

~~42 VAC 5-220-380. 12 VAC 5-220-490. Injunctive relief.~~

On petition of the commissioner, the Board of Health or the Attorney General, the circuit court of the county or city where a project is under construction or is intended to be constructed, located or undertaken shall have jurisdiction to enjoin any project which is constructed, undertaken or commenced without a certificate or to enjoin the admission of patients to the project or to enjoin the provision of services through the project.

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PART X XI. OTHER.

~~12 VAC 5-220-390. Certificate of public need moratorium. 12 VAC 5-220-500. Exemption of state home for aged and infirm veterans.~~

~~Notwithstanding any law to the contrary, the commissioner shall not approve, authorize or accept applications for the issuance of any certificate of public need pursuant to the chapters for a medical care facility project which would increase the number of beds in which nursing facility or extended care services are provided from the effective date of the chapters through June 30, 1995. However, the commissioner may approve or authorize the issuance of a certificate of public need for the following projects:~~

~~1. The renovation or replacement on-site of a nursing home, intermediate care or extended care facility or any portion thereof or replacement off-site of an existing facility at a location within the same city or county and within reasonable proximity to the current site when replacement on the current site is proven unfeasible when a capital expenditure is required to comply with life safety codes, licensure, certification or accreditation standards. Under no circumstances shall the State Health Commissioner approve, authorize, or accept an application for the issuance of a certificate for any project which would result in the continued use of the facility replaced as a nursing facility.~~

~~2. The conversion on-site of existing licensed beds of a medical care facility other than a nursing facility or nursing home, extended care, or intermediate care facility to beds certified for skilled nursing services (SNF) when (i) the total number of beds to be converted does not exceed the lesser of 20 beds or 10% of the beds in the facility; (ii) the facility has demonstrated that the SNF beds are needed specifically to serve a specialty heavy care patient population, such as ventilator dependent and AIDS patients and that such patients otherwise will not have reasonable access to such services in existing or approved facilities; and (iii) the facility further commits to admit such patients on a priority basis once the SNF unit is certified and operational.~~

~~3. The conversion on-site of existing beds in an adult care residence licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1 of the Code of Virginia as of March 1, 1990, to beds certified as nursing facility beds when (i) the total number of beds to be converted does not exceed the lesser of 30 beds or 25% of the beds in the adult care residence; (ii) the adult care residence has demonstrated that nursing facility beds are needed specifically to serve a patient population of AIDS, or ventilator dependent, or head and spinal cord injured patients, or any combination of the three, and that such patients otherwise will not have reasonable access to such services in existing or approved nursing facilities; (iii) the adult care residence further commits to admit such patients once the nursing facility beds are certified and operational; and (iv) the licensed adult care residence otherwise meets the standards for nursing facility beds as set forth in the chapters of the Board of Health.~~

~~4. Any project for an increase in the number of beds in which nursing facility or nursing home or extended care services are provided, or the creation of new beds in which such services are to be provided, by a continuing care provider registered as of January 15, 1991, with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia, if (i) the total number of new or additional nursing home beds does not exceed 32 when the beds are to be added by new construction, or 25 when the beds are to be added by conversion on-site of existing beds in an adult care residence licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1 of the Code of Virginia as of January 15, 1991, and (ii) such beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility pursuant to continuing care contracts meets the requirements of § 38.2-4905 of the Code of Virginia. No application for a certificate of public need for the creation or addition of nursing facility or nursing home beds pursuant to this section shall be accepted from a provider who, as of January 15, 1991, had an existing complement of beds, unless such provider agrees in writing not to seek certification for the use of such new or additional beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United State Social Security Act. Further, if a certificate is approved, pursuant to this section, to increase the number of nursing facility or nursing home beds for a provider who has an existing complement of such beds, admissions to such beds shall, thereafter, be restricted to persons who have entered into continuing care contracts meeting the requirements of § 38.2-4905 of the Code of Virginia.~~

~~5. Notwithstanding the foregoing and other provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia, the state home for aged and infirm veterans authorized by Chapter 668, 1989 Acts of Assembly, shall be exempt from all certificate of public need review requirements as a medical care facility.~~

~~6. The development of a project in an existing nursing facility owned and operated by the governing body of a county when (i) the total number of new beds to be added by construction does not exceed the lesser of 30 beds or 25% of the existing nursing facility beds in the facility; (ii) the facility has demonstrated that the nursing facility beds are needed specifically to serve a specialty heavy care patient population, such as dementia, ventilator dependent, and AIDS patients; and (iii) the facility has executed an agreement with a state-supported medical college to provide training in geriatric nursing.~~

~~7. The development of a nursing facility project located in the City of Staunton when (i) the total number of new beds to be constructed does not exceed 30 beds; (ii) the facility is owned by and will be operated as a nonprofit entity; and (iii) the project is proposed as part of a retirement community that is a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.~~

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8. The issuance of a certificate of public need for any project for an increase in the number of beds in which nursing home or extended care services are provided or the creation of new beds in which such services are to be provided, by any continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia if (i) the total number of new or additional nursing home beds plus any existing nursing home beds operated by the provider does not exceed 20% of the continuing care provider's total existing or planned independent living and adult care residence population when the beds are to be added by new construction, or 25 beds when the beds are to be added by conversion on site of existing beds in an adult care residence licensed pursuant to Chapter 9 (§ 63-1-172 et seq.) of Title 63-1 of the Code of Virginia; (ii) such beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility pursuant to continuing care contracts meeting the requirements of § 38.2-4905 of the Code of Virginia; (iii) the provider agrees in writing not to seek certification for the use of such new or additional beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act; (iv) the provider agrees in writing to obtain prior to admission of every resident of the continuing care facility, the resident's written acknowledgment that the provider does not serve recipients of medical assistance services and that in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement such resident shall not be eligible for placement in the provider's nursing facility unit; and (v) the provider agrees in writing that only continuing care contract holders will be admitted to the nursing home beds after the first three years of operation.

Further, if a certificate is approved pursuant to this subdivision, admissions to such new or additional beds shall be restricted for the first three years of operation to patients for whose care, pursuant to an agreement between the facility and the individual financially responsible for the patient, private payment will be made or persons who have entered into an agreement with the facility for continuing care contracts meeting the requirements of § 38.2-4905 of the Code of Virginia.

9. The issuance of a certificate of public need for a nursing facility project associated with a continuing care provider which did not operate a nursing home on January 1, 1993, and was registered as of January 1, 1993, with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia if (i) the total number of new beds to be constructed does not exceed 60 beds; (ii) the facility is owned by and will be operated as a nonprofit entity; (iii) after the first three years of operation, the facility will admit only retired officers of the United States uniformed forces and their surviving spouses; (iv) the provider agrees in writing not to seek certification for the use of such beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United

States Social Security Act; and (v) the provider agrees in writing to obtain prior to admission of every resident of the continuing care facility, the written acknowledgment that the provider does not serve recipients of medical assistance services and that in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement such resident shall not be eligible for placement in the provider's nursing facility unit. Further, if a certificate is approved pursuant to this subdivision, admissions to such beds shall be restricted to persons for whose care, pursuant to an agreement with the facility, private payment will be made or persons who have entered into an agreement with the facility for continuing care contracts meeting the requirements of § 38.2-4905 of the Code of Virginia.

10. The issuance of a certificate of public need for a nursing facility project located in the city of Norfolk if (i) the total number of beds to be constructed does not exceed 120 beds; (ii) the facility will replace an existing facility in the City of Chesapeake; (iii) the construction of the facility has been delayed by environmental contamination caused by leaking underground storage tanks; and (iv) the total capital costs of the facility will not exceed \$4,387,000.

12. VAC 5-220-400. Extension of the schedule of completion for nursing home projects approved prior to January 1, 1994.

Notwithstanding the authority of the commissioner to grant an extension of a schedule for completion of the project pursuant to Part VI of this chapter, no extension shall be granted beyond June 30, 1992, for any nursing home project approved prior to January 1, 1994. However, the commissioner may grant an extension of a schedule for completion for an additional nine months upon determining that (i) substantial and continuing progress has been made toward completion of the project; (ii) the project owner had agreed in writing prior to February 13, 1994, to delay the project to facilitate cost savings for the Commonwealth; and (iii) construction of the project was initiated on or before April 15, 1992. The commissioner may also grant an extension of a schedule for completion for an additional six months to project owners who did not agree in writing prior to February 13, 1994, to delay their projects upon determining that (i) substantial and continuing progress has been made toward completion of the project and (ii) construction of the project was initiated on or before April 15, 1992. The certificate for any such nursing home bed project approved prior to January 1, 1994, which has not been completed by June 30, 1992, or by the expiration date of any approved extension, which in no case shall be later than March 31, 1993, shall be revoked. However, the commissioner shall not revoke the certificate of public need for:

1. Any nursing home bed project for 60 beds proposed as part of a retirement community that is not a continuing care provider as defined in § 38.2-4900 of the Code of Virginia if (i) the certificate of public need was issued after May 1, 1989, and was in force on November 1, 1991; (ii) construction of the nursing home bed project is initiated by June 30, 1992; and (iii) the facility is completed by June 30, 1993.

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2. Any nursing home bed project to add 40 beds to an existing facility if (i) the project owner had agreed to delay the project to facilitate cost savings for the Commonwealth prior to February 13, 1991, (ii) the owner was seeking funding from the Department of Housing and Urban Development prior to February 13, 1992, (iii) the facility receives a feasibility approval for such funding from the Department of Housing and Urban Development by May 1, 1992, (iv) the facility closes a loan to fund the project by October 30, 1992, and (v) the facility is completed by October 31, 1993.

3. Any nursing home bed project for less than 30 beds proposed as part of a retirement community that is not a continuing care provider as defined in § 38.2-4900 of the Code of Virginia if (i) the certificate of public need was issued after May 1, 1988, and was in force on November 1, 1991, (ii) construction of the nursing home bed project was initiated before December 1, 1991, (iii) the owner of the nursing home bed project agrees in writing prior to July 1, 1992, to restrict use of the nursing home beds to residents of such retirement community, (iv) construction on the nursing home bed project that was not completed by August 27, 1991, is resumed by August 1, 1993, and (v) the nursing home bed project is completed by July 31, 1994.

V.A.R. Doc. No. R97-170; Filed December 3, 1996, 3:10 p.m.

Title of Regulation: 12 VAC 5-360-10 et seq. State Medical Facilities Plan: Nursing Home Services (amending 12 VAC 5-360-10 through 12 VAC 5-360-70).

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

Effective Date: January 24, 1997.

Summary:

This regulation establishes standards for the review of nursing home facility projects requesting Certificates of Public Need (COPNs). The changes respond to amendments to the Certificate of Public Need (COPN) Law that became effective on July 1, 1996, through the passage of HB 1302 from the 1996 Session of Virginia's General Assembly. This law eliminated the moratorium on the issuance of nursing home bed COPNs which had existed in Virginia since 1988 and replaced it with a process by which the Department of Health will issue Requests for Applications for nursing home bed projects, at least annually. The regulations modify and expand the project review standards of the current State Medical Facilities Plan (SMFP) and are intended to make the SMFP a better tool for defining the need for nursing home bed applicants.

No substantial changes were made after the regulation was published in the proposed version. However, several nonsubstantive modifications were made in response to comments received. Chief among these were reduction of the bed occupancy threshold of 97% for expansion of existing facilities to 95% (12 VAC 5-360-

40), retention of a definition of "life care contract" (12 VAC 5-360-10), specification that only the planning district (and not the health planning region, as well) will be the geographic unit for analysis of the distributional benefits of specific nursing home certificate of public need requests (12 VAC 5-360-30), exclusion of federal facilities and the Virginia Veterans Care Center from the calculation of nursing home bed need (12 VAC 5-360-40), modification of the minimum nursing home size standard to allow for consideration of proposals with any size nursing home component when combined with adult care residence beds (12 VAC 5-360-40), and elimination of the standard restricting consideration of nursing home bed COPNs by applicants with a history of serious deficiencies and complaints.

Summary of Public Comment and Agency 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.

Agency Contact: Copies of the regulation may be obtained from Paul Parker, Division of Certificate of Public Need, Office of Health Facilities Regulation, Department of Health, 3600 West Broad Street, Suite 216, Richmond, VA 23230, telephone (804) 367-2126.

PART I. DEFINITIONS.

12 VAC 5-360-10. Definitions.

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

"Competing applications" means nursing home bed applications accepted for review in the same review cycle which propose facilities to be located in the same planning district.

"Continuing care ~~contracts~~ contract" means the written agreement [] which [, in effect, provides for continuing care consistent with the requirements of Chapter 49 (§ 38.2-4900, et seq.) of Title 38.2 of the Code of Virginia. It] functions as an insurance policy, whereby the individual resident purchases from the a Continuing Care Retirement Community (CCRC), through an entrance fee and periodic adjustable payments, a package of residential and healthcare services which the CCRC is obligated to provide at the time these residential and health care services are required. The health care services include ~~home for~~ adult care residence services (also known as domiciliary care, assisted living services or personal care) and nursing home services. Continuing care contracts are regulated by the Virginia Bureau of Insurance of the Virginia State Corporation Commission.

"Continuing Care Retirement Community (CCRC)" means those retirement communities for the elderly that provide residential, health care and support services through a continuing care contract. CCRCs can have nursing home services available either on-site, or at licensed facilities off-site.

~~"Demand" or "use rates" means the rate at which an age cohort of the population uses nursing home beds. The rates are determined from periodic patient origin surveys conducted by the department and the regional planning agencies. The nursing facility demand rates are expressed as ratio per 1,000 population.~~

~~"Department" means the Virginia Department of Health.~~

~~"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.~~

~~"Life care community (LCC)" means those retirement communities for the elderly that provide residential and health care services through a life care contract.~~

~~["Life care contract"] means a written agreement between the resident of a life care community and the sponsor of the life care community, whereby the resident contract holder is provided at least board, lodging and nursing services as needed, in exchange for payment of fixed periodic charges adjusted, at most, annually, or an entrance fee, or both. Life care contracts are not insurance policies as defined in the Code of Virginia. [means a continuing care contract.]~~

~~"Nursing home facility" means those facilities or components thereof licensed by the department to provide long-term nursing care, primarily to the portion of the population 65 years of age and older [including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities].~~

~~"Nursing home services" means the provision, on a continuing basis, of nursing services and health related care for treatment, and inpatient care services provided to inpatients, on a continuing basis, in a licensed nursing home facility.~~

~~"Planning district" means a contiguous area within the boundaries established by the Department of Planning and Budget as set forth in § 15.1-1402 of the Code of Virginia.~~

~~"Planning horizon year" means the particular year for which beds are projected to be needed.~~

~~"Relevant reporting period" means the most recent 12 month period, prior to the beginning of the Certificate of Public Need application's review cycle, for which data are available and acceptable to the department.~~

~~"Use rate" means the rate at which an age cohort or the population uses nursing home beds. The rates are determined from periodic patient origin surveys conducted by the department and the regional [health] planning agencies.~~

PART II. CRITERIA AND STANDARDS.

12 VAC 5-360-20. Acceptability; consumer participation.

A. *Consumer participation.* Providers of nursing home services should have written policies and procedures regarding the treatment of patients residents and the management of patient resident care which are available to residents and their families.

B. *Consumer satisfaction.* Providers of nursing home services should have established mechanisms for evaluating resident and resident family satisfaction with the services they provide. Preference will be given in the review of competing applications to providers who can demonstrate high levels of resident and resident family satisfaction with their services through [~~creditable evaluation methods their active and on-going evaluation process~~].

12 VAC 5-360-30. Accessibility; travel time; location; financial considerations.

A. *Travel time.* Nursing home beds should be accessible within a 45 minute driving time, under normal conditions, to 90% of all Virginians. Preference will be given in the review of competing applications to proposed nursing home facilities which substantively improve geographic access and reduce travel time to nursing home services within a planning district [~~or health planning region or both~~].

B. *Access to highway system.* Nursing home services facilities should be linked by paved roads to a state or federal highway and should be accessible by public transportation, when such systems exist in an area. [In urban areas,] preference will be given in the review of competing applications to proposed nursing facilities which are fully accessible by private and public modes of transportation.

C. *Financial.* Nursing home services should be accessible to all persons in need of such services without regard to their ability to pay or the payment source. Preference will be given in the review of competing applications to proposed nursing facilities which will be accessible to all persons in need of such services without regard to their ability to pay or the payment source and can demonstrate a record of such accessibility.

D. *In the case of competing applications, Distribution of beds.* Preference will be given in the review of competing applications to proposals which correct any maldistribution of beds within a planning district.

12 VAC 5-360-40. Availability; need for new service; expanded services.

A. *Need for additional nursing home beds.* No new nursing home beds should be approved in any planning district will be considered to have a need for additional nursing home facility beds unless: (i) the resulting number of licensed and approved bed need forecast for nursing home beds in that planning district does not exceed the projected number of (see subsection C of this section) exceeds the current inventory of [nonfederal] licensed and authorized beds projected to be needed in that planning district for the third planning horizon year; and (ii) the aggregate utilization [

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~~estimated] average annual occupancy of all existing Medicaid-certified nursing facility beds in the planning district where the new beds are proposed is was at least 95% for the relevant reporting period most recent three years for which bed utilization has been reported to the department. [(The bed inventory and utilization of the Virginia Veterans Care Center will be excluded from consideration in the determination of nursing home facility bed need.)]~~

~~2. No new nursing home beds should be approved if the approval of such beds will cause excess capacity to occur as a result of such approval, or if there are any approved but uncompleted nursing facility beds in the planning district where the new beds are proposed will be considered to have a need for additional nursing home beds if there are uncompleted nursing facility beds authorized for the planning district that will be Medicaid-certified beds.~~

~~3. No new free standing nursing homes should be approved which have less than 60 nursing facility beds.~~

~~B. Expansion of existing nursing facilities. Proposals for the expansion of existing nursing facility services facilities should not be approved unless the utilization facility has operated for at least three years and average annual occupancy of the facility's existing beds operated by the applicant exceeds 95% for the relevant reporting period and the proposed expanded nursing facility services shall comply with all applicable sections of this State Medical Facilities Plan component, as determined by the department was at least [97% 95%] in the most recent year for which bed utilization has been reported to the department.~~

~~Exceptions to this standard will be considered for facilities that have operated at less than [97% 95%] average annual occupancy in the most recent year for which bed utilization has been reported to the department when the facility can demonstrate that it has a rehabilitative or other specialized care focus which results in a relatively short average length of stay and, consequently, cannot achieve an average annual occupancy rate of [97% 95%].~~

~~Preference will be given in the review of competing applications to proposals which involve the expansion of freestanding nursing home facilities of [less than 60 beds 60 or fewer beds] when such facilities can demonstrate substantial compliance with the standards of the State Medical Facilities Plan.~~

~~In a case where no competing applicant is a freestanding nursing home facility with [less than 60 beds 60 or fewer beds or where freestanding nursing homes of 60 or fewer and 61 to 90 beds are competing], preference will [also] be given in the review of competing applications to proposals which involve the expansion of freestanding nursing home facilities of [60 to] 90 [or fewer] beds when such facilities can demonstrate substantial compliance with the standards of the State Medical Facilities Plan.~~

~~C. Bed need forecasting method. The number of nursing home facility beds projected forecast to be needed in a given planning district in a given year will be computed by multiplying that planning district's population, in thousands (for that year, for each specified age group) times its corresponding projected nursing home bed use (demand)~~

~~rates rounding these products to the nearest whole bed, and summing the results. The population for a given year will be that most recently published by the Virginia Employment Commission. Projected nursing home bed demand rates (per 1,000 population) will be made available by the department and will be updated periodically by the department, as follows:~~

$$PDBN = (UR64 * PP64) + (UR69 * PP69) + (UR74 * PP74) + (UR79 * PP79) + (UR84 * PP84) + (UR85+ * PP85+)$$

~~where:~~

~~PDBN = Planning district bed need.~~

~~UR64 = The nursing home bed use rate of the population aged 0 to 64 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.~~

~~PP64 = The population aged 0 to 64 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.~~

~~UR69 = The nursing home bed use rate of the population aged [64 65] to 69 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.~~

~~PP69 = The population aged [64 65] to 69 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.~~

~~UR74 = The nursing home bed use rate of the population aged 70 to 74 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.~~

~~PP74 = The population aged 70 to 74 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.~~

~~UR79 = The nursing home bed use rate of the population aged 75 to 79 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.~~

~~PP79 = The population aged 75 to 79 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.~~

~~UR84 = The nursing home bed use rate of the population aged 80 to 84 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.~~

~~PP84 = The population aged 80 to 84 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.~~

~~UR85+ = The nursing home bed use rate of the population aged 85 and older in the planning district as~~

determined in the most recent nursing home patient origin study authorized by the department.

PP85+ = The population aged 85 and older projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

Planning district bed need forecasts will be rounded as follows:

Planning District Bed Need (from above method)	Rounded Bed Need
1 - 29	0
30 - 44	30
45 - 84	60
85 - 104	90
105 - 184	120
185+	240

except in the case of a planning district which has two or more nursing facilities, has had an average annual occupancy rate of nursing home facility beds in excess of [97% 95%] for the most recent three years for which bed utilization has been reported to the department, and has a forecasted bed need of 15 to 29 beds. In such a case, the bed need for this planning district will be rounded to 30.

D. Minimum size of new nursing home facilities. No new freestanding nursing home facilities of less than 120 beds should be authorized. Consideration will be given to the authorization of new [freestanding] facilities [~~that combine with fewer than 120~~] nursing home facility [~~bed components of 60 to 119~~] beds [when these beds are combined] with adult care residence facilities.

~~D. Notwithstanding the standards E. Continuing Care Retirement Communities. Proposals for approval the development of new nursing home beds provided in subsection C of this section, consideration will be given to the approval of new nursing home beds which will be located in a life care community, even if those beds exceed the bed need projection for a given year, if facilities or the expansion of existing facilities by Continuing Care Retirement Communities will be considered in accordance with the following standards:~~

1. The addition total number of new or additional beds would plus any existing nursing home facility beds operated by the continuing care provider does not result in the life care community's nursing bed capacity exceeding exceed 20% of its nonnursing capacity for life care contract holders the continuing care provider's total existing or planned independent living and adult care residence population;

2. The proposed beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility pursuant to continuing care contracts meeting the requirements of § 38.2-4905 of the Code of Virginia;

~~2. 3. The applicant provides written assurances that: (i) all admissions to the nursing home beds that the LCC is~~

~~requesting which occur after three years from the date of the project's completion shall be restricted to LCC contract holders; (ii) beginning the third year following the date of the project's completion, the LCC will promptly submit all data requested by the department pertaining to the number of contract holders and its policies with respect to admission to its nursing home beds; and (iii) the application contains written acknowledgement that a breach of any of the preceding assurances shall constitute grounds for revocation of the certificate of public need whose issuance was predicated upon those assurances. agrees in writing not to seek certification for the use of such new or additional beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act;~~

4. The applicant agrees in writing to obtain, prior to admission of every resident of the Continuing Care Retirement Community, the resident's written acknowledgement that the provider does not serve recipients of medical assistance services and that, in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement, such resident shall not be eligible for placement in the provider's nursing facility unit;

5. The applicant agrees in writing that only continuing care contract holders who have resided in the Continuing Care Retirement Community as independent living residents or adult care residents and are holders of standard continuing care contracts will be admitted to the nursing home facility beds after the first three years of operation.

12 VAC 5-360-50. Continuity; coordination of services.

~~A. Any application for new, expanded or replacement Coordination of services. Nursing facility services home facilities should have written agreements with acute care hospitals for the transfer of patients residents in need of acute medical services, and should be located within reasonable access to acute care and other medical facilities.~~

B. Emergency medical care. Emergency medical services should be within a 15 minutes driving minute response time from the location of the proposed a nursing home beds facility [, under normal conditions].

C. Care continuum. Preference will be given in the review of competing applications to projects which provide multiple levels of long-term care and can demonstrate that they function effectively as a continuum of care which optimizes the match between resident needs and the facilities and services provided.

D. Family support. Nursing home facilities should provide services, such as adult day care services and respite care programs, and engage in activities, such as caregiver education, caregiver support groups, and referral programs, which support the ability of families to provide long-term care to their family members within the home. Preference will be given in the review of competing applications to project applicants who can demonstrate a history or commitment to the provision of services and activities which support the

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ability of families to provide long-term care to their family members within the home.

E. *Noninstitutional service support.* Nursing home facilities should facilitate the use of noninstitutional long-term care services whenever such services are an appropriate alternative for persons in need of long-term care. Preference will be given in the review of competing applications to project applicants who can demonstrate a history of or commitment to investing in noninstitutional long-term care services in their communities.

12 VAC 5-360-60. ~~Costs; reasonable construction costs; operating.~~

A. *Development costs.* The [direct] construction cost per square foot of new construction proposed nursing facilities should be within the construction cost index used as a cap by the Department of Medical Assistance Services or be comparable with or lower than state, regional, and planning district costs the recently observed cost for similar facilities in the same health planning region. Other development [cost costs] of proposed nursing facilities should be comparable with the recently observed [cost costs] for similar facilities in the same health planning region. Preference will be given in the review of competing applications to proposals which have lower development costs than their competitors and can demonstrate that their cost estimates are creditable.

B. ~~Proposals for the conversion of underutilized space in an existing facility should include the remaining depreciable value of the space to house the proposed nursing facility beds as part of the calculation of the total capital cost of the project.~~

C. ~~B.~~ Consideration should will be given to the experience of an applicant or developer applicants in completing similar projects on time and within the authorized capital costs. Preference will be given in the review of competing applications to applicants who have a good record of performance in completing projects on time and within the authorized capital costs.

D. ~~C.~~ *Operating costs and charges.* The applicant should demonstrate that the projected operating costs and charge structure will charges of nursing home facilities should be comparable or less than similar with those of nursing home facilities operating in the planning district where the beds are to be located same health planning region that provide similar staffing levels and a similar range of services. Preference will be given in the review of competing applications to applicants who can reasonably project lower operating costs and charges than their competitors at staffing levels appropriate to their intended level of care.

2. ~~In the case of projects that involve off-site~~ Proponents of the replacement and relocation of nursing home facility beds, the applicant should, in addition to the above standard, reasonably demonstrate that the replacement and relocation will allow for [lower comparable] operating costs and charge structure for the beds at the new site will be comparable or less charges over the life of the replacement facility than continued operations at operation of the existing facility.

12 VAC 5-360-70. ~~Quality; accreditation; track record.~~

A. ~~1. All applicants for nursing facility beds~~ *Licensure and accreditation.* Nursing home facilities should provide assurances that the beds will be designed, staffed be maintained and operated in compliance with all applicable state licensure regulations. Preference will be given in the review of competing applications to applicants who can demonstrate a consistent history of compliance with state licensure regulations.

2. ~~All applications for nursing facility beds~~ *Nursing home facilities should seek accreditation* be accredited by the Joint Commission on Accreditation of Health Care Organizations or other another appropriate accrediting body. Preference will be given in the review of competing applications to applicants who are accredited or can demonstrate a history of operating accredited facilities.

B. ~~An applicant's or developer's track record in the development and operation of nursing facilities should be considered~~ *Record in the provision of quality care.* Preference will be given in the review of an application for new, expanded or replacement nursing facility beds competing applications to applicants who can demonstrate a consistent pattern of licensure surveys with few deficiencies and a consistent history of [complaint-free operation few complaints]. [Applicants with a history of serious deficiencies or substantiated complaints that relate to the quality of care provided in a medical care facility will not be eligible for consideration of certificate of public need authorization for additional nursing home facility beds.]

VA.R. Doc. No. R97-171; Filed December 3, 1996, 3:09 p.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulation: 12 VAC 30-50-95 through 12 VAC 30-50-310. Narrative for the Amount, Duration and Scope of Services (amending 12 VAC 30-50-160 and 12 VAC 30-50-210).

12 VAC 30-80-10 et seq. Methods and Standards for Establishing Payment Rates--Other Types of Care (amending 12 VAC 30-80-40).

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

Effective Date: February 1, 1997.

Summary:

The proposed amendments would have allowed the Department of Medical Assistance Services (DMAS) to pay for certain over-the-counter (OTC) therapeutic products where these products may be used in place of a more expensive legend-only drug. DMAS is recommending, in this final regulation, to permit the use of an over-the-counter drug prior to a legend drug at the discretion of the licensed prescriber.

Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. Item 396 E 8 of Chapter 853 of the 1995 Acts of

Assembly (1995 Appropriations Act), the General Assembly and Governor directed DMAS to "participate in the voluntary Virginia Health Outcomes Partnership project, and ... implement enhancements to the automated prospective drug utilization system." This provision is interpreted to require the department to save \$4.5 million in general funds.

Historically, the Joint Legislative Audit and Review Commission recommended, in 1993, that Medicaid cover OTC drugs. Also, in 1994, the American Medical Association adopted a policy which recommended to physicians that they adopt the practice of prescribing OTC medications to their patients.

As a result of the increased movement of drug products from prescription only (legend) to OTC status during recent years, a large number of effective drug products are available to the public in dosage forms/strengths previously obtainable only on prescription. These have been reviewed extensively by expert panels at the U.S. Food and Drug Administration (FDA) and deemed safe and effective. This FDA initiative has resulted in mass production of drugs for the OTC market and the volume of such products, combined with the competitive marketing and pricing, has provided cost savings as an economy of scale. DMAS expects this policy to have a positive impact on families because it expands the covered pharmacy services to include certain OTC drugs which, at least for the noninstitutionalized population, have heretofore not been covered. This will alleviate some of this financial burden which has been borne by families.

These savings are a part of the savings which are required in Item 396 E 8 of Chapter 853 of the 1995 Acts of Assembly (1995 Appropriations Act). This initiative should produce cost saving in individual patient care in the affected categories. The numbers of prescribers and pharmacy providers should not be affected. The program will be implemented statewide and no negative impact is anticipated to providers. Patient compliance should improve as a result, thereby decreasing the potential for additional, more costly therapies. The overall effect is expected to be cost savings to the public in the Medicaid program.

Summary of Public Comment and Agency 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.

Agency Contact: Copies of the regulation may be obtained from Victoria P. Simmons or Roberta J. Jonas, Regulatory Coordinators, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

12 VAC 30-50-160. Home health services.

A. Service must be ordered or prescribed and directed or performed within the scope of a license of a practitioner of the healing arts. Home health services shall be provided in accordance with guidelines found in the Virginia Medicaid Home Health Manual.

- B. Nursing services provided by a home health agency.
 - 1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.
 - 2. Patients may receive up to 32 visits by a licensed nurse annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services. Payment shall not be made for additional service unless authorized by DMAS.
- C. Home health aide services provided by a home health agency.
 - 1. Home health aides must function under the supervision of a registered nurse.
 - 2. Home health aides must meet the certification requirements specified in 42 CFR 484.36.
 - 3. For home health aide services, patients may receive up to 32 visits annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.
- D. Durable medical equipment (DME) and supplies suitable for use in the home.
 - 1. General requirements and conditions.
 - a. All medically necessary supplies and equipment shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.
 - b. DME providers shall adhere to all applicable DMAS policies, laws, and regulations for durable medical equipment and supplies. DME providers shall also comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of coverage for durable medical equipment or supplies which are regulated by such licensing agency or agencies.
 - c. DME and supplies must be furnished pursuant to a Certificate of Medical Necessity (CMN) (DMAS-352).
 - d. A CMN shall contain a physician's diagnosis of a recipient's medical condition and an order for the durable medical equipment and supplies that are medically necessary to treat the diagnosed condition and the recipient's functional limitation. The order for DME or supplies must be justified in the written documentation either on the CMN or attached thereto. The CMN shall be valid for a maximum period of six months for Medicaid recipients 21 years of age and younger. The maximum valid time period for Medicaid recipients older than 21 years of age is 12 months.

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The validity of the CMN shall terminate when the recipient's medical need for the prescribed DME or supplies ends.

e. DME must be furnished exactly as ordered by the attending physician on the CMN. The CMN and any supporting verifiable documentation must be complete (signed and dated by the physician) and in the provider's possession within 30 days from the time the ordered DME and supplies are initially furnished by the DME provider. Each component of the DME must be specifically ordered on the CMN by the physician. For example, the order must specify IV pole, pump, and tubing. A general order for IV supplies shall not be acceptable.

f. The CMN shall not be changed, altered, or amended after the attending physician has signed it. If changes are necessary, as indicated by the recipient's condition, in the ordered DME or supplies, the DME provider must obtain a new CMN. New CMNs must be signed and dated by the attending physician within 30 days from the time the ordered supplies are furnished by the DME provider.

g. DMAS shall have the authority to determine a different (from those specified above) length of time a CMN may be valid based on medical documentation submitted on the CMN. The CMN may be completed by the DME provider or other health care professionals, but it must be signed and dated by the attending physician. Supporting documentation may be attached to the CMN but the attending physician's entire order must be on the CMN.

h. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for DMAS' post payment audit review purposes. DME providers shall not create nor revise CMNs or supporting documentation for this service after the initiation of the post payment review audit process. Attending physicians shall not complete, nor sign and date, CMNs once the post payment audit review has begun.

2. Preauthorization is required for incontinence supplies provided in quantities greater than two cases per month.

3. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:

a. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners;

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office;

c. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales);

d. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface); mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience (i.e., electric wheelchair plus a manual chair); cleansing wipes;

e. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (effective July 1, 1989);

f. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, ~~over-the-counter drugs~~; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; ~~and support stockings; and ~~nonlegend drugs~~~~);

g. Orthotics, including braces, splints, and supports;

h. Home or vehicle modifications;

i. Items not suitable for or not used primarily in the home setting (i.e., car seats, equipment to be used while at school, etc.); *and*

j. Equipment that the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.).

4. For coverage of blood glucose meters for pregnant women, refer to 12 VAC 30-50-500.

5. Reserved.

6. The medical equipment and supply vendor must provide the equipment and supplies as prescribed by the physician on the certificate of medical necessity. Orders shall not be changed unless the vendor obtains a new certificate of medical necessity prior to ordering or providing the equipment or supplies to the patient.

7. Medicaid shall not provide reimbursement to the medical equipment and supply vendor for services provided prior to the date prescribed by the physician or prior to the date of the delivery or when services are not provided in accordance with published policies and procedures. If reimbursement is denied for one of these reasons, the medical equipment and supply vendor may not bill the Medicaid recipient for the service that was provided.

8. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to the department. Medically necessary DME and supplies shall be:

a. Ordered by the physician on the CMN;

b. A reasonable and necessary part of the recipient's treatment plan;

c. Consistent with the recipient's diagnosis and medical condition particularly the functional limitations and symptoms exhibited by the recipient;

d. Not furnished solely for the convenience, safety, or restraint of the recipient, the family, attending physician, or other practitioner or supplier;

e. Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and

f. Furnished at a safe, effective, and cost effective level suitable for use in the recipient's home environment.

9. Coverage of enteral nutrition (EN) [~~and total parenteral nutrition (TPN)~~] which [~~de does~~] not include a legend drug shall be limited to when the nutritional supplement is the sole source form of nutrition, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of EN [~~and TPN~~] shall not include the provision of routine infant formulae. A nutritional assessment shall be required for all recipients receiving nutritional supplements.

E. Physical therapy, occupational therapy, or speech/language pathology services and audiology services provided by a home health agency or physical rehabilitation facility.

1. Service covered only as part of a physician's plan of care.

2. Patients may receive up to 24 visits for each rehabilitative therapy service ordered annually without authorization. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

F. The following services are not covered under the home health services program:

1. Medical social services;

2. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing services, or items of comfort which have no medical necessity, such as television;

3. Community food service delivery arrangements;

4. Domestic or housekeeping services which are unrelated to patient care and which materially increase the time spent on a visit;

5. Custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care; and

6. Services related to cosmetic surgery.

12 VAC 30-50-210. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a

physician skilled in diseases of the eye or by an optometrist.

A. Prescribed drugs.

1. Drugs for which Federal Financial Participation is not available, pursuant to the requirements of § 1927 of the Social Security Act (OBRA '90 § 4401), shall not be covered ~~except for over the counter drugs when prescribed for nursing facility residents.~~

2. ~~The following prescribed, nonlegend drugs/drug devices shall be covered: (i) insulin, (ii) syringes, (iii) needles, (iv) diabetic test strips for clients under 21 years of age, (v) family planning supplies, and (vi) those prescribed to nursing home residents. Nonlegend drugs shall be covered by Medicaid in the following situations:~~

a. *Insulin, syringes, and needles for diabetic patients;*

b. *Diabetic test strips for Medicaid recipients under 21 years of age;*

c. *Family planning supplies;*

d. *Designated categories of nonlegend drugs for Medicaid recipients in nursing homes;*

e. *[Designated] drugs [~~designated in the Prior Authorization Program~~ prescribed by a licensed prescriber] to be used as less expensive [therapeutic] alternatives to [covered] legend drugs.*

3. Legend drugs are covered, with the exception of anorexiants drugs prescribed for weight loss and the drugs [~~for or~~] classes of drugs identified in 12 VAC 30-50-520.

4. Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, and in compliance with the provision of § 4401 of the Omnibus Reconciliation Act of 1990, § 1927(e) of the Social Security Act as amended by OBRA 90, and pursuant to the authority provided for under § 32.1-325 A of the Code of Virginia, prescriptions for Medicaid recipients for multiple source drugs subject to 42 CFR 447.332 shall be filled with generic drug products unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.

5. New drugs shall be covered in accordance with the Social Security Act § 1927(d) (OBRA 90 § 4401).

6. The number of refills shall be limited pursuant to § 54.1-3411 of the Drug Control Act.

7. Drug prior authorization.

a. Definitions. The following words and terms used in these regulations shall have the following meaning, unless the context clearly indicates otherwise:

"Board" means the Board for Medical Assistance Services.

"Committee" means the Medicaid Prior Authorization Advisory Committee.

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"Department" means the Department of Medical Assistance Services.

"Director" means the Director of Medical Assistance Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).

b. Medicaid Prior Authorization Advisory Committee; membership. The Medicaid Prior Authorization Committee shall consist of 10 members to be appointed by the board. Five members shall be physicians, at least three of whom shall care for a significant number of Medicaid patients; four shall be pharmacists, two of whom shall be community pharmacists; and one shall be a Medicaid recipient.

(1) A quorum for action by the committee shall consist of six members.

(2) The members shall serve at the pleasure of the board; vacancies shall be filled in the same manner as the original appointment.

(3) The board shall consider nominations made by the Medical Society of Virginia, the Old Dominion Medical Society and the Virginia Pharmaceutical Association when making appointments to the committee.

(4) The committee shall elect its own officers, establish its own procedural rules, and meet as needed or as called by the board, the director, or any two members of the committee. The department shall provide appropriate staffing to the committee.

c. Duties of the committee.

(1) The committee shall make recommendations to the board regarding drugs or categories of drugs to be subject to prior authorization, prior authorization requirements for prescription drug coverage and any subsequent amendments to or revisions of the prior authorization requirements. The board may accept or reject the recommendations in whole or in part, and may amend or add to the recommendations, except that the board may not add to the recommendation of drugs and categories of drugs to be subject to prior authorization.

(2) In formulating its recommendations to the board, the committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 9-6.14:1 et seq.). The committee shall, however, conduct public hearings prior to making recommendations to the board. The committee shall give 30 days written notice by mail of the time and place of its hearings and meetings to any manufacturer whose product is being reviewed by the committee and to those manufacturers who request of the committee in writing that they be informed of such hearings and meetings. These

persons shall be afforded a reasonable opportunity to be heard and present information. The committee shall give 30 days notice of such public hearings to the public by publishing its intention to conduct hearings and meetings in the Calendar of Events of The Virginia Register of Regulations and a newspaper of general circulation located in Richmond.

(3) In acting on the recommendations of the committee, the board shall conduct further proceedings under the Administrative Process Act.

d. Prior authorization of prescription drug products, coverage.

(1) The committee shall review prescription drug products to recommend prior authorization under the state plan. This review may be initiated by the director, the committee itself, or by written request of the board. The committee shall complete its recommendations to the board within no more than six months from receipt of any such request.

(2) Coverage for any drug requiring prior authorization shall not be approved unless a prescribing physician obtains prior approval of the use in accordance with regulations promulgated by the board and procedures established by the department.

(3) In formulating its recommendations to the board, the committee shall consider the potential impact on patient care and the potential fiscal impact of prior authorization on pharmacy, physician, hospitalization and outpatient costs. Any proposed regulation making a drug or category of drugs subject to prior authorization shall be accompanied by a statement of the estimated impact of this action on pharmacy, physician, hospitalization and outpatient costs.

(4) The committee shall not review any drug for which it has recommended or the board has required prior authorization within the previous 12 months, unless new or previously unavailable relevant and objective information is presented.

(5) Confidential proprietary information identified as such by a manufacturer or supplier in writing in advance and furnished to the committee or the board according to this subsection shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.1-340 et seq. of the Code of Virginia). The board shall establish by regulation the means by which such confidential proprietary information shall be protected.

e. Immunity. The members of the committee and the board and the staff of the department shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this subsection while serving as a member of such board, committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

f. Annual report to joint commission. The committee shall report annually to the Joint Commission on Health Care regarding its recommendations for prior authorization of drug products.

B. Dentures. Dentures are provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

C. Prosthetic devices.

1. Prosthetics services shall mean the replacement of missing arms and legs. Nothing in this regulation shall be construed to refer to orthotic services or devices.

2. Prosthetic devices (artificial arms and legs, and their necessary supportive attachments) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

D. Eyeglasses. Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

12 VAC 30-80-40. Fee-for-service providers: Pharmacy.

Payment for pharmacy services shall be the lowest of items 1 through 5 (except that items 1 and 2 will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331 (c) if the brand cost is greater than the HCFA upper limit of VMAC cost) subject to the conditions, where applicable, set forth in items 6 and 7 below:

1. The upper limit established by the Health Care Financing Administration (HCFA) for multiple source drugs pursuant to 42 CFR §§ 447.331 and 447.332, as determined by the HCFA Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

2. The Virginia Maximum Allowable Cost (VMAC) established by the agency plus a dispensing fee, if a legend drug, for multiple source drugs listed on the VVF.

3. The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percentage discount established by the methodology set out in a through c below. [~~Pursuant to OBRA 90 § 4401, from January 1, 1991, through December 31, 1994, no changes in reimbursement limits or dispensing fees shall be made which reduce such limits or fees for covered outpatient drugs.~~]

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

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

c. The agency will conduct surveys at intervals deemed necessary by DMAS [~~but no less frequently than triennially~~].

4. A ~~mark-up allowance (150%) of the Estimated Acquisition Cost (EAC) for covered nonlegend drugs and oral contraceptives (Reserved).~~

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

6. Payment for pharmacy services will be as described above; however, payment for legend drugs will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. ~~However, oral contraceptives shall not be subject to the one-month dispensing rule.~~ Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements.

7. The Program [~~recognizes pays additional reimbursement for~~] the 24-hour unit dose delivery system of dispensing drugs [~~. This service is paid~~] only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose add-on fee and an allowance for the cost of unit dose packaging established by the state agency. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC based on the 60th percentile cost level identified by the state agency or HCFA's upper limits. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency.

8. Determination of EAC was the result of an analysis of FY'89 paid claims data of ingredient cost used to develop a matrix of cost using 0 to 10% reductions from AWP as well as discussions with pharmacy providers. As a result of this analysis, AWP minus 9.0% was determined to represent prices currently paid by providers effective October 1, 1990.

The same methodology used to determine AWP minus 9.0% was utilized to determine a dispensing fee of \$4.40 per prescription as of October 1, 1990. A periodic review of dispensing fee using Employment Cost Index - wages and salaries, professional and technical workers will be done with changes made in dispensing fee when appropriate. As of July 1, 1995, the Estimated Acquisition Cost will be AWP minus 9.0% and dispensing fee will be \$4.25.

VA.R. Doc. No. R97-160; Filed November 27, 1996, 11:49 a.m.

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STATE MILK COMMISSION

REGISTRAR'S NOTICE: The State Milk Commission is exempt from the Administrative Process Act in accordance with § 9-6.14:4.1 A 7 of the Code of Virginia, which exempts the Milk Commission in promulgating regulations regarding (i) producers' license and base; (ii) classification and allocation of milk, computation sales and shrinkage; and (iii) class prices for producers' milk, time and method of payment, butterfat testing and differential.

Title of Regulation: 2 VAC 15-20-10 et seq. Rules and Regulations for the Control, Regulation, and Supervision of the Milk Industry in Virginia (amending 2 VAC 15-20-80).

Statutory Authority: §§ 3.1-430 and 3.1-437 of the Code of Virginia.

Effective Date: December 1, 1996.

Summary:

The amendment removes a sunset provision so that certain modifications to the indexes used in determining the monthly composite index utilized in calculating the Class I price for Virginia Class Milk Commission marketing areas will continue to be used.

Agency Contact: Copies of the regulation may be obtained from Edward C. Wilson, Jr., State Milk Commission, 200 North Ninth Street, Suite 1015, Richmond, VA 23219, telephone (804) 786-2013.

2 VAC 15-20-80. Class prices for producer's milk time and method of payment butterfat testing and differential.

A. Class prices.

1. Class I	July through February	March through June
Eastern Virginia Market	\$8.46/cwt.	\$8.26/cwt.
Southwest Virginia Market	\$7.96/cwt.	\$7.76/cwt.
Western Virginia Market	\$8.16/cwt.	\$7.96/cwt.

The above established Class I prices shall be adjusted automatically in accordance with the following procedure, provided:

- (1) a. The Eastern Market Class I price shall not exceed the average prevailing Class I price of Federal Order No. 4 and Federal Order No. 5 base zone by more than \$0.80 per hundredweight, nor be less than \$0.30 per hundredweight above the average prevailing Class I price of Federal Order No. 4 and Federal Order No. 5 base zone;
- b. The Southwest Market Class I price shall not exceed the prevailing Class I price of Federal Order No. 11 by more than \$0.60 per hundredweight nor be less than \$0.30 per hundredweight above the prevailing Class I price of Federal Order No. 11 and;

c. The Western Market Class I price shall not exceed the average prevailing Class I price of Federal Order No. 4 and Federal Order No. 5, Northwest Zone by more than \$0.60 per hundredweight nor be less than \$0.30 per hundredweight above the prevailing Class I price of Federal Order No. 4 and Federal Order No. 5, Northwest Zone:

(2) Class I prices shall be increased by an amount determined by multiplying the number of two point brackets that the average bi-monthly composite index exceeds 101.0 by \$.20; and

(3) Class I prices shall be decreased by an amount determined by multiplying the number of two point brackets that the average bi-monthly composite index descends below 99.0 by \$.20.

(4) The average bi-monthly composite index brackets shall be in accordance with the following schedule:

Average Bi-monthly Composite Index Brackets	Amount of Adjustment
Nos. through Nos. Continued	Cents Continued
96.9 - 98.9	- 20
99.0 - 101.0	- 0
101.1 - 103.1	+ 20
103.2 - 105.2	+ 40
105.3 - 107.3	+ 60
107.4 - 109.4	+ 80
109.5 - 111.5	+100
111.6 - 113.6	+120
113.7 - 115.7	+140
115.8 - 117.8	+160
117.9 - 119.9	+180
120.0 - 122.0	+200
122.1 - 124.1	+220
124.2 - 126.2	+240
126.3 - 128.3	+260
128.4 - 130.4	+280
130.5 - 132.5	+300
132.6 - 134.6	+320
134.7 - 136.7	+340
136.8 - 138.8	+360
138.9 - 140.9	+380
141.0 - 143.0	+400
143.1 - 145.1	+420
145.2 - 147.2	+440
147.3 - 149.3	+460
149.4 - 151.4	+480
151.5 - 153.5	+500
153.6 - 155.6	+520
155.7 - 157.7	+540
157.8 - 159.8	+560
159.9 - 161.9	+580
162.0 - 164.0	+600
164.1 - 166.1	+620
166.2 - 168.2	+640
168.3 - 170.3	+660
170.4 - 172.4	+680
172.5 - 174.5	+700

174.6 - 176.6	+720
176.7 - 178.7	+740
178.8 - 180.8	+760
180.9 - 182.9	+780
183.0 - 185.0	+800
185.1 - 187.1	+820
187.2 - 189.2	+840
189.3 - 191.3	+860
191.4 - 193.4	+880
193.5 - 195.5	+900
195.6 - 197.6	+920
197.7 - 199.7	+940
199.8 - 201.8	+960
201.9 - 203.9	+980
204.0 - 206.0	+1000
206.1 - 208.1	+1020
208.2 - 210.2	+1040
210.3 - 212.3	+1060
212.4 - 214.4	+1080
214.5 - 216.5	+1100
216.6 - 218.6	+1120
Continued	Continued

(5) A monthly composite index shall be determined by dividing the sum of the index numbers of the six factors shown in subsections (a x 1), (b x 1), (c x 1), (d x 1), (e x 1), (f x 2) of this subparagraph by seven. The latest available published monthly data for any of the above six factors shall be used in determining the monthly index number.

(a) The U.S. Index of prices paid, taxes, and farm wage rates as published in "Agricultural Prices" by the U.S.D.A.

(b) The U.S. Index of prices received as published in "Agricultural Prices" by the U.S.D.A.

(c) The average price per ton paid by Virginia farmers for 16% dairy feed, as published in "Agricultural Prices" by the U.S.D.A.

(d) The average cost of the market basket for Richmond-Norfolk-Virginia Beach-Portsmouth, as published in "The Market Basket and Retail Food Prices" by the Virginia Department of Labor and Industry.

(e) The average weekly earnings of workers in Virginia manufacturing industries, as published in "Trends in Employment Hours and Earnings Virginia and Statistical Metropolitan Areas" by the Virginia Department of Labor and Industry.

(f) An average of the prevailing Class I prices in North Carolina, Federal Milk Marketing Order No. 4 and Federal Milk Marketing Order No. 11.

(6) The six month average, November 1973 through April 1974, shall equal 100 for each of the above factors for the purpose of determining the monthly index number for each factor.

(7) The current month's Class I price adjustment, if any, shall be determined by a bi-monthly composite index which shall be a simple average of the monthly

composite indices of the second and third preceding months.

(8) On or before the seventh day of each month the commission shall determine the Class I prices for the following month and announce same to all licensed processing general distributors.

Effective May 1, 1995, and continuing until December 1, 1996, unless amended or terminated by a majority vote of the commission the following modifications to the indexes will be utilized in determining the monthly composite index used in calculating the Class I price for Virginia State Milk Commission marketing areas pursuant to subdivisions A 1 (1) through A 1 (7) of this section:

The U.S. Index of prices paid, taxes, and farm wage rates as published in "Agricultural Prices" by the U.S.D.A. will be determined by using the monthly movement of the reweighted and reconstructed prices paid index (PPITW) as published by the U.S.D.A. The monthly movement of the new prices paid index (PPITW) will be applied each month to the preceding month's revised index of prices paid, taxes, and farm wage rates using December 1994 as the base month.

The U.S. Index of prices received as published in "Agricultural Prices" by the U.S.D.A. will be determined by using the monthly movement of the reweighted and reconstructed prices received index as published by the U.S.D.A. The monthly movement of the new prices received index will be applied each month to the preceding month's revised index of prices received using December 1994 as the base month.

The average price per ton paid by all Virginia farmers for 16% dairy feed as published in "Agricultural Prices" by the U.S.D.A. will be determined by using the monthly movement of the index of prices paid, production items, complete feeds as published by the U.S.D.A. The monthly movement of this index will be applied each month to the preceding month's index of 16% dairy feed, Appalachian using April 1995 as the base month.

The authoritative publisher of the Market Basket for Richmond-Norfolk-Virginia Beach-Portsmouth will be the Virginia Department of Agriculture and Consumer Services. The resultant index numbers derived from the above calculations will be utilized as specified in the cited regulation.

2. Class I-A. The price used in computing each distributor's obligation for producer milk (of 3.5% butterfat) allocated to Class I-A shall be the Class II price.

3. Class II. The price per cwt. for all markets shall be the monthly Class II price announced by the Market Administrator of the Tennessee Valley Marketing Area (Federal Order No. 11).

4. The total value of base deliveries made in accordance with 2 VAC 15-20-50 B (2) shall be discounted in accordance with the following procedure to reflect the cost savings of transporting, storing and handling of producer milk on a uniform daily bases:

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(a) Subtract from each cooperative association's total pounds of base deliveries allocated to Class I sales for each delivery period an amount equal to twice the sum of the differences between the pounds of assigned daily base and the pounds of daily base deliveries which are less than the pounds of assigned daily base for each day during the delivery period.

(b) The net hundredweight (not less than zero) resulting from the above procedure multiplied by \$0.11 will be the amount of discount for base deliveries during the delivery period.

5. Producers or their agents shall not sell milk or offer milk for sale at prices other than those established.

B. Butterfat differential. In making payments to producers and/or cooperative associations of producers required pursuant to this section, each general distributor shall add for each one-tenth of one percent of average butterfat content above 3.5%, and shall deduct for each one-tenth of one percent of average butterfat content below 3.5% as a butterfat differential an amount per hundredweight announced each month by the Market Administrator of the Tennessee Valley Marketing Area (Federal Order No. 11).

C. Butterfat testing. Butterfat testing shall be conducted in accordance with the following procedure:

1. General distributors shall determine the average butterfat content of all assigned producer milk delivered by each producer who is not a member of a cooperative association, as defined in 2 VAC 15-20-10 by four or more tests made at approximately equal intervals during each delivery period.

2. All assigned producer milk accompanied by a bill of lading that is delivered by a cooperative association to a licensed distributor and is accepted by the distributor shall be paid for by the distributor at a rate that is determined by the butterfat test specified on the bill of lading accompanying the load of milk.

3. The butterfat content of all assigned cooperative association milk delivered by methods other than specified in subdivision C 2 above, shall be determined in accordance with procedures specified by the commission, if mutual agreement between the cooperative association and the distributor cannot be reached as to the butterfat content of such deliveries.

4. All sampling and testing shall be conducted by persons licensed by the Virginia Department of Agriculture and Consumer Services. These tests shall be made by the Babcock Test, or other tests approved by that department and shall, as directed by the commission, be subject to check tests made by a licensed tester.

D. Time of payment.

1. On or before the last day of a delivery period general distributors shall make a partial payment to producers or cooperative associations of producers for base deliveries received during the first 15 days of the delivery period. The partial payment shall be not less than an amount determined by multiplying the previous month's Class II

price for 3.5% milk by the hundredweight of base deliveries for the first 15 days of the delivery period; provided full and final payment for the preceding delivery period was made in accordance with subdivision D 2 of this section, otherwise the partial payment shall be not less than an amount determined by multiplying the current Class I price for 3.5% milk by the hundredweight of base deliveries for the first 15 days of the delivery period.

2. On or before the 15th day following the close of a delivery period general distributors shall make full and final payment to producers or cooperative associations of producers for deliveries received during such delivery period pursuant to this chapter.

3. Certified or registered mail may be required for all U.S. Postal Service deliveries of producer payments made by general distributors pursuant to subdivisions D 1 and D 2 of this section when directed in writing by the commission.

4. The commission may, after a hearing, require individual general distributors to make settlement with producers or cooperative associations of producers for deliveries at intervals other than provided in subdivisions D 1 and D 2 of this section.

5. All licensed producers or association of producers supplying base deliveries to processing general distributors located in Norfolk, Portsmouth, Hampton, Newport News or Chesapeake shall be allocated \$0.10 per hundredweight from the total monthly Eastern Market Class I producer payments. This allocation shall be made prorata in accordance with the monthly base deliveries to the processing general distributors located in the aforementioned cities.

6. Before the 15th day of each month the commission shall determine the required monthly equalization payments and give written notice to all affected parties of the amounts payable. The monthly equalization payments shall be made to the Milk Commission Equalization Fund no later than the 25th day of the month subsequent to the end of each delivery period. On or before the last day of each month the commission shall disburse all funds (less a balance necessary to pay all bank charges) paid in during the current month in accordance with subdivision D 5 of this section.

E. Redistribution of producer losses. When the commission is satisfied that when one or more licensed distributor(s) is/are unable, due to bankruptcy or receivership, to fulfill the financial obligation to producers and/or cooperative associations of producers for base deliveries, the commission may authorize the establishment of a temporary producer redistribution fund to reallocate a distributor's deficient financial obligation.

1. When it is determined that an obligation for base milk deliveries cannot be satisfied, the distributor(s), producer(s) or cooperative associations of producers involved shall notify the commission within five working days of a voluntary filing or adjudication of bankruptcy or receivership, or within five working days of the effective date of this regulation for licensed distributors currently

in bankruptcy or receivership. This notification shall be in writing accompanied by copies of pertinent court documents.

2. The producer funded redistribution of losses of an unfulfilled obligation of base deliveries shall be limited to an amount not to exceed the unsecured value of base deliveries calculated in accordance with this chapter.

3. A producer funded redistribution rate shall be established which will be the lesser of the actual dollar loss under subdivision E 2 or the dollars generated by a rate not in excess of .10/cwt., levied on producer's and/or cooperative associations of producers monthly Class I allocated base deliveries for a period not to exceed 12 months for each bankruptcy.

Each distributor shall remit to the Milk Commission no later than the 15th of each month the amount collected in accordance with this subdivision, applicable to the prior months delivery period at the rate established by the commission.

4. The Milk Commission shall disburse all redistribution funds, net of applicable bank charges, collected each month for the redistribution fund by the last day of the month. Funds will be disbursed prorata in relationship to the loss incurred by producers and/or cooperative associations of producers, less applicable bank charge.

5. Producers or cooperative associations of producers shall assign to the commission that portion of their loss claim which pertains to the value of redistributed funds paid on Virginia base deliveries by the commission in order to participate in the producer redistribution fund.

6. Any overpayment or recovery of loss claims assigned to the commission by producers or cooperative associations of producers to the producer redistribution fund shall be disbursed to producers or cooperative associations of producers on a prorata basis of payments made to the fund.

VA.R. Doc. No. R97-159; Filed November 27, 1996, 9:43 a.m.

BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

Title of Regulation: 18 VAC 115-20-10 et seq. Regulations Governing the Practice of Professional Counseling (amending 18 VAC 115-20-20, 18 VAC 115-20-100 and 18 VAC 115-20-110).

Statutory Authority: §§ 54.1-113, 54.1-2400 and 54.1-3503 of the Code of Virginia.

Effective Date: January 22, 1997.

Summary:

The amendments comply with statutory requirements to maintain revenue within 10% of expenditures over each biennium. The board adopted the following fee changes:

1. Reduce the application processing fee (currently \$100) to \$25 in FY 1997, adjusted to \$50 for FY 1998 and thereafter.

2. Reduce the registration of supervision fee (currently \$75) to \$20.

3. Change the current annual renewal fee of \$75 to a biennial renewal of \$75.

Summary of Public Comment and Agency 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.

Agency Contact: Copies of the regulation may be obtained from Janet Delorme, Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9575.

18 VAC 115-20-20. Fees required by the board.

A. The board has established the following fees applicable to licensure as a professional counselor:

	After December 31, 1996	After June 30, 1997
Registration of supervision	\$75 [\$25 \$20]	[\$25 \$20]
[Change of supervisor	\$20	\$20]
Application processing	\$400 \$25	\$50
Examination	\$120	
Biennial license renewal	\$85 \$75	\$75
Duplicate license	\$15	\$15
Endorsement to another jurisdiction	\$10	\$10
Late renewal	\$10	\$10
Replacement of or additional wall certificate	\$15	\$15
Returned check	\$15	\$15

B. Examination fees shall be paid directly to the examination service according to its requirements.

B. C. Fees shall be paid by check or money order made payable to the Treasurer of Virginia and forwarded to the board. All fees are nonrefundable.

C. All fees are nonrefundable.

18 VAC 115-20-100. Annual Biennial renewal of licensure.

A. All licensees shall renew licenses on or before June 30 of each odd-numbered year.

A. B. Every license holder who intends to continue to practice shall submit to the executive director board on or before June 30 of each odd-numbered year:

1. A completed application for renewal of the license; and
2. The renewal fee prescribed in 18 VAC 115-20-20.

B. C. Failure to receive a renewal notice from the board shall not relieve the license holder from the renewal requirement.

18 VAC 115-20-110. Late renewal; reinstatement.

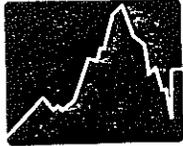
A. A person whose license has expired may renew it within four years after its expiration date by paying the penalty fee prescribed in 18 VAC 115-20-20 as well as the license fee

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prescribed for each year *biennium* the license was not renewed.

B. A person who fails to renew a license for four years or more and wishes to resume practice shall reapply and pay the application fee prescribed in 18 VAC 115-20-20 and take the written examination.

C. Upon approval for reinstatement, the applicant shall pay the penalty fee prescribed in 18 VAC 115-20-20 and the license fee prescribed for each year *biennium* the license was not renewed.



Department of Health Professions
6606 West Broad Street, 4th Floor
Richmond, Virginia 23230-1717

COMMONWEALTH OF VIRGINIA
BOARD OF PROFESSIONAL COUNSELORS
AND
MARRIAGE AND FAMILY THERAPISTS

**PROFESSIONAL COUNSELOR
LICENSURE APPLICATION**

I hereby make application for licensure to practice as a Professional Counselor in the Commonwealth of Virginia. The following evidence of my qualifications is submitted with a check or money order in the amount of \$25.00 made payable to the Treasurer of Virginia. The application fee is non-refundable.

INSTRUCTIONS PLEASE TYPE OR PRINT USE BLACK INK

1. Applicants must complete all sections.
2. Completed application should be mailed to the above address.
3. Application and supporting documents must be received no less than 90 days prior to the date of the written examination.

I. GENERAL INFORMATION

Name (Last, First, M.I., Suffix, Maiden Name)	Social Security Number	Date of Birth
Mailing Address (Street and/or Box Number, City, State, ZIP Code)		Home Telephone Number
Business Name and Address (if different from above)		Business Telephone Number

EDUCATION: State in chronological order the name and location of each graduate school where graduate course work has been completed. GRADUATE TRANSCRIPTS MUST BE SUBMITTED DIRECTLY TO THE BOARD OFFICE FROM THE GRADUATE INSTITUTION.

Institution	Dates of Attendance		Major and/or Concentration	Degree Received	Date Degree Conferred
	From	To			

ANSWER THE FOLLOWING QUESTIONS:

	YES	NO
1. Have you ever been denied the privilege of taking an occupational licensure or certification examination? If yes, state what type of occupational examination and where: _____	[]	[]
2. Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending? If yes, explain in detail (use extra paper if necessary): _____	[]	[]
3. Have you ever been convicted of a violation of or pled nolo contendere to any federal, state, or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except for driving under the influence.) If yes, explain in detail: _____	[]	[]
4. Have you ever been terminated or asked to withdraw from any health care facility, agency, or practice? If yes, provide an explanation on a separate sheet of paper. _____	[]	[]

II. SUPERVISED COUNSELING EXPERIENCE

Indicate below person(s) designated as your supervisor(s) for professional counseling supervised experience, to whom verification forms will be sent. Verification of Supervision forms must be returned to the applicant by the supervisor in an envelope with the supervisor's signature on the envelope seal.

Supervisor's Name _____

Institution or Business Name and Address _____

Current Address (if different from above) _____

Dates Applicant Employed From: _____ To: _____	Total Hours of Face-to-Face Supervision	Total Hours of Group Supervision
---	---	----------------------------------

Description of Supervised Work Experience _____

Supervisor's Name		
Institution or Business Name and Address		
Current Address (if different from above)		
Dates Applicant Employed From: To:	Total Hours of Face-to-Face Supervision	Total Hours of Group Supervision
Description of Supervised Work Experience		
Supervisor's Name		
Institution or Business Name and Address		
Current Address (if different from above)		
Dates Applicant Employed From: To:	Total Hours of Face-to-Face Supervision	Total Hours of Group Supervision
Description of Supervised Work Experience		
III. POST-GRADUATE DEGREE INTERNSHIP (May not apply to all applicants) Have you had a post-graduate degree internship or practicum? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Institution or Business Name: _____		
Street Address: _____		
City	State	ZIP Code
Hours per week: _____	Dates: From _____ to _____	
(If Applicable, Submit Verification of Supervision Form)		

IV. STANDARDS OF PRACTICE - Your practice is limited to your demonstrated areas of competence. Please list below your specialized areas of practice that can be supported by documentation of training or education.			
CLIENT POPULATION(S)	COUNSELING TECHNIQUES USED	ASSESSMENT INSTRUMENTS USED	
V. LICENSURE/CERTIFICATION - List all the states in which you now hold or have ever held an occupational license or certificate to practice professional counseling in order of attainment.			
STATE	LICENSE/CERTIFICATE NUMBER	ISSUE DATE	TYPE OF LICENSE/CERTIFICATE
VI. REFERENCES - Please list and submit references from three individuals other than your supervisors who are acquainted with your professional work.			
NAME AND ADDRESS		TITLE	

The following statement must be executed by a Notary Public. This form is not valid unless properly notarized.

AFFIDAVIT
(To be completed before a notary public)

State of _____ County/City of _____

Name _____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a professional counselor in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

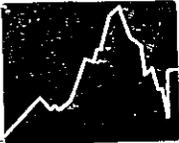
Signature of Applicant

Subscribed to and sworn to before me this _____ day of _____, 19____

My commission expires on _____

Signature of Notary Public

SEAL



COMMONWEALTH OF VIRGINIA
BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

Department of Health Professions
 6606 West Broad Street, 4th Floor
 Richmond, Virginia 23230-1717
 (804) 662-9912

**REGISTRATION OF SUPERVISION
 POST-GRADUATE DEGREE SUPERVISED EXPERIENCE**

FEES: \$20.00 Each Registration (one supervisor)
 Make all checks payable to THE TREASURER OF VIRGINIA - Registration fees are NON-REFUNDABLE

THIS FORM IS TO BE COMPLETED BY THE TRAINEE AND THE SUPERVISOR

CHECK ONE: Initial Registration Add Supervisor Change Supervisor

TRAINEE INFORMATION (Please type or print)

Name (Last, First, M.I., Suffix, Maiden Name)		Social Security Number	Date of Birth
Mailing Address (Street and/or Box Number, City, State, ZIP Code)			Home Telephone Number
Business Name and Address (Where you are providing supervised counseling services)			Business Telephone Number

EDUCATION: State in chronological order the name and location of each graduate school where graduate course work has been completed. GRADUATE TRANSCRIPTS MUST BE SUBMITTED DIRECTLY TO THE BOARD OFFICE FROM THE GRADUATE INSTITUTION PRIOR TO APPROVAL OF SUPERVISION.

	Dates of Attendance		Major and or	Degree	Date Degree
	From	To			

REGISTRATION OF SUPERVISION (continued)

SUPERVISOR INFORMATION			
Name (Last, First, M.I., Suffix, Maiden Name)		Social Security Number	Date of Birth
Business Address		Telephone Number	
License	License Number	Initial Licensure Date	Licensure Expiration Date
State: _____ (If supervisor is not licensed in Virginia, a completed Verification of Licensure form from the state in which the supervisor is licensed must be submitted to the Board.)			
SUPERVISION CONTRACT			
<p>SUPERVISION TO BE PROVIDED TRAINEE - Supervision agreement should include at least one hour per week of face-to-face supervision. Two hours of group supervision may be substituted for one hour of individual face-to-face supervision for one-half of the required 200 hours of supervision. Indicate whether supervision is on-site or off-site. Provide detailed information of supervision to be given.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			
<p>SERVICES TO BE RENDERED BY THE TRAINEE WHILE IN SUPERVISION - Include population of clients to receive service, assessments to be used, and counseling techniques to be used.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			
<p>I, _____, declare under penalty of perjury under the laws of the Commonwealth of Virginia that I have professional training in supervision, and that I will not provide supervision to _____ in areas outside of the competencies of my license to practice as a _____ (Trainee) _____ As supervisor, I assume responsibility for the clinical activities of the individual _____ (License of Supervisor) registered under my supervision. We hereby agree to this supervision contract which is being registered with the Board of Professional Counselors and Marriage and Family Therapists.</p> <p>Signature of Supervisor: _____ Date: _____</p> <p>Signature of Trainee: _____ Date: _____</p>			

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Final Regulations

Department of Health Professions
COMMONWEALTH OF VIRGINIA

RENEWAL NOTICE AND APPLICATION

Board of

Telephone

TYPE OF RENEWAL

CURRENT EXPIRATION	RENEWAL PERIOD	
	FROM	TO
CURRENT AMOUNT DUE	LATE PAYMENT	
\$	PAY ONLY IF AFTER	

INSTRUCTIONS	
1. Complete item 1 below if you do not wish to renew.	
2. Make any address changes on this application when renewing.	
3. Make any name changes on this application and enclose a copy of your marriage license or court order.	
4. Note name and license number on all enclosures.	
5. Return this application in the enclosed envelope.	
1. <input type="checkbox"/> Check here if you do not wish to renew, and sign below.	
_____ Signature	

NUMBER:

MAKE CHECKS PAYABLE TO THE "TREASURER OF VIRGINIA"

C 3712B

Title of Regulation: 18 VAC 115-30-10 et seq. Regulations Governing the Certification of Substance Abuse Counselors (amending 18 VAC 115-30-30, 18 VAC 115-30-110, and 18 VAC 115-30-120).

Statutory Authority: §§ 54.1-113, 54.1-2400, and 54.1-3503 of the Code of Virginia.

Effective Date: January 22, 1997.

Summary:

The amendments comply with statutory requirements to maintain revenue within 10% of expenditures over each biennium. The board adopted the following fee changes:

- Reduce the application processing fee (currently \$50) to \$20 in FY 1997, adjusted to \$25 for FY 1998 and thereafter.
- Reduce the registration of supervision fee (currently \$25) to \$10 in FY 1997, adjusted to \$15 for FY 1998 and thereafter.
- Change the current annual renewal fee of \$40 to a biennial renewal of \$40.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Copies of the regulation may be obtained from Janet Delorme, Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9575.

18 VAC 115-30-30. Fees required by the board.

A. The board has established the following fees applicable to the certification of substance abuse counselors:

	<i>After December 31, 1996</i>	<i>After June 30, 1997</i>
Registration of supervision	\$25 \$10	\$15
Application processing	\$50 \$20	\$25
Examination	\$120	
Biennial certification renewal	\$40	\$40
Duplicate certificate	\$15	\$15
Late renewal	\$10	\$10
Replacement of or additional wall certificate	\$15	\$15
Name change	\$10	\$10
Returned check	\$15	\$15

B. Fees shall be paid by check or money order. Examination fees shall be made payable to the examination service and mailed directly to the examination service. All other fees shall be made payable to the Treasurer of Virginia and forwarded to the Board of Professional Counselors and Marriage and Family Therapists.

18 VAC 115-30-110. Annual Biennial renewal of certificate.

Every certificate issued by the board shall expire on June 30 of each *odd-numbered* year.

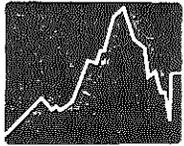
1. Along with the renewal application, the certified substance abuse counselor shall submit the renewal fee prescribed in 18 VAC 115-30-30 of this chapter.
2. Failure to receive a renewal notice and application forms shall not excuse the certified substance abuse counselor from the renewal requirement.

18 VAC 115-30-120. Reinstatement.

A. A person whose certificate has expired may renew it within four years after its expiration date by paying the penalty fee prescribed in 18 VAC 115-30-30 and the certification fee prescribed for each year *biennium* the certificate was not renewed.

B. A person who fails to renew a certificate for four years or more shall:

1. Pay the late renewal fee prescribed in 18 VAC 115-30-30 and the certification fee prescribed for each year *biennium* the certificate was not renewed;
2. Provide evidence satisfactory to the board of current ability to practice as evidenced by:
 - a. Continuous practice of substance abuse counseling during the preceding two years and completion of 20 hours of continuing education in substance abuse counseling per year for the preceding two years; or
 - b. Completing at least 40 hours of substance abuse education in the preceding 12 months.



**COMMONWEALTH OF VIRGINIA
BOARD OF PROFESSIONAL COUNSELORS AND
MARRIAGE AND FAMILY THERAPISTS**

Department of Health Professions
6606 West Broad Street, 4th Floor
Richmond, Virginia 23230-1717
(804) 662-7328

**APPLICATION FOR CERTIFICATION AS A
SUBSTANCE ABUSE COUNSELOR**

I hereby make application for certification to practice as a Substance Abuse Counselor in the Commonwealth of Virginia. The following evidence of my qualifications is submitted with a check or money order in the amount of \$20.00 made payable to the Treasurer of Virginia. The application fee is non-refundable.

INSTRUCTIONS	PLEASE TYPE OR PRINT	USE BLACK INK
1. Applicants must complete all sections. 2. Completed application should be mailed to the above address. 3. Application and supporting documents must be received no less than 90 days prior to the date of the written examination.		

I. GENERAL INFORMATION			
Name (Last, First, M.I., Suffix, Maiden Name)		Social Security Number	Date of Birth
Mailing Address (Street and/or Box Number, City, State, ZIP Code)		Home Telephone Number	
Business Name and Address (if different from above)		Business Telephone Number	

II. EDUCATIONAL EXPERIENCE								
Applicants must submit official transcripts in sealed, signed envelopes with this application. Applicants with GED certificates must include official documentation of that certificate in a sealed, signed envelope.								
Educational Institutions Attended High School/G.E.D., College	City & State	Dates Attended				Degree	Conferred	
		From	To				Month	Year
		Mo.	Yr.	Mo.	Yr.			

III. SUPERVISED COUNSELING EXPERIENCE		
Indicate below person(s) designated as your supervisor(s) for substance abuse counseling supervised experience. Verification of Supervision forms must be returned to the applicant by the supervisor in an envelope with the supervisor's signature on the envelope seal.		
Supervisor's Name		
Institution or Business Name and Address		
Current Address (if different from above)		
Dates Applicant Employed From: To:	Total Hours of Face-to-Face Supervision	Total Hours of Group Supervision
Description of Supervised Work Experience		
Supervisor's Name		
Institution or Business Name and Address		
Current Address (if different from above)		
Dates Applicant Employed From: To:	Total Hours of Face-to-Face Supervision	Total Hours of Group Supervision
Description of Supervised Work Experience		

IV. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL REQUIREMENTS

Applicants are required to document 400 hours in a substance abuse educational program from one of the following: (1) an accredited university or college; (2) an integrated program approved by the Board; (3) an individualized program or seminars and workshops approved by the Board at the time of the application.

COURSE WORK MUST BE VERIFIED THROUGH OFFICIAL TRANSCRIPTS TO BE INCLUDED IN THE APPLICATION PACKAGE. CLOCK HOURS REPORTED MUST BE ONLY THOSE HOURS SPENT COVERING THE SPECIFIC CONTENT AREA. TO VERIFY COURSE CONTENT, ADDITIONAL INFORMATION SUCH AS COURSE DESCRIPTIONS OR SYLLABI MAY BE REQUIRED BY THE BOARD.

SEMINARS AND WORKSHOPS MUST BE VERIFIED THROUGH COPIES OF CERTIFICATES. IF CLOCK HOURS OR C.E.U.s ARE NOT RECORDED ON THE CERTIFICATE, SEPARATE DOCUMENTATION OF CLOCK HOURS, SIGNED BY THE PRESENTER OR YOUR SUPERVISOR MUST BE INCLUDED.

IV.A. DIDACTIC TRAINING (220 HOURS)

A minimum of ten (10) hours in each of the following areas must be documented.

Content	Institution/Agency	Course Number and Title/ Workshop Title	Clock Hours*
Understanding the Dynamics of Human Behavior			
Signs and Symptoms of Substance Abuse			
Counseling and Treatment Approaches, Substance Abuse Research, Group Therapy and Other Adjunctive Treatment and Support Groups			
Continuum of Care and Case Management Skills			
Recovery Process and Relapse Prevention Methods			
Ethics and Professional Identity			

* One semester credit is equivalent to 15 clock hours; One quarter credit is equivalent to 10 clock hours; One C.E.U. credit is equivalent to 10 clock hours.

IV.B. SUBSTANCE ABUSE EDUCATION TASKS (180 HOURS)

A minimum of eight (8) hours in each of the following areas must be documented. Please provide school transcripts for practicums and internships. If tasks were completed on the job, supervisor must sign the form verifying each task completed.

Tasks	Number of Hours Completed	School/Facility Agency	Course Number and Title of Practicum/Internship or Supervisor's Signature	Date
1. Screening				
2. Intake				
3. Orientation				
4. Assessment				
5. Treatment Plan				
6. Counseling Individual				
7. Case Management				
8. Crisis Intervention				
9. Client Education				
10. Referral				
11. Reports and Recordkeeping				
12. Consultation (with other professionals)				

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ANSWER THE FOLLOWING QUESTIONS:

	YES	NO																
1. Have you ever been denied the privilege of taking an occupational licensure or certification examination? If yes, state what type of occupational examination and where: _____ _____	[]	[]																
2. Do you currently hold, or have you ever held, an occupational license or certification to practice as a substance abuse counselor in any other state or jurisdiction? If yes, please list below: <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">State</td> <td style="width: 15%;">Number</td> <td style="width: 15%;">Issue Date</td> <td style="width: 15%;">Type</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>State</td> <td>Number</td> <td>Issue Date</td> <td>Type</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	State	Number	Issue Date	Type	_____	_____	_____	_____	State	Number	Issue Date	Type	_____	_____	_____	_____	[]	[]
State	Number	Issue Date	Type															
_____	_____	_____	_____															
State	Number	Issue Date	Type															
_____	_____	_____	_____															
3. Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending? If yes, explain in detail (use extra paper if necessary): _____ _____	[]	[]																
4. Have you ever been convicted of a violation of or pled nolo contendere to any federal, state, or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except for driving under the influence.) If yes, explain in detail: _____ _____	[]	[]																
5. Have you ever been terminated or asked to withdraw from any health care facility, agency, or practice? If yes, provide an explanation on a separate sheet of paper.	[]	[]																

The following statement must be executed by a Notary Public. This form is not valid unless properly notarized.

AFFIDAVIT
(To be completed before a notary public)

State of _____ County/City of _____

Name _____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for certification to practice as a substance abuse counselor in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

Signature of Applicant

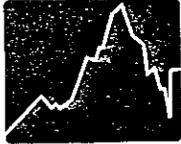
Subscribed to and sworn to before me this _____ day of _____, 19_____.

My commission expires on _____.

Signature of Notary Public

SEAL

rev. 11/96

	<p>COMMONWEALTH OF VIRGINIA BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS</p> <p>Department of Health Professions 6606 West Broad Street, 4th Floor Richmond, Virginia 23230-1717 (804) 662-7328</p>
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**REGISTRATION OF SUPERVISION FOR
 SUBSTANCE ABUSE COUNSELOR CERTIFICATION**

FEES: \$10.00 Each Supervisor Registered
 Make all checks payable to THE TREASURER OF VIRGINIA - Registration fees are NON-REFUNDABLE

CHECK ONE: <input type="checkbox"/> Initial Registration <input type="checkbox"/> Add Supervisor <input type="checkbox"/> Change Supervisor			
TRAINEE INFORMATION (Please type or print clearly)			
Name (Last, First, M.I., Suffix, Maiden Name)		Social Security Number	Date of Birth
Mailing Address (Street and/or Box Number, City, State, ZIP Code)		Home Telephone Number	
Business Name and Address		Business Telephone Number	
Highest Level of Education Achieved	Degree	Institution	
SUPERVISOR INFORMATION (Please type or print clearly)			
Name (Last, First, M.I., Suffix, Maiden Name)		Social Security Number	Date of Birth
Mailing Address (Street and/or Box Number, City, State, ZIP Code)		Home Telephone Number	
Business Name and Address		Business Telephone Number	
Type of License/Certification	License or Certificate Number	State	
Supervisor must complete attached experience and education form A or B			

NATURE OF SUPERVISION	
Supervisory setting (Name of Institution, Agency) _____	
Hours of individual and/or group supervision planned PER WEEK: Individual _____ Group _____ <i>Review Section 18 VAC 115-30-60 of the regulations which outlines the experience requirement.</i>	
Nature of services to be rendered by the supervisee: _____ _____ _____	
Nature of services to be rendered by the supervisor: _____ _____ _____	
SUPERVISORY AGREEMENT	
I, _____, agree to provide supervision as described within this agreement. (Name of Supervisor)	
<i>(Review Section 18 VAC 115-30-60 of the regulations which outlines the experience requirement.)</i> I agree to supervise _____ in accordance with the regulations of the Virginia Board of Professional (Name of Supervisee) Counselors and Marriage and Family Therapists governing the Certification of Substance Abuse Counselors. I also agree to report the performance of the supervisee on a form provided by the Board at the conclusion of the supervised experience.	
I, _____, agree to present myself for supervision for the number of hours designated in this (Name of Supervisee) agreement. I understand _____ is responsible for my professional activities during the (Name of Supervisor) time I am working under his/her supervision.	
DATE SUPERVISION BEGAN/WILL BEGIN: _____	
_____ Signature of Supervisor	_____ Signature of Supervisee
Date: _____	
NOTE: 1. SUPERVISEES MUST SUBMIT A REGISTRATION OF SUPERVISION FORM FOR EACH INDIVIDUAL PROVIDING SUPERVISION FOR THE PURPOSE OF CERTIFICATION. 2. THIS FORM WILL NOT BE REVIEWED BY THE BOARD UNTIL OFFICIAL TRANSCRIPTS ARE RECEIVED DOCUMENTING COMPLETION OF HIGH SCHOOL OR A COLLEGE DEGREE.	

APPLICANT'S NAME: _____

**FORM A
SUPERVISOR'S EXPERIENCE AND EDUCATION**

Supervisor is a Certified Substance Abuse Counselor in the Commonwealth of Virginia:

1. Who has two years experience as a board certified substance abuse counselor by the Virginia Board of Professional Counselors and Marriage and Family Therapists;

Certificate Number	Issue Date	Expiration Date

AND

2. Who also has board recognized national certification in substance abuse counseling.

Certificate Issued By	Issue Date	Expiration Date

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE COMMONWEALTH OF VIRGINIA THAT THE FOREGOING IS TRUE AND CORRECT.

Supervisor's Signature

Date

CERTIFIED SUBSTANCE ABUSE COUNSELORS

APPLICANT'S NAME: _____

FORM B

**SUPERVISOR'S EXPERIENCE AND EDUCATION
(To be used by Licensed Professional listed below)**

Supervisor is licensed as one of the following:
(Please check the appropriate profession)

- | | |
|--|--|
| <input type="checkbox"/> Licensed Professional Counselor | <input type="checkbox"/> Licensed Clinical Psychologist |
| <input type="checkbox"/> Licensed Psychologist | <input type="checkbox"/> Licensed Clinical Social Worker |
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Registered Nurse |

WITH:

1. One year experience in substance abuse counseling (List substance abuse experience in the space below).

DATES OF EMPLOYMENT		PLACE OF EMPLOYMENT (Complete Address)	DUTIES	HOURS PER WEEK
FROM	TO			

AND

2. One hundred hours of didactic education in the following:

- Understanding the dynamics of human behavior;
- Signs and symptoms of substance abuse;
- Counseling and treatment approaches: (substance abuse research, group therapy and other adjunctive treatment and recovery support groups);
- Continuum of care and case management skills;
- Recovery process and relapse prevention methods; and
- Ethics and professional identity;

LIST SUBSTANCE ABUSE COURSES IN SPACE BELOW

COURSE	DATE	UNIVERSITY/PROGRAM/WORKSHOP	HOURS
			TOTAL HOURS:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE COMMONWEALTH OF VIRGINIA THAT THE FOREGOING IS TRUE AND CORRECT.

Supervisor's Signature

Date

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Department of Health Professions
COMMONWEALTH OF VIRGINIA

RENEWAL NOTICE AND APPLICATION

Board of

Telephone

TYPE OF RENEWAL

CURRENT EXPIRATION	RENEWAL PERIOD FROM TO	
CURRENT AMOUNT DUE \$	LATE PAYMENT PAY ONLY IF AFTER	

<p>INSTRUCTIONS</p> <ol style="list-style-type: none"> 1. Complete item 1 below if you do not wish to renew. 2. Make any address changes on this application when renewing. 3. Make any name changes on this application and enclose a copy of your marriage license or court order. 4. Note name and license number on all enclosures. 5. Return this application in the enclosed envelope.
<p>1. <input type="checkbox"/> Check here if you do not wish to renew, and sign below.</p> <p>_____</p> <p style="text-align: right;">Signature</p>

NUMBER:

MAKE CHECKS PAYABLE TO THE "TREASURER OF VIRGINIA"

C 37128

DEPARTMENT OF TRANSPORTATION
(COMMONWEALTH TRANSPORTATION BOARD)

the Virginia Code Commission Regulations allows regulations concerning state property or funds to be filed by description subject to the authorization of the Registrar of Regulations.

REGISTRAR'S NOTICE: The following regulations were filed by description with the Registrar of Regulations in accordance with § 2.3 of the Virginia Code Commission Regulations Implementing the Virginia Register Act. Section 2.3 of the Virginia Code Commission Regulations allows the Registrar to authorize the filing of a regulatory document by description in lieu of filing the entire text pursuant to criteria identified in that section.

Description:

The Underground Utility Policy establishes the conditions under which transportation funds shall be used to reimburse a portion of the additional cost involved to place overhead utility facilities underground in connection with new transportation improvement construction. The policy applies to projects for the urban system of highways which are created and constructed in accordance with § 33.1-44 of the Code of Virginia. It is elective to local jurisdictions, which must also satisfy other criteria.

Title of Regulation: 24 VAC 30-80-10. State Noise Abatement Policy.

Statutory Authority: § 33.1-12 of the Code of Virginia.

Effective Date: January 1, 1997.

Exemptions Claimed:

This regulation is exempt from the Administrative Process Act pursuant to § 9-6.14.4.1 B 3 of the Code of Virginia, which exempts agency action relating to the location, design, specifications or construction of public buildings or other facilities. Subdivision 2 e of § 2.3 of the Virginia Code Commission Regulations allows regulations concerning state property or funds to be filed by description subject to the authorization of the Registrar of Regulations.

Document available for inspection at the following location:

*Right of Way and Utilities Division
Virginia Department of Transportation
1401 East Broad Street, 5th Floor
Richmond, VA 23219*

VA.R. Doc. No. R97-173; Filed November 22, 1996, 3:42 p.m.

Description:

VDOT's Noise Abatement Policy sets forth the criteria and procedures used in determining the need for and the reasonableness and feasibility of noise abatement measures along Virginia's highways. The policy is based on the use of 23 CFR Part 772 as the guiding document for the analysis and abatement of highway traffic noise.

Document available for inspection at the following location:

*Environmental Division
Virginia Department of Transportation
1201 East Broad Street, 2nd Floor
Richmond, VA 23219*

VA.R. Doc. No. R97-174; Filed December 3, 1996, 2:01 p.m.

Title of Regulation: 24 VAC 30-210-10. Underground Utility Policy.

Statutory Authority: §§ 33.1-12, 33.1-44, and 33.1-96 of the Code of Virginia.

Effective Date: November 22, 1996.

Exemptions Claimed:

This regulation is exempt from the Administrative Process Act pursuant to § 9-6.14.4.1 B 3 of the Code of Virginia, which exempts agency action relating to the location, design, specifications or construction of public buildings or other facilities. Subdivision 2 e of § 2.3 of

EMERGENCY REGULATIONS

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulation: 12 VAC 30-90-10 et seq. **Methods and Standards for Establishing Payment Rates for Long-Term Care** (amending 12 VAC 30-90-10 and 12 VAC 30-90-290; adding 12 VAC 30-90-350, 12 VAC 30-90-360, and 12 VAC 30-90-370).

Statutory Authority: § 32.1-325 of the Code of Virginia and Item 322(D)(2) of Chapter 916 of the Virginia Acts of Assembly.

Effective Dates: December 2, 1996, through December 1, 1997.

Summary:

1. **REQUEST:** The Governor is hereby requested to approve this agency's adoption of the emergency regulation entitled Specialized Care Services Payment Methodology. This regulation will replace the current fixed per diem rate reimbursement system for all categories of specialized care with a prospective reimbursement system.

2. **RECOMMENDATION:** Recommend approval of the Department's request to take an emergency adoption action regarding Specialized Care Services Payment Methodology. The Department intends to initiate the public notice and comment requirements contained in the Code of Virginia § 9-6.14.7.1.

/s/ Joseph M. Teefey, Director
Date: November 13, 1996

3. **CONCURRENCES:**

/s/ Robert C. Metcalf
Secretary of Health and Human Resources
Date: November 25, 1996

4. **ACTION:**

/s/ George Allen
Governor
Date: November 27, 1996

5. **FILED:**

/s/ Jane D. Chaffin
Deputy Registrar of Regulations
Date: December 2, 1996

DISCUSSION

6. **BACKGROUND:** The sections of the State Plan affected by this action are Attachment 4.19D, Methods and Standards for Establishing Payment Rates for Long-Term Care (12 VAC 30-90-10); the Nursing Home Payment System Appendix III, Cost Reimbursement Limitations (12 VAC 30-90-290), Supplement 2 to Attachment 4.19D, Methods and Standards for Establishing Payment Rates for Specialized Care (12 VAC 30-90-350); Specialized Care Appendix I, Normalized Case Mix Index (12 VAC 30-90-360); and Specialized Care Appendix II, National RUG-III Categories and Weights (12 VAC 30-90-370).

On October 1, 1991, the Department of Medical Assistance Services (DMAS) implemented a new reimbursement system for nursing facilities based on patient care intensity and a new level of service, called specialized care. Specialized care was described as care required by residents who have long-term health conditions which demand close medical supervision, 24-hour licensed nursing care, and specialized services or equipment. For payment purposes, services for specialized care residents were grouped into four categories: Comprehensive Rehabilitation, Complex Care, Ventilator Dependent, and AIDS.

The Specialized Care program was DMAS' response to the need for access to care and the appropriate provision of services to those Medicaid recipients who required more intensive resources than average nursing facility residents. The DMAS Nursing Home Manual states that Specialized Care includes residents "...who have needs that are so intensive or non-traditional that they cannot be adequately captured by a patient intensity rating system, e.g., ventilator dependent or AIDS patients."

While Medicaid reimbursement for services for general nursing facility residents historically has been based on allowable cost data, DMAS had no cost data available in 1991 for this newer type of resident who required more resources and was becoming more prevalent in nursing facilities. Therefore, when rates were initially established for the specialized care categories, the per diem rates were statewide flat rates for each of the four categories.

Expenditures, utilization, and provider participation have increased dramatically since the inception of the Specialized Care program in 1991. Program statistics are available from FY93 forward and show total expenditures increasing from \$3.6 million in FY93 to over \$21 million in FY96, an increase of 496 percent in three years. The number of recipients served in FY93 was 205. By FY96 the number of recipients served (579) was almost three times greater. The number of providers participating in the Specialized Care program was ten in FY93 and by FY96 was 41, a fourfold increase in three years. During this time period, DMAS became increasingly concerned over the rapid expansion of expenditures, utilization, and provider participation. After careful analysis of the Specialized Care program, DMAS reported that the actual costs to providers of specialized care services appeared to be well below the flat rates that the providers were being reimbursed. Recommendations for reductions in the specialized care rates were submitted to the General Assembly. Hearings and discussions ensued between the legislature, DMAS and the provider community which resulted in the legislature mandating a formal study of the Specialized Care program.

The study group that was organized to evaluate the specialized care program included DMAS staff, representatives from industry trade associations (including the Virginia Health Care Association and the Virginia Hospital and Healthcare Association), and supporting staff from the Center for Health Policy Studies, commissioned by DMAS. The study group produced a report providing a comprehensive review of the existing Specialized Care program. The report examines resident and provider criteria governing participation in the Specialized Care program,

provides an overview of DMAS Utilization Review (UR) and Control guidelines and processes for specialized care providers, reviews Medicare and DMAS specialized care payment policies and issues for nursing facility services, and describes the new payment methodology developed for the Specialized Care program.

The report presents DMAS' recommendations for a collection of changes in the Specialized Care program. These recommendations include changes in specialized care categories and payment methodologies, and clarifications and changes in specialized care resident and provider criteria. These emergency regulations only address the recommendations for changes in specialized care categories and payment methodologies. Recommendations for changes in specialized care resident and provider criteria will be proposed through a separate policy and regulatory package.

Two recommended changes in the Specialized Care program are addressed by these emergency regulations.

First, DMAS recommends the elimination of the AIDS Care category. During site visits with specialized care providers, administrators and staff noted that their facilities serve very few people with AIDS (PWAs). The small number of PWAs who are served by specialized care providers typically qualify for the Complex Health Care category rather than for the AIDS Care category. In all of Virginia's nursing facilities that provide specialized care services, less than one percent of specialized care stays for both Fiscal Years 1995 and 1996 were for the AIDS Care category. In accordance with this recommendation, PWAs that qualify for the Complex Health Care Category will be served within that category.

Second, DMAS recommends the elimination of the current fixed per diem rate reimbursement structure for all categories of specialized care. The existing structure will be replaced by a prospective reimbursement system with final cost settlement. This methodology is similar to that applied to regular nursing facility services under the current nursing home payment system. The new reimbursement system will determine a specific rate for each specialized care provider. Prospective ceilings will be the weighted average (weighted by days) of specialized care rates presently in effect, net of a statewide average amount based on audited 1994 cost data for capital and ancillary costs that have been adjusted for inflation. A separate ceiling and separate rates would be used for qualifying distinct part pediatric units.

The proposed payment methodology will have the following major differences from the current Nursing Home Payment System (NHPS) for regular nursing facility services. First, ancillary costs (such as x-ray, lab, etc.) will be paid on a pass-through basis. Second, the operating ceiling will be adjusted by nine geographical areas, instead of the three areas used in the current NHPS. Use of the nine geographical areas is consistent with the Medicare payment methodology for nursing facilities. Third, the nursing cost component will be adjusted using the Resource Utilization Groups, Version III (RUG-III) nursing-only index score, instead of the existing Patient Intensity Rating System (PIRS) scoring system. The RUG-III system is a patient classification system for nursing facility residents that divides individuals into distinct groups using information collected from the Minimum Data Set (MDS) assessment instrument.

7. AUTHORITY TO ACT: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:4.1(C)(5), for an agency's adoption of emergency regulations subject to the Governor's prior approval. Subsequent to the emergency adoption action and filing with the Registrar of Regulations, this agency intends to initiate the public notice and comment process contained in Article 2 of the APA.

Chapter 916 of the 1996 Virginia Acts of Assembly, in Item 332(D)(2), requires DMAS to conduct a study of the Specialized Care program and develop rates for specialized care services. Upon conclusion of the study, DMAS is directed to implement the rates as determined in the study. The General Assembly adjusted DMAS' appropriations for the 1996-1998 biennium to account for the savings anticipated from the implementation of the new rate methodology.

Without an emergency regulation, this amendment to the State Plan cannot become effective until the publication and concurrent comment and review period requirements of the APA's Article 2 are met. Therefore, an emergency regulation is needed to meet the December 1, 1996 effective date necessary to achieve the savings established by the General Assembly.

8. NEED FOR EMERGENCY ACTION: The Code § 9-6.14:4.1(C)(5) provides for regulations which an agency finds are necessitated by an emergency situation. To enable the Director, in lieu of the Board of Medical Assistance Services, to comply with Chapter 916 of the 1996 Virginia Acts of Assembly, Item 322 (D)(2), he is to implement a new payment methodology for specialized care services. This issue qualifies as an emergency regulation as provided for in § 9-6.14:4.1(C)(5)(ii), because the Virginia appropriation act requires this regulation be effective within 280 days from the enactment of the law. As such, this regulation may be adopted without public comment with the prior approval of the Governor. Since this emergency regulation will be effective for no more than 12 months and the Director wishes to continue regulating the subject entities, the Department is initiating the Administrative Process Act Article 2 procedures.

9. FISCAL/BUDGETARY IMPACT:

During FY 1996, specialized care services were provided by 41 nursing facilities to 579 Medicaid recipients, and accounted for approximately \$21.6 million in expenditures. Most recipients are served under the Complex Health Care category, which accounted for 67% of all specialized care stays during FY 1996. The program demonstrated sharp growth in recipient utilization, provider participation, and expenditures between Fiscal Years 1993 and 1995, although the rate of growth slowed considerably in FY 1996.

Expenditures for the program are unevenly distributed among the participating facilities. For FY 1996, three of the 41 participating facilities accounted for one-third of the program

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expenditures. Specialized care also represents one of the most expensive services provided by Medicaid, on a per-individual basis. Residents with continuous specialized care stays account for annual expenditures of nearly \$150,000 per resident.

It is estimated that implementation of the reimbursement changes will result in \$5 to \$6 million (total funds) savings in calendar year 1997 (the first full year of implementation). This estimate is very approximate, because the case mix and service volume data necessary for an accurate estimate are not yet available. Changes in provider billing practices that were necessary to bring the program into compliance with federal requirements were implemented August 1, 1996. These changes reinforced the requirement that Medicaid must be considered the payor of last resort. It is estimated that these changes may yield another \$2 to \$3 million (total funds) savings per year. Therefore, the combined estimated savings, based on data currently available, is \$7 to \$9 million per year (total funds). This estimate is very tentative and will be verified before January 1997.

Based on the above estimates, and the different implementation dates of the two policy changes described above, the present estimate of fiscal impact, by state fiscal year, is as follows:

	GF	NGF	TOTAL
SFY 1997	\$3.1 million	\$3.2 million	\$6.3 million
SFY 1998	\$4.4 million	\$4.6 million	\$9.0 million

There are no localities which are uniquely affected by these regulations as they apply statewide.

10. RECOMMENDATION: Recommend approval of this request to adopt this emergency regulation to become effective December 1, 1996. From its effective date, this regulation is to remain in force for one full year or until superseded by final regulations promulgated through the APA. Without an effective emergency regulation, the Department would lack the authority to implement the Specialized Care Services Payment Methodology changes and achieve the necessary savings directed by the General Assembly.

11. APPROVAL SOUGHT for 12 VAC 30-90-10, 12 VAC 30-90-290, and 12 VAC 30-90-350 through 12 VAC 30-90-370.

Approval of the Governor is sought for an emergency modification of the Medicaid State Plan in accordance with the Code of Virginia § 9-6.14:4.1(C)(5) to adopt the following regulation:

12 VAC 30-90-10. Methods and standards for establishing payment rates for long-term care.

The policy and the method to be used in establishing payment rates for nursing facilities listed in § 1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs.

- a. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan to the extent these are available to the general population.

- b. Participation in the Program will be limited to providers of services who accept, as payment in full, the amounts so paid.

- c. Payment for care of service will not exceed the amounts indicated to be reimbursed in accord with the policy and the methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.253(b)(2). The state agency has continuing access to data identifying the maximum charges allowed. Such data will be made available to the Secretary, HHS, upon request.

- d. Payments for services to nursing facilities shall be on the basis of reasonable cost in accordance with the standards and principles set forth in 42 CFR 447.252 as follows:

- (1) A uniform annual cost report which itemizes allowable cost will be required to be filed within 90 days of each provider's fiscal year end.

- (2) The determination of allowable costs will be in accordance with Medicare principles as established in the Provider Reimbursement Manual (PRM-15) except where otherwise noted in this Plan.

- (3) Field audits will be conducted on the cost data submitted by the provider to verify the accuracy and reasonableness of such data. Audits will be conducted for each facility on a periodic basis as determined from internal desk audits and more often as required. Audit procedures are in conformance with SSA standards set forth in PRM-13-2. Internal desk audits are conducted annually within six months of receipt of a completed cost report from the provider.

- (4) Reports of field audits are retained by the state agency for at least three years following submission of the report.

- (5) Facilities are paid on a cost-related basis in accordance with the methodology described in the Plan.

- (6) Modifications to the Plan for reimbursement will be submitted as Plan amendments.

- (7) Covered cost will include such items as:

- (a) Cost of meeting certification standards.

- (b) Routine services which include items expense providers normally incur in the provision of services.

- (c) The cost of such services provided by related organizations except as modified in the payment system at 12 VAC 30-90-20 et seq.

- (8) Bad debts, charity and courtesy allowances shall be excluded from allowable cost.

- (9) Effective for facility cost reporting periods beginning on or after October 1, 1978, the reimbursable amount will be determined prospectively on a facility by facility basis, except that mental institutions and mental retardation facilities shall continue to be reimbursed retrospectively. The

prospective rate will be based on the prior period's actual cost (as determined by an annual cost report and verified by audit as set forth in subsection d (3) above) plus an inflation factor. Payments will be made to facilities no less than monthly.

(10) The payment level calculated by the prospective rate will be adequate to reimburse in full such actual allowable costs that an economically and efficiently operated facility must incur. In addition, an incentive plan will be established as described in the payment system at 12 VAC 30-90-20 et seq.

(11) Upper limits for payment within the prospective payment system shall be as follow:

(a) Allowable cost shall be determined in accordance with Medicare principles as defined in PRM-15, except as may be modified in this plan.

(b) Reimbursement for operating costs will be limited to regional ceilings.

(c) Reimbursement, in no instance, will exceed the charges for private patients receiving the same services. In accordance with § 1903(a)(2)(B) of the Social Security Act, nursing facility costs incurred in relation to training and competency evaluation of nurse aides will be considered as State administrative expenses and, as such, shall be exempted from this provision.

(12) In accordance with 42 CFR 447.205, an opportunity for public comment was permitted before final implementation of rate setting processes.

(13) A detailed description of the prospective reimbursement formula is attached for supporting detail.

(14) Item 398D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

e. Reimbursement of non-enrolled long term care facilities.

(1) Non-enrolled providers of institutional long term care services shall be reimbursed based upon the average per diem cost, updated annually, reimbursed to enrolled nursing facility providers.

(2) Prior approval must be received from the DMAS for recipients to receive institutional services from non-enrolled long-term care facilities. Prior approval can only be granted:

(a) When the non-enrolled long term care facility with an available bed is closer to the recipient's Virginia residence than the closest facility located in Virginia with an available bed, or

(b) When long term care special services, such as intensive rehabilitation services, are not available in Virginia, or

(c) If there are no available beds in Virginia facilities.

f. ~~Specialized Care Services.~~ Nothing in this regulation is intended to preclude DMAS from reimbursing for specialized care services, such as rehabilitation, ventilator dependent, and AIDS services. ~~Specialized care services shall be provided to patients requiring, but not necessarily limited to, rehabilitation, complex healthcare, ventilator dependent and AIDS services.~~

(1) ~~Reimbursement for rehabilitation, complex healthcare, and ventilator dependent services shall be determined by using as the base period allowable per diem rate the FY 1990 average per diem rate of freestanding rehabilitation hospitals, inpatient rehabilitation units of acute care hospitals and long-stay hospitals which are providing rehabilitation services, averaged with the per diem bids of nursing facilities proposing to provide such services and obtained during the same time period.~~

(2) ~~Reimbursement for services to individuals with AIDS shall be determined by using as the base period allowable per diem rate for FY 1990 skilled facility rate plus the estimated cost of additional services uniquely necessary to the care of AIDS patients. These additional services are nursing services, non-nutritional supplies required for the care of AIDS patients, psychological services, and nutritional elements.~~

(3) ~~The rates will be updated on or about July 1 each year based on the previous 12 months historical inflation. The allowance for inflation shall be based on the percent of change in the moving average of the Skilled Nursing Facility Market Basket of Routine Service Cost, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the first quarter each year.~~

12 VAC 30-90-290. Cost reimbursement limitations (Appendix III).

A. Foreword. The attached information outlines operating, NATCEPs and plant cost limitations that are not referenced in previous sections of these regulations.

All of the operating cost limitations are further subject to the applicable operating ceilings.

B. Directors' fees.

1. Although Medicaid does not require a board of directors (Medicare requires only an annual stockholders' meeting), the Program will recognize reasonable costs for directors' meetings related to patient care.

2. It is not the intent of DMAS to reimburse a facility for the conduct of business related to owner's investments, nor is it the intent of the Program to recognize such costs in a closely held corporation where one person owns all stock, maintains all control, and approves all decisions.

3. To receive reimbursement for directors' meetings, the written minutes must reflect the name of the facility for which the meeting is called, the content and purpose of the meeting, members in attendance, the time the meeting began and ended, and the date. If multiple facilities are discussed during a meeting, total allowable

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director fees, as limited herein, shall be pro-rated between such facilities.

4. Bona fide directors may be paid an hourly rate of \$125 up to a maximum of four hours per month. These fees include reimbursement for time, travel, and services performed.

5. Compensation to owner/administrators who also serve as directors, shall include any and director's fees paid, subject to the above referenced limit these set forth in these regulations.

C. Membership fees.

1. These allowable costs will be restricted to membership in health care organizations and appropriate professional societies which promote objectives in the provider's field of health care activities.

2. Membership fees in health care organizations and appropriate professional societies will be allowed for the administrator, owner, and home office personnel.

3. Comparisons will be made with other providers to determine reasonableness of the number of organizations to which the provider will be reimbursed for such membership and the claimed costs, if deemed necessary.

D. Management fees.

1. External management services shall only be reimbursed if they are necessary, cost effective, and nonduplicative of existing NF internal management services.

2. Costs to the provider, based upon a percentage of net and/or gross revenues or other variations thereof, shall not be an acceptable basis for reimbursement. If allowed, management fees must be reasonable and based upon rates related to services provided.

3. Management fees paid to a related party may be recognized by the Program as the owner's compensation subject to administrator compensation guidelines.

4. A management fees service agreements exists when the contractor provides nonduplicative personnel, equipment, services, and supervision.

5. A consulting service agreement exists when the contractor provides nonduplicative supervisory or management services only.

6. Limits will be based upon comparisons with other similar size facilities and/or other DMAS guidelines and information.

Effective for all providers' cost reporting periods ending on or after October 1, 1990, a per patient day ceiling for all full service management service costs shall be established. The ceiling limitation for cost reporting periods ending on or after October 1, 1990, through December 31, 1990, shall be the median per patient day cost as determined from information contained in the most recent cost reports for all providers with fiscal years ending through December 31, 1989. These limits will be

adjusted annually by a Consumer Price Index effective January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually.

E. Pharmacy consultants fees. Costs will be allowed to the extent they are reasonable and necessary.

F. Physical therapy fees (for outside services). Limits are based upon current PRM-15 guidelines.

G. Inhalation therapy fees (for outside services). Limits are based upon current PRM-15 guidelines.

H. Medical directors' fees. Costs will be allowed up to the established limit per year to the extent that such fees are determined to be reasonable and proper. This limit will be escalated annually by the CPI-U January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually. The following limitations apply to the time periods as indicated:

Jan. 1, 1988 - Dec. 31, 1988	\$6,204
Jan. 1, 1989 - Dec. 31, 1989	\$6,625

I. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

J. Personal automobile.

1. Use of personal automobiles when related to patient care will be reimbursed at the maximum of the allowable IRS mileage rate when travel is documented.

2. Flat rates for use of personal automobiles will not be reimbursed.

K. Seminar expenses. These expenses will be treated as allowable costs, if the following criteria are met:

1. Seminar must be related to patient care activities, rather than promoting the interest of the owner or organization.

2. Expenses must be supported by:

a. Seminar brochure,

b. Receipts for room, board, travel, registration, and educational material.

3. Only the cost of two persons per facility will be accepted as an allowable cost for seminars which involve room, board, and travel.

L. Legal retainer fees. DMAS will recognize legal retainer fees if such fees do not exceed the following:

BED SIZE	LIMITATIONS
0 - 50	\$100.00 per month
51 - 100	\$150.00 per month

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101 - 200	\$200.00 per month
201 - 300	\$300.00 per month
301 - 400	\$400.00 per month

The expense to be allowed by DMAS shall be supported by an invoice and evidence of payment.

M. Architect fees. Architect fees will be limited to the amounts and standards as published by the Virginia Department of General Services.

N. Administrator/owner compensation.

DMAS ADMINISTRATOR/OWNER COMPENSATION SCHEDULE

JANUARY 1, 1989 - DECEMBER 31, 1989

BED SIZE	NORMAL ALLOWABLE FOR ONE ADMINISTRATOR	MAXIMUM FOR 2 OR MORE ADMINISTRATORS
1 - 75	32,708	49,063
76 - 100	35,470	53,201
101 - 125	40,788	61,181
126 - 150	46,107	69,160
151 - 175	51,623	77,436
176 - 200	56,946	85,415
201 - 225	60,936	91,399
226 - 250	64,924	97,388
251 - 275	68,915	103,370
276 - 300	72,906	108,375
301 - 325	76,894	115,344
326 - 350	80,885	121,330
351 - 375	84,929	127,394
376 & over	89,175	133,763

These limits will be escalated annually by the CPI-U effective January 1 of each calendar year to be effective for all provider's cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually.

O. Kinetic therapy. For specialized care reimbursement effective January 1, 1997, a limitation per patient day on kinetic therapy shall be established. This limit shall be reviewed annually by January 1 of each calendar year, and revised if appropriate, to be effective for all providers' cost reporting periods ending on or after that date. The limit will be published and distributed to providers annually. It shall be:

January 1, 1997 - December 1, 1997 \$102.00 per day

12 VAC 30-90-350. Specialized care services.

Specialized care services provided in conformance with Attachment 3.1 C, § 2.0(C) (12 VAC 30-60-40) (5) and (8), and Supplement 1 to Attachment 3.1-C, Parts II and III (12 VAC 30-60-320 and 12 VAC 30-60-340) shall be reimbursed under the following methodology. The nursing facilities (NFs) that provide adult specialized care for the categories of Ventilator Dependent Care, Comprehensive Rehabilitation Care, and Complex Health Care will be placed in one group for rate determination. The NFs that provide pediatric specialized care in a dedicated pediatric unit of 8 beds or more will be placed in a second group for rate determination.

1. *Routine Operating Cost:* Routine operating cost shall be defined as in the Nursing Home Payment System (NHPS) Appendix I (12 VAC 30-90-270), § 2.1 A and B, and § 3.1. To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days.

2. *Allowable Cost Identification and Cost Reimbursement Limitations:* The provisions of the NHPS Article 3 (12 VAC 30-90-50) and of NHPS Appendix III (12 VAC 30-90-290) shall apply to specialized care cost and reimbursement.

3. *Routine Operating Cost Rates:* Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in § 2.7 of the NHPS (12 VAC 30-90-40).

4. *Facility-Specific Prospective Routine Operating Ceiling:* Each NF's prospective routine operating ceiling shall be calculated as:

(a) *Statewide Ceiling:* The statewide routine operating ceiling shall be the weighted average (weighted by 1994 days) of specialized care rates in effect on July 1, 1996, reduced by statewide weighted average ancillary and capital cost per day amounts based on audited 1994 cost data from the twelve facilities whose 1994 FY specialized care costs were audited during 1996. This routine operating ceiling amount shall be adjusted for inflation by the percent of change in the moving average of the Virginia specific Skilled Nursing Facility Market Basket Of Routine Service Costs, as developed by DRI/McGraw-Hill, using the second quarter 1996 DRI table. The respective statewide operating ceilings will be adjusted each quarter in which the provider's most recent fiscal year ends, by adjusting the most recent interim ceiling by 100% of historical inflation and 50% of forecasted inflation to the end of the provider's next fiscal year.

(b) The portion of the statewide routine operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for Skilled Nursing Facilities, divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the Health Care Financing Administration (HCFA) publishes wage indices for skilled nursing facilities (SNFs). Updated normalization shall be effective for fiscal years starting on and after the January 1, for which the normalization is calculated.

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(c) The percentage of the statewide routine operating ceiling relating to the Nursing Labor and Non-Labor costs (as determined by the 1994 audited cost report data or 71.05%) will be adjusted by the NF's specialized care average Resource Utilization Groups, Version III (RUG-III) Nursing-Only Normalized Case Mix Index (NCMI). The NCMI for each NF will be based on all specialized care patient days rendered during the six month period prior to that in which the ceiling applies (see 6 below).

5. **Normalized Case Mix Index (NCMI):** Case mix shall be measured by RUG-III nursing-only Index scores based on Minimum Data Set (MDS) data. The RUG-III nursing-only weights developed at the national level by the Health Care Financing Administration (HCFA) (see Appendix II) shall be used to calculate a facility-specific case mix index (CMI). The facility-specific CMI, divided by the statewide CMI shall be the facility's NCMI. The steps in the calculation are as follows:

(a) The facility-specific CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all patient days in the facility during the six months prior to the six month period to which the NCMI shall be applied to the facility's routine operating cost and ceiling.

(b) The statewide CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all specialized care patient days in all Specialized Care NFs in the state during the six months prior to the six month period to which the NCMI shall be applied. A new statewide CMI shall be calculated for each six month period for which a provider-specific rate must be set.

(c) The facility-specific NCMI for purposes of this rate calculation shall be the facility-specific CMI from (a) above divided by the statewide CMI from (b) above.

(d) Each facility's NCMI shall be updated semi-annually, at the start and the midpoint of the facility's fiscal year.

(e) Patient days for which the lowest RUG-III weight is imputed, as provided in 14(c) below, shall not be included in the calculation of the NCMI.

6. **Facility-specific prospective routine operating base cost per day:** The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted (using DRI-Virginia inflation factors) by 50% of historical inflation and 50% of the forecasted inflation, and adjusted for case mix as described below:

(a) An NCMI rate adjustment shall be applied to each facility's prospective routine nursing labor and non-labor operating base cost per day for each semi-annual period of the facility's fiscal year.

(b) The NCMI calculated for the second semi-annual period of the previous fiscal year shall be divided by

the average of that (previous) fiscal year's two semi-annual NCMI's to yield an "NCMI cost rate adjustment" to the prospective nursing labor and non-labor operating cost base rate in the first semi-annual period of the subsequent fiscal year.

(c) The NCMI determined in the first semi-annual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's two semi-annual NCMI's to determine the NCMI cost rate adjustment to the prospective nursing labor and non-labor operating base cost per day in the second semi-annual period of the subsequent fiscal year.

See Appendix I (12 VAC 30-90-360) for an illustration of how the NCMI is used to adjust routine operating cost ceilings and semi-annual NCMI adjustments to the prospective routine operating base cost rates.

7. **Interim rates:** Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report and Minimum Data Set (MDS) data available at the time the interim rates must be set, except that failure to submit cost and MDS data timely may result in adjustment to interim rates as provided elsewhere.

8. **Ancillary Costs:** Specialized care ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:

(a) All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. See NHPS Appendix III (12 VAC 30-90-290) for the cost reimbursement limitations.

(b) Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See Appendix III (12 VAC 30-90-290) for the cost reimbursement limitations.

(c) Kinetic therapy devices will be reimbursed only if a resident is being treated for wounds that meet specialized care Complex Health Care Category wound care criteria. Residents receiving this wound care must require kinetic bed therapy (that is, low air loss mattresses, fluidized beds, and/or rotating/turning beds) and require treatment for a grade (stage) IV decubitus, a large surgical wound that can not be closed, or second to third degree burns covering more than 10% of the body.

9. **Covered ancillary services** are defined as follows: laboratory, X-ray, medical supplies (e.g., infusion pumps, incontinence supplies), physical therapy, occupational therapy, speech therapy, inhalation therapy, IV therapy, enteral feedings, and kinetic therapy. The following are not specialized care ancillary services and are excluded from specialized care reimbursement: physician services, psychologist services, total parenteral nutrition (TPN), and drugs. These services must be separately billed to DMAS. An interim rate for the covered ancillary

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services will be determined (using data from the most recent settled cost report) by dividing allowable ancillary costs by the number of patient days for the same cost reporting period. The interim rate will be retroactively cost settled based on the specialized care NF cost reporting period.

10. **Capital Costs (excluding pediatric specialized care units):** Capital cost reimbursement shall be in accordance with the current NHPS, except that the 95% (85% if applicable) occupancy requirement shall not be separately applied to specialized care. Capital cost related to specialized care patients will be cost settled on the respective NF's cost reporting period. In this cost settlement the 95% (85% if applicable) occupancy requirement shall be applied to all the NF's licensed NF beds inclusive of specialized care. An occupancy requirement of 70% shall be applied to distinct part pediatric specialized care units.

11. **Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEP) costs:** NATCEPS costs will be paid on a pass-through basis in accordance with the current NHPS.

12. **Pediatric Routine Operating Cost Rate:** For pediatric specialized care in a distinct part pediatric specialized care unit, one routine operating cost ceiling will be developed. The routine operating cost ceiling will be computed as follows:

(a) The Complex Health Care Payment Rate effective July 1, 1996, and updated for inflation, will be reduced by (1) the weighted average capital cost per day developed from the 1994 audit data and (2) the weighted average ancillary cost per day from the 1994 audit data updated for inflation in the same manner as described in 4(a) above.

(b) The state-wide operating ceiling shall be adjusted for each NF in the same manner as described in 4 and 5 above.

(c) The final routine operating cost reimbursement rate shall be computed as described for other than pediatric units in 3 above.

13. **Pediatric Unit Capital Cost.** Pediatric unit capital costs will be reimbursed in accordance with the current NHPS, except that the occupancy requirement shall be 70% rather than 95% or 85%. An interim capital rate will be calculated from the latest cost report and retrospectively cost settled on the respective specialized care provider's cost reporting period.

14. **MDS Data Submission:** MDS data relating to specialized care patients must be submitted to the Department in a submission separate from that which applies to all NF patients.

(a) Within thirty days of the end of each month, each specialized care NF shall submit to the Department, separately from its submission of MDS data for all patients, a copy of each MDS Version 2.0 which has been completed in the month for a Medicaid

specialized care patient in the NF. This shall include 1) the MDS required within 14 days of admission to the NF (if the patient is admitted as a specialized care patient), 2) the one required by the Department upon admission to Specialized Care, 3) the one required within 12 months of the most recent full assessment, and 4) the one required whenever there is a significant change of status.

(b) In addition to the monthly data submission required in (a) above, the same categories of MDS data required in (a) above shall be submitted for all patients receiving specialized care from January 1, 1996, through December 31, 1996, and shall be due February 28, 1997.

(c) If a provider does not submit a complete MDS record for any patient within the required timeframe, the Department shall assume that the RUG-III weight for that patient, for any time period for which a complete record is not provided, is the lowest RUG-III weight in use for specialized care patients. A complete MDS record is one that is complete for purposes of transmission and acceptance by the Health Care Financing Administration.

15. **Case mix Measures in the Initial Semi-Annual Periods:** In any semi-annual periods for which calculations in Appendix I (12 VAC 30-90-360) requires an NCMI from a semi-annual period beginning before January 1996, the case mix used shall be the case mix applicable to the first semi-annual period beginning after January 1, 1996, that is a semi-annual period in the respective provider's fiscal period. For example, December year end providers' rates applicable to the month of December 1996, would normally require (in Appendix I) an NCMI from July to December 1995, and one from January to June 1996, to calculate a rate for July to December 1996. However, because this calculation requires an NCMI from a period before January 1996, the NCMI's that shall be used will be those applicable to the next semi-annual period. The NCMI from January to June 1996, and from July to December 1996, shall be applied to December 1996, as well as to January to June 1997. Similarly, a provider with a March year end would have its rate in December 1996, through March 1997, calculated based on an NCMI from April through September 1996, and October 1996, through March 1997.

16. Cost reports of specialized care providers are due not later than 150 days after the end of the provider's fiscal year. Except for this provision, the requirements of Articles 5 and 6 (12 VAC 30-90-70 and 12 VAC 30-90-80) of the NHPS shall apply.

12 VAC 30-90-360. Normalized Case Mix Index (NCMI).

The following is an illustration of how a specialized care provider's Normalized Case Mix Index (NCMI) is used to adjust the prospective routine operating cost base rate and prospective operating ceiling.

A. Assumptions.

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1. The NF's fiscal years are December 31, 1996 and December 31, 1997.

2. The average allowable routine nursing labor and non-labor base rate for December 31, 1996 is \$205.

3. The average allowable indirect patient care operating base rate for December 31, 1996 is \$90.

4. The allowance for inflation is 3% for the fiscal year end beginning January 1, 1997.

5. The NF's statewide ceiling for the fiscal year end beginning January 1, 1997 is \$300.

6. The NF's normalized HCFA nursing wage index is 1.0941 for the fiscal year end beginning January 1, 1997.

7. The NF's semi-annual normalized NCMIs are as follows:

1996 First Semi-Annual NCMI	1.2000
1996 Second Semi-Annual NCMI	1.2400
1997 First Semi-Annual NCMI	1.2600

B. Calculation of NF's Operating Ceiling.

1. Period January 1, 1997 through June 30, 1997.

FYE 1997 Statewide ceiling		\$300
Nursing Labor Component Percentage	67.22%	\$201.66
Normalized Wage Index	x 1.0941	
Adjusted Nursing Labor Ceiling Component		\$220.64
Nursing Non-Labor Ceiling Component		\$ 11.49
Adjusted Nursing Labor and Non-Labor Ceiling		\$232.13
FYE 1996 Second Semi-Annual NCMI	x 1.2400	\$287.84
Indirect Patient Care Ceiling Component	(\$300.00 - 201.66 - 11.49) + 86.85	
Total Facility Operating Ceiling		\$374.69

2. Period July 1, 1997 through December 31, 1997.

Adjusted Nursing Labor and Non-Labor Ceiling per B.1. above		\$232.13
FYE 1997 First Semi-Annual NCMI	x 1.2600	\$292.48
Indirect Patient Care Ceiling Component	+ 86.85	
Total Facility Operating Ceiling		\$379.33

C. Calculation of NF's Prospective Operating Cost Rate.

1. Prospective Operating Cost Base Rate.

FYE 1996 Nursing Labor and Non-Labor Operating Base Rate		\$205
Allowance for Inflation - FYE 1997	x 1.03	
Prospective Nursing Labor and Non-Labor Cost Rate		\$211.15
FYE 1996 Indirect Patient Care Operating Base Rate		\$ 90.00
Allowance for Inflation - FYE 1997	x 1.03	
Prospective Indirect Patient Care Operating Cost Rate		92.70

2. Calculation of FYE 1996 Average NCMI.

First Semi-Annual Period NCMI	1.200
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Second Semi-Annual Period NCMI	1.240
Average FYE 1996 NCMI	1.220

3. Calculation of FYE 1997 NCMI Rate Adjustments.

a. Rate adjustment for the period January 1, 1997 through June 30, 1997.

1996 Second Semi-Annual NCMI		1.2400
1996 Average NCMI (from C 2)		1.2200
Calculation:	1.2400/1.2200	
Rate Adjustment Factor	1.0164	
Prospective Nursing Labor and Non-Labor Operating Cost Base Rate (from C 1)		211.15
	x 1.0164	214.61
Prospective Indirect Patient Care Operating Cost Rate (from C 1)	+ 92.70	
Total Prospective Operating Cost Rate		\$307.31

b. Rate Adjustment for the Period July 1, 1997 through December 31, 1997.

1997 First Semi-Annual NCMI		1.2600
1996 Average NCMI (From C 2)		1.2200
Calculation:	1.2600/1.2200	
Rate Adjustment Factor	1.0328	
Prospective Nursing Labor and Non-Labor Operating Cost Rate (From C 1)		\$211.15
Rate Adjustment Factor	x 1.0328	
Prospective Indirect Patient Care Operating Cost Rate (from C 1)	+ 92.70	
Total Prospective Operating Cost Rate		\$310.78

D. In this illustration the NF's Operating Reimbursement Rate for FYE 1997 would be as follows:

1. For the period January 1, 1997, through June 30, 1997, the operating reimbursement rate would be \$307.31 since the prospective operating cost rate is lower than the NF's NCMI adjusted ceiling of \$374.69 (from B 1)

2. For the period July 1, 1997, through December 31, 1997, the operating reimbursement rate would be \$310.78 since the prospective operating cost rate is lower than the NF's NCMI adjusted ceiling of \$379.33 (from B 2)

12 VAC 30-90-370. National RUG-III Categories and Weights

National RUG-III Categories and Weights			
RUG-III Category	Group Code	Final Placement Criteria	Nursing Only Weights
Extensive Services	SE3	3 treatments	3.97
	SE2	2 treatments	2.65
	SE1	1 treatment	1.78

Emergency Regulations

<i>Extensive Services</i>	SE3	3 treatments	3.97
	SE2	2 treatments	2.65
	SE1	1 treatment	1.78
<i>Special Care</i>	SSC	ADLs 17-18	1.61
	SSB	ADLs 14-15	1.47
	SSA	ADLs 7-13	1.28
<i>Clinically Complex</i>	CD2	ADLs 17-18, Depressed	1.46
	CD1	ADLs 17-18, Not depressed	1.37
	CC2	ADLs 11-15, Depressed	1.19
	CC1	ADLs 11-15, Not depressed	1.16
	CB2	ADLs 5-10, Depressed	1.08
	CB1	ADLs 5-10, Not depressed	0.94
	CA2	ADLs 4-5, Depressed	0.76
	CA1	ADLs 4-5, Not depressed	0.67
<i>Special Rehabilitation</i>	RVC	Weekly therapy = 450 minutes or more, ADLs 14-18	1.79
	RVB	Weekly therapy = 450 minutes or more, ADLs 8-13	1.18
	RVA	Weekly therapy = 450 minutes or more, ADLs 4-7	0.82

VA.R. Doc. No. R97-168; Filed December 2, 1996, 11:48 a.m.

DOCUMENTS INCORPORATED BY REFERENCE

PRM-13 (Medicare Intermediary Manual HCFA Pub 13), U.S. Government Printing Office, May 1996.

PRM-15 (Provider Reimbursement Manual), U.S. Government Printing Office, June 1996.

STATE CORPORATION COMMISSION

DIVISION OF ENERGY REGULATION

AT RICHMOND, NOVEMBER 12, 1996

COMMONWEALTH OF VIRGINIA, ex rel.

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. PUE950089

Ex Parte: In the matter of reviewing and considering Commission policy regarding restructuring of and competition in the electric utility industry

ORDER

By Order entered September 18, 1995, in this proceeding, the Commission directed the Staff to continue and expand its investigation of current issues related to potential restructuring in the electric industry and to file a report on its observations and recommendations. All investor-owned electric utilities and electric cooperatives were made parties to the proceeding and directed to respond to the Staff's requests for information. Interested parties were invited to file written comments and requests for oral argument in response to the Staff Report.

The Staff filed its report on July 31, 1996. Comments have been received from a number of parties, filed both before and after filing of the Staff Report, and several parties requested oral argument. However, as the Staff Report constitutes only the initial stage of what will be an extended evolutionary process, and the scope of the issues addressed herein is limited, oral argument is premature at this time.

We believe that significantly more evaluation is necessary to determine what, if any, restructuring may best serve the public interest in Virginia. To facilitate such evaluation, Staff made various recommendations that will require consideration of utility-specific data relevant to potential changes in the electric industry.

Accordingly, we are establishing by separate orders new dockets directing certain investor-owned electric utilities to provide information relevant to Recommendations Nos. 1, 2, 3, 4, 6 and 13 of the Staff Report. The requested information and analyses address: cost-of-service studies; illustrative tariffs reflecting unbundled rates for generation, transmission and distribution functions; means of improving price signals to customers; determining reserve margins, future incremental capacity needs and capacity solicitation processes; and conservation and load management programs. In addition, all investor-owned utilities were directed to file with the Commission copies of any filings made with federal or other state regulatory bodies that relate to any of the recommendations in the Staff Report or to alternative forms of regulation.

Although we are not instituting separate proceedings for electric cooperatives at this time, similar proceedings may be required of cooperatives in the future. Moreover, any cooperative proposing an alternative form of regulation

should be prepared to address the Staff recommendations outlined above.

In addition to the data to be filed by certain companies in the above-referenced proceedings, all investor-owned electric utilities and cooperatives that have non-utility generation that impacts their Virginia jurisdictional rates are directed to file, by June 1, 1997, a report detailing their efforts to restructure contracts with non-utility generators ("NUGs") to mitigate their potentially negative effect on current and future rates. Each utility shall also subsequently file quarterly reports detailing its continuing efforts in this area.

Staff recommendations also stated the need for monitoring certain aspects of the electric industry to better assess particular restructuring and competition issues. Areas identified by Staff warranting closer inspection include developments in the wholesale power market, retail wheeling experiments of other states and electric utility service quality.

We believe that the information derived from monitoring such activities will be valuable in considering possible restructuring alternatives. Staff, therefore, is directed to monitor developments in the wholesale power market and evaluate wholesale competition and its impact and potential impact on Virginia's utilities. Staff shall file a report of its findings by June 1, 1997, and shall file reports thereafter as necessary.

Staff is further directed to prepare a report by September 1, 1997, on the results of retail wheeling experiments and activities in other states. Staff shall make appropriate recommendations based upon its study.

Also, Staff shall report by July 1, 1997, on whether, and if so, how to increase monitoring of electric utility service quality. Staff's recommendations should address whether the Commission should establish service quality standards.

Accordingly, IT IS ORDERED THAT:

(1) On or before June 1, 1997, each investor-owned electric utility and electric cooperative that has non-utility generation that impacts its Virginia jurisdictional rates shall file a report on its efforts to renegotiate its NUG contracts as appropriate and shall thereafter file similar reports quarterly;

(2) The Commission Staff shall continue to monitor developments in the wholesale power market and file a report as outlined above on or before June 1, 1997. Staff shall file reports thereafter as necessary;

(3) On or before September 1, 1997, Staff shall file a report on the retail wheeling experiments of other states and make appropriate recommendations;

(4) On or before July 1, 1997, Staff shall file a report recommending whether, and if so, how to increase monitoring of electric utility service quality; and

(5) This matter shall be continued generally until further order of the Commission.

AN ATTESTED COPY of this Order shall be sent by the Clerk of the Commission to: all Virginia Electric Cooperatives and Electric Utilities as set out in Appendix A to this Order; the additional service list attached as Appendix B to this

Order; Philip F. Abraham, Esquire, Hazel & Thomas, P.C., P.O. Box 788, Richmond, Virginia 23206; John A. Pirko, Esquire, LeClair Ryan, 4201 Dominion Boulevard, #200, Glen Allen, Virginia 23060; Donald R. Hayes, Esquire, Washington Gas Light Company, 1100 H. Street, N.W., Washington, D.C. 20080; James L. Dobson, CFA, Donaldson, Lufkin & Jenrette, 140 Broadway, New York, New York 10005; James E. Franklin, Cogentrix Energy, Inc., 9405 Arrowpoint Boulevard, Charlotte, North Carolina 28273-8110; Lisa J. Gefen, Allied Signal, Inc., 6 Eastmans Road, Parsippany, New Jersey 07054; Michael A. Stosser, Esquire, Heller, Ehrman, White & McAuliffe, 895 15th Street, N.W., #610, Washington, D.C. 20005; Eric R. Todderud, Esquire, Heller, Ehrman, White & McAuliffe, 200 S.W. Market Street, #1750, Portland, Oregon 97201; Jean Ann Fox, President, Virginia Citizens Consumer Counsel, 114 Coachman Drive, Yorktown, Virginia 23693; Edward L. Petrini, Esquire, Office of the Attorney General, Division of Consumer Counsel, 900 East Main Street, Richmond, Virginia 23219; Dennis R. Bates, Esquire, Office of Fairfax County, 12000 Government Center Parkway, #549, Fairfax, Virginia 22035-0064; Wayne S. Leary, Peat Energy, Inc., P.O. Box 14309, New Bern, North Carolina 28561-4309; Frederick H. Ritts, Esquire, and Vincent P. Duane, Esquire, 1025 Thomas Jefferson Street, Suite 800, Washington, D.C. 20007; Andrew Gelbaugh, C.C. Page Resources, 4375 Fairlakes Court, #2000, Fairfax, Virginia 22033; Jim O'Reilly, McKinsey & Company, Inc., 1101 Pennsylvania Avenue, N.W., Suite 700, Washington, D.C. 20004; S. Lynn Sutcliffe, Sycom Enterprises, 1010 Wisconsin Avenue, Suite 340, Washington, D.C. 20007; Allen C. Barringer, Esquire, Potomac Electric Power Company, 1900 Pennsylvania Avenue, N.W., Room 841, Washington, D.C. 20068; Frann G. Francis, 1050 17th Street, N.W., Washington, D.C. 20036; David B. Kearney, Esquire, City of Richmond, 900 East Broad Street, Suite 300, Richmond, Virginia 23219; Steven W. Ruback, The Columbia Group, Inc., 785 Washington Street, Canton, Massachusetts 02021; Dee Tagliavia, Executive Director, Mid-Atlantic Independent Power, 105-A E. Holly Avenue, Sterling, Virginia 20164; Jeffrey M. Gleason, Esquire, Southern Environmental Law Center, 201 W. Main Street, Suite 14, Charlottesville, Virginia 22902; Douglas D. Wilson, Esquire, Wilson & Associates, P.C., P.O. Box 8190, Roanoke, Virginia 24014; Joe Lenzi, Energy Engineer, CEK Consulting Engineering, P.O. Box 907, Mechanicsville, Virginia 23111; Carter Glass, IV, Esquire, Municipal Electric Power Association, P.O. Box 1122, Richmond, Virginia 23218-1122; James H. Gentry, Tennessee Valley Authority, 1101 Market Street, Chattanooga, Tennessee 37402-2801; Louis R. Monacell, Esquire, and John D. Sharer, Esquire, Christian & Barton, 909 East Main Street, Suite 1200, Richmond, Virginia 23219-3095; Eric M. Joffe, President, Ultimate Lighting Systems, Inc., 2136 Great Neck Square, #402, Virginia Beach, Virginia 23454; David X. Kolk, PHD, Power Resource Managers, L.L.C., 1233 Shelburne Road, #200, South Burlington, Vermont 05403; Dasil R. Sizemore, System Council U-1, IBEW, P.O. Box 6537, Richmond, Virginia 23230; Sarah D. Sawyer, Legal Assistant, Bracewell & Patterson, L.L.P., 2000 K Street, N.W., Suite 500, Washington, D.C. 20006-1872; Gary T. Piacentini, Esquire, Maloney, Barr & Huennekens, 1111 E. Main Street, Suite 800, Richmond, Virginia 23219-3103; Karen Sinclair, National Renewable Energy Lab, 1617 Cole Boulevard, Golden, Colorado 80401;

Albert J. Francese, Esquire, 6597 Rockland Drive, Clifton, Virginia 22024; Pamela Johnson, Esquire, Virginia Electric & Power Company, P.O. Box 26666, Richmond, Virginia 23261; Legal Environmental Assistance Foundation, 1115 N. Gadsden Street, Tallahassee, Florida 32303-6327; Glenn J. Berger, Esquire, Union Camp Corporation, 1440 New York Avenue, N.W., Washington, D.C. 20005-2111; Norman D. Reiser, Director, D.C. Public Service Commission, 450 5th Street, N.W., Washington, D.C. 20001; Richard Silkman, Richard Silkman & Associates, 163 Main Street, Yarmouth, Maine 04096; Robert Blohm, 3 Dover Road, Hamilton, New Jersey 08620; James R. Kibler, Jr., Esquire, Mezzullo & McCandlish, P.O. Box 796, Richmond, Virginia 23218; Sarah Hopkins Finley, Esquire, Williams, Mullen, Christian & Dobbins, P.O. Box 1320, Richmond, Virginia 23210; Josh Flynn, KPMG Peat Marwick, 8200 Greensboro Drive, #400, McLean, Virginia 22102; Donald A. Fickenschler, Esquire, Virginia Natural Gas Company, 5100 E. Virginia Beach Boulevard, Norfolk, Virginia 23502; Allen Glover, Esquire, and Michael J. Quinan, Esquire, Woods, Rogers & Hazlegrove, P.O. Box 14125, Roanoke, Virginia 24011; and to the Commission's Divisions of Energy Regulation, Economics and Finance, and Public Utility Accounting.

APPENDIX A

Electric Cooperatives in Virginia

- A&N Electric Cooperative
Mr. Vernon N. Brinkley
Executive Vice President
P.O. Box 1128
Parksley, Virginia 23421
- B-A-R-C Electric Cooperative
Mr. Hugh M. Landes
General Manager
P.O. Box 264
Millboro, Virginia 24460-0264
- Central Virginia Electric Cooperative
Mr. Howard L. Scarboro
General Manager
P.O. Box 247
Lovingston, Virginia 22949
- Community Electric Cooperative
Mr. J. M. Reynolds
General Manager
Post Office Box 267
Windsor, Virginia 23487
- Craig-Botetourt Electric Cooperative
Mr. Gerald H. Groseclose
General Manager
Post Office Box 265
New Castle, VA 24127
- Mecklenburg Electric Cooperative
Mr. John Bowman
General Manager
Caller 2451
Chase City, Virginia 23924-2451
- Northern Neck Electric Cooperative
Mr. Charles R. Rice, Jr.

State Corporation Commission

General Manager
Post Office Box 288
Warsaw, Virginia 22572-0288

Northern Virginia Electric Cooperative
Mr. Stanley C. Feuerberg
General Manager
Post Office Box 2710
Manassas, VA 20108-0875

Powell Valley Electric Cooperative
Mr. Randell W. Meyers
General Manager
Post Office Box 308
Church Street
Jonesville, VA 24263

Prince George Electric Cooperative
Mr. Dale Bradshaw
General Manager
Post Office Box 168
Waverly, VA 23890

Rappahannock Electric Cooperative
Mr. Cecil E. Viverette, Jr.
President
Post Office Box 7388
Fredericksburg, VA 22404-7388

Shenandoah Valley Electric Cooperative
Mr. C. Douglas Wine
Executive Vice President
Post Office Box 236
Route 257
Mt. Crawford, VA 22841-0236

Southside Electric Cooperative
Mr. John C. Anderson
President and CEO
Post Office Box 7
Crewe, VA 23930

Electric Companies in Virginia

Appalachian Power Company
Mr. R. Daniel Carson, President
Post Office Box 2021
Roanoke, VA 24022-2121

Delmarva Power & Light Company
Mr. R. Erik Hansen
General Manager, Pricing and Regulation
800 King Street
Post Office Box 231
Wilmington, Delaware 19899

Kentucky Utilities Company
Mr. Robert M. Hewett
Vice President, Regulation and Economic Planning
One Quality Street
Lexington, Kentucky 40507

The Potomac Edison Company
Mr. R. A. Roschli, Vice-President
10435 Downsville Pike
Hagerstown, Maryland 21740

Virginia Electric and Power Company
Mr. Edgar M. Roach, Jr.
Senior Vice President-Finance, Regulation and General
Counsel
Box 26666
Richmond, VA 23261

APPENDIX B

ADDITIONAL SERVICE LIST

Allied-Signal, Inc.
Edward R. Pruitt
P.O. Box 2006R
Morristown, New Jersey 07960

American Lung Association of Virginia
Stephen M. Ayres, M.D.
P.O. Box 7065
Richmond, Virginia 23221-0065

Appomattox Cogeneration, Ltd.
Hopewell Cogeneration, L.P.
Wythe Park Power
Enron-Richmond Power Corporation
Cogentrix of Virginia Leasing
Mark J. LaFratta, Esquire
McGuire, Woods, Battle & Boothe
One James Center
Richmond, Virginia 23219-4030

Celanese Fibers, Inc.
Robert Gribben
Narrows, Virginia 24124

CRSS Capital, Inc.
Timothy R. Dunne, Esquire
P.O. Box 22477
Houston, Texas 77227-2427

Corning Glass Works
Hooker W. Horton
Purchasing Manager-Energy
HP-ME-1-10
Corning, New York 14831

Virginia Hydro Power Association
Chesapeake Paper Products Company
c/o Edward L. Flippen, Esquire
Mays & Valentine
P.O. Box 1122
Richmond, Virginia 23208-1122

Department of Energy
Lawrence A. Gollomp
Assistant General Counsel for Regulatory Interventions and
Power Marketing
Room 6d-033
1000 Independence Avenue, S.W.
Washington, D.C. 20585

Dan River Mills
K.W. Parrish
Director of Engineering and Utilities
P.O. Box 261
Danville, Virginia 24523

State Corporation Commission

Du Pont/Conoco
Steven A. Huhman
Coordinator-Regulatory Affairs
CH1002
P.O. Box 2197
Houston, Texas 77252

Department of Environmental Quality
Tom Griffith, Env. Review Coordinator
629 East Main Street, 6th Floor
Richmond, Virginia 23219

Ford Motor Company
F. C. Corley, P.E.
Energy Efficiency and Supply Dept.
15201 Century Drive, Suite 602 CPN
Dearborn, Michigan 48120

Owens-Brockway Glass Container, Inc.
John Wesolowski
One Seagate
Toledo, Ohio 43604

Griffin Pipe Products Co.
John Keenan
Director, Purchasing and Traffic
1400 Opus Place, Suite 700
Downers Grove, Illinois 60515-5700

Hershey Foods
Don A. Hornung
Energy Affairs Officer
19 East Chocolate Avenue
Hershey, Pennsylvania 17033-0819

Home Builders Association of Virginia
Eric M. Page, Esquire
316 West Broad Street
Richmond, Virginia 23220

ICI Americas, Inc.
Rod Davies, Energy Specialist
Corporate Purchasing
Delaware Corporate Center One
Wilmington, Delaware 19897

Internet Foundry
S. Reid Vass
Corporate Energy Department
P.O. Box 11589
Lynchburg, Virginia 24506-1589

Kenworth E. Lion, Esquire
Jackson, Pickus & Associates
2201 West Broad Street, Suite 100
Richmond, Virginia 23235

Metro Machine Corporation
Charles Garland
Imperial Docks
P.O. Box 1860
Norfolk, Virginia 23501

Nabisco Brands, Inc.
Henry Riewerts
100 DeForest Avenue
P.O. Box 1911
East Hanover, New Jersey 07936

National Independent Energy Prod.
c/o Karen A. Tomcala, Esquire
Latham & Watkins
1001 Pennsylvania Avenue, N.W., #1300
Washington, D.C. 20004-2505

Natural Resources Defense Council
Daniel Lashof
1350 New York Avenue, N.W.
Washington, D.C. 20005

Piedmont Environmental Council
28-C Main Street
P.O. Box 460
Warrenton, Virginia 22186

Old Dominion Electric Cooperative
Ronald W. Watkins
President and Chief Exec. Officer
4201 Dominion Boulevard, Suite 300
Glen Allen, Virginia 23060

Reynolds Metals Company
Kenneth A. Berry, Esquire
Law Department, EXO-21
P.O. Box 27003
Richmond, Virginia 23261

Plantation House
J. B. Hall, Jr.
1108 East Main Street, Suite 700
Richmond, Virginia 23219

Rural Virginia, Inc.
Richard D. Cagan, Registered Agent
Virginia Council of Churches
1214 West Graham Road, #3
Petersburg, Virginia 23220-1409

Rock-Tenn Company
Al Smith
P.O. Box 4098
Norcross, Georgia 30091

Va. Assn. of Non-Utility Power Prod.
August Wallmeyer, Exec. Director
700 East Franklin Street, Suite 701
Richmond, Virginia 23219

Sierra Club - Virginia Chapter
William B. Grant, Chair
Energy Conservation Subcommittee
803 Marbank Drive
Yorktown, Virginia 23692-4353

Virginia-Maryland-Delaware Assn.
Charles C. Jones, Jr.
Executive Vice President
4201 Dominion Boulevard, Suite 200
Glen Allen, Virginia 23060

State Corporation Commission

Union Camp Corporation
Edward C. Minor, Assoc. Gen. Counsel
Route 58 East
Franklin, Virginia 23851-0178

Virginia Coop. Extn. Service
VPI and State University
Lori Marsh
Assistant Professor and Extension Agricultural Engineer
Blacksburg, Virginia 24061-0512

Virginia Cogen
David C. Pace
P.O. Box 34652
Richmond, Virginia 23234

Energy Consultants, Inc.
William D. Kee, Jr., President
1439 Great Neck Road, Suite 202L
Virginia Beach, Virginia 23454-1347

Virginia Citizen Action
1531 West Main Street, 2nd Floor
Richmond, Virginia 23220

Loral Federal Systems
David M. Karle, Advisory Engineer
9500 Godwin Drive
Manassas, Virginia 22110

Virginia Council Trout Unlimited
DuBose Egleston, Jr., Chairman
P.O. Box 838
Waynesboro, Virginia 22980

SEI Birchwood, Inc.
Douglas L. Miller, Esquire
600 Peachtree St., N.E., Suite 5200
Atlanta, Georgia 30308-2216

Westvaco Corporation
c/o John J. Carrara, Esquire
299 Park Avenue
New York, New York 10171

Electric Generation Association
Margaret A. Welsh
2101 L Street, N.W., #405
Washington, D.C. 20037

Browning-Ferris Gas Service
Philip F. Abraham, Esquire
Hazel & Thomas, P.C.
P.O. Box 788
Richmond, Virginia 23206

Fairfax County Board of Supervisors
Dennis R. Bates, Esquire
12000 Government Center Parkway, #549
Fairfax, Virginia 22035

Philip Morris, USA
Frederick H. Ritts, Esquire
1025 Thomas Jefferson Street, #800
Washington, D.C. 20007

VA.R. Doc. No. R97-157; Filed November 25, 1996, 10:26 a.m.

DIVISION OF SECURITIES AND RETAIL FRANCHISING

AT RICHMOND, NOVEMBER 18, 1996

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. SEC960081

Ex Parte, in re: Promulgation of
rules pursuant to Virginia Code
§ 13.1-523 (Securities Act) and
§ 13.1-572 (Retail Franchising Act)

ORDER AMENDING AND ADOPTING RULES

On or about September 30, 1996, the Division of Securities and Retail Franchising mailed to broker-dealers and investment advisors registered or pending registration under the Securities Act (Va. Code § 13.1-501 et seq.), issuers who had agents registered or pending registration under the Securities Act, franchisors who had franchises registered or pending registration under the Retail Franchising Act (Va. Code § 13.1-557 et seq.), and to other interested parties summary notice of proposed amendments to the existing Securities Act and Retail Franchising Act Rules and forms, and of the opportunity to file comments and request to be heard with respect to any objections to the proposals. Similar notice was published in several newspapers in general circulation throughout the Commonwealth. This notice also was published in "The Virginia Register of Regulations," Vol. 13, Issue 2, Oct. 14, 1996, p. 144. The notice stated that the purposes of the proposed changes are to correct misspellings and other minor errors in the Rules and to reformat and renumber the Rules so they conform to the numbering scheme and format of the Rules as published in the Virginia Administrative Code. No comments or requests to be heard were filed and no hearing was held.

The Commission, upon consideration of the proposals and the recommendations of the Division, is of the opinion and finds that the proposals should be adopted as noticed. Accordingly, it is

ORDERED:

- (1) That evidence of mailing and publication of notice of the proposed amendments to the Rules be filed in this case;
- (2) That the proposed amendments previously noticed be, and they hereby are, adopted and shall become effective as of December 1, 1996; and,
- (3) That this matter is dismissed from the Commission's docket and the papers herein be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent to each of the following by the Division of Securities and Retail Franchising: The Commission's Division of Information Resources; Securities Regulation and Law Report, c/o The Bureau of National Affairs, 1231 25th Street, N.W., Washington, D.C. 20037; and, Blue Sky Law Reporter, c/o Commerce Clearing House, Inc., 4025 West Peterson Avenue, Chicago, Illinois 60646.

VA.R. Doc. No. R97-156; Filed November 25, 1996, 10:26 a.m.

MARINE RESOURCES COMMISSION

MARINE RESOURCES COMMISSION

NOTICE: The Marine Resources Commission is exempted from the Administrative Process Act (§ 9-6.14:4.1 of the Code of Virginia); however, it is required by § 9-6.14:22 B to publish all final regulations.

Title of Regulation: 4 VAC 20-720-10 et seq. Pertaining to Restrictions on Oyster Harvests (amending 4 VAC 20-720-40, 4 VAC 20-720-50, 4 VAC 20-720-80, and adding 4 VAC 20-720-105).

Statutory Authority: §§ 28.2-201 and 28.2-507 of the Code of Virginia.

Effective Date: December 1, 1996.

Preamble:

This regulation sets times of closure and other restrictions on the harvest of oysters from all oyster grounds in the Chesapeake Bay and its tributaries and on the Seaside of Eastern Shore. This regulation is promulgated pursuant to authority contained in §§ 28.2-201 and 28.2-507 of the Code of Virginia. This regulation amends and readopts 4 VAC 20-720-10 et seq., which was adopted on September 24, 1996, and was effective October 1, 1996. The effective date of these amendments is December 1, 1996.

Agency Contact: Copies of the regulation may be obtained from Katherine V. Leonard, Marine Resources Commission, P.O. Box 756, Newport News, VA 23607-0756, telephone (804) 247-2120.

4 VAC 20-720-40. Open season and areas.

The lawful seasons and areas for the harvest of oysters from the public oyster grounds and unassigned grounds are as follows:

1. James River Seed Area: October 1, 1996, through April 30, 1997.
2. James River Jail Island and Point of Shoals Clean Cull Areas: October 1, 1996, through April 30, 1997.
3. Seaside of Eastern Shore: for clean cull oysters only, November 1, 1996, through January 31, 1997.
4. ~~Pocomoke and Tangier Sounds Management Area: December 1, 1996, through January 31, 1997.~~

4 VAC 20-720-50. Closed harvest season and areas.

It shall be unlawful for any person to harvest oysters from the following areas during the specified periods:

1. All public oyster grounds and unassigned grounds in the Chesapeake Bay and its tributaries, including the tributaries of the Potomac River, except the James River Seed Area and the James River Jail Island and Point of Shoals Clean Cull Areas: October 1, 1996, through September 30, 1997.
2. James River Seed Area and James River Jail Island and Point of Shoals Clean Cull Areas: May 1, 1997, through September 30, 1997.

3. All public oyster grounds and unassigned grounds on the Seaside of Eastern Shore: for clean cull oysters, October 1 through October 31, 1996, and February 1, 1997, through September 30, 1997; and for seed oysters, all year. Oyster harvest from leased oyster ground and fee simple oyster ground shall require a permit from the Marine Resources Commission as set forth in 4 VAC 20-720-90.

~~4. All public grounds and unassigned grounds in the Pocomoke and Tangier Sounds Management Area: October 1, 1996, through November 30, 1996, and February 1, 1997, through September 30, 1997.~~

4 VAC 20-720-80. Quotas and catch limits.

A. In the James River Seed Areas there shall be an oyster harvest quota of 80,000 bushels of seed oysters. It shall be unlawful for any person to harvest seed oysters from the James River Seed Area after the 80,000 bushel quota has been reached.

B. In the James River Clean Cull areas there shall be an oyster harvest quota of 10,000 bushels of clean cull oysters. It shall be unlawful for any person to harvest clean cull oysters from the James River Clean Cull areas after the 10,000 bushel quota has been reached.

~~C. In the Pocomoke and Tangier Sounds Management Area there shall be a 15 bushel limit per boat per day and a 2,500 bushel quota limit. It shall be unlawful for any person to take or harvest more than 15 bushels per boat per day and to take or harvest oysters after the 2,500 bushel quota limit has been reached.~~

4 VAC 20-720-105. Special Pocomoke and Tangier Sound broodstock restoration project.

A. *This project will begin December 2, 1996, and will continue until the quota has been caught, or until the project has been terminated by the commissioner, whichever occurs first.*

B. *In this project there will be a quota of 2,500 bushels of clean cull oysters. It shall be unlawful to harvest oysters in this area after the 2,500 bushel quota has been reached or after the project has been terminated.*

C. *All clean cull oysters harvested in the Pocomoke and Tangier Sound Management Areas shall be sold to the Marine Resources Commission for an oyster broodstock restoration project on the Great Wicomico Reef site. It shall be unlawful to sell any oysters from Pocomoke and Tangier Sound Management Areas except to the Marine Resources Commission.*

D. *Price will be set by the commission at a fair market value.*

E. *The commissioner may terminate the project at any time if the project is not economically feasible.*

F. *Only standard oyster dredges (maximum weight 100 pounds with attachment, maximum width of 50 inches, maximum tooth length four inches, minimum teeth spacing three inches) or standard oyster patent tongs (maximum*

Marine Resources Commission

weight 100 pounds, maximum teeth length four inches) may be used in the project.

G. No hard clam bycatch is allowed.

H. No blue crab bycatch is allowed.

I. Harvesting activity shall terminate by 2 p.m. daily so that all oysters can be loaded on the commission buyboat prior to sunset.

J. Oysters shall be offloaded daily.

K. Permits to harvest oysters in Pocomoke and Tangier Sounds shall be required for all participants.

/s/ William A. Pruitt
Commissioner

VA.R. Doc. No. R97-169; Filed November 27, 1996, 9:37 a.m.

FORMS

STATE CORPORATION COMMISSION

EDITOR'S NOTICE: The following forms have been revised by the Division of Securities and Retail Franchising as a result of Case No. SEC960081, which changed cites from rule and section numbers to VAC numbers. Copies of the forms may be obtained from Angela Bowser, Regulatory Coordinator, State Corporation Commission, P.O. Box 1197, Richmond, VA 23209, telephone (804) 371-9141.

Title of Regulation: 21 VAC 5-85-10. Adopted Securities Forms.

CHAPTER 85. FORMS.

21 VAC 5-85-10. Adopted securities forms.

The Commission adopts for use under the Act the forms contained in the Appendix (not included in Virginia Administrative Code) and listed below.

Broker-Dealer and Agent Forms

Form BD - Uniform Application for Registration of a Broker-Dealer (5/94).

Form S.A.1. - Supplemental Information for Commonwealth of Virginia to Be Furnished with Revised Form BD (rev. 11/96).

Agreement for Inspection of Records.

Form S.A.11 - Broker-Dealer's Surety Bond (rev. 1982).

Form S.A.2. - ~~Non-NASD Broker-Dealer Renewal Application (rev. 1989).~~ Application for Renewal of a Broker-Dealer's Registration (rev. 11/96).

Form S.D.4. - Non-NASD Broker-Dealer or Issuer Agent Renewal Application (1972).

Form S.D.4.A. - Non-NASD Broker-Dealer or Issuer Agents to be Renewed Exhibit (1974).

Form S.D.4.B. - Non-NASD Broker-Dealer or Issuer Agents to be Canceled with no disciplinary history (1974).

Form S.D.4.C. - Non-NASD Broker-Dealer or Issuer Agents to be Canceled with disciplinary history (1974).

Form BDW - Uniform Notice of Termination or Withdrawal of Registration as a Broker-Dealer.

Form U-4 - Uniform Application for Securities Industry Registration (11/91).

Form U-5 - Uniform Termination Notice for Securities Industry (11/91).

Investment Advisor and Investment Advisor Representative Forms

Form ADV - Uniform Application for Registration of Investment Advisors (eff. July 2, 1987).

Agreement for Inspection of Records.

Surety Bond Form.

Form U-4 - Application for Investment Advisor Representative Registration. See Form U-4 above.

Form U-5 - Application for Withdrawal of an Investment Advisor Representative. See Form U-5 above.

Form S.A.3. - Affidavit for Waiver of Series-65 Examination (40/92 rev. 11/96).

Securities Registration Forms

Form U-1 - Uniform Application to Register Securities.

Form U-2 - Uniform Consent to Service of Process.

Form U-2a - Uniform Form of Corporate Resolution.

Form S.A.4. - Registration by Notification - Original Issue (rev. 11/96).

Form S.A.5. - Registration by Notification - Non-Issuer Distribution (rev. 11/96).

Form S.A.6. - Registration by Notification - Pursuant to Rule 403 21 VAC 5-30-50 Non-Issuer Distribution "Secondary Trading" (1989).

Form S.A.8. - Registration by Qualification.

Form S.A.10 - Request for Refund Affidavit (Unit Investment Trust).

Form S.A.12 - Escrow Agreement.

Form S.A.13 - Impounding Agreement.

Form VA-1, Parts 1 and 2 - Notice of Limited Offering of Securities (rev. 11/96).

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

EDITOR'S NOTICE: The following forms apply to pharmacy claims (12 VAC 30-80-40). Copies of the forms may be obtained from Roberta J. Jonas or Vicki P. Simmons, Regulatory Coordinators, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

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

Pharmacy Claim Form (3/96)

Compound Prescription Pharmacy Claim Form (3/96)

Forms

PLEASE PRINT CLEARLY
 Provider Medicaid Number
 01

Virginia Department of Medical Assistance Services PHARMACY CLAIM FORM



Patient's Last Name, First Name		Patient's Medicaid Number	Sex	Birth Date	Level of Svc	Days Supply	Refill	DAW	Patient Loc
1		03	04	05	06	07	08	09	10
Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number		Metric Decimal Quantity		Unit Dose	
11	12	13	14	15		16		17	
Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed		COB	Payment by Primary Carrier		
18	19	20	21	22 \$		23	24 \$		
2		03	04	05	06	07	08	09	10
Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number		Metric Decimal Quantity		Unit Dose	
11	12	13	14	15		16		17	
Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed		COB	Payment by Primary Carrier		
18	19	20	21	22 \$		23	24 \$		
3		03	04	05	06	07	08	09	10
Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number		Metric Decimal Quantity		Unit Dose	
11	12	13	14	15		16		17	
Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed		COB	Payment by Primary Carrier		
18	19	20	21	22 \$		23	24 \$		
4		03	04	05	06	07	08	09	10
Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number		Metric Decimal Quantity		Unit Dose	
11	12	13	14	15		16		17	
Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed		COB	Payment by Primary Carrier		
18	19	20	21	22 \$		23	24 \$		
5		03	04	05	06	07	08	09	10
Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number		Metric Decimal Quantity		Unit Dose	
11	12	13	14	15		16		17	
Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed		COB	Payment by Primary Carrier		
18	19	20	21	22 \$		23	24 \$		
6		03	04	05	06	07	08	09	10
Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number		Metric Decimal Quantity		Unit Dose	
11	12	13	14	15		16		17	
Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed		COB	Payment by Primary Carrier		
18	19	20	21	22 \$		23	24 \$		

Provider Name, Address and Telephone Number
 25

This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will come from Federal and State funds, and that any falsification of claims, statements or documents or concealment of material facts may be prosecuted under applicable Federal or State laws.

Signature of Provider or Representative.
 26

Date (mm-dd-yy) [] [] [] [] [] [] [] [] [] []

PHARMACY CLAIM FORM COMPLETION

The following instructions describe each field by referencing the field number found in the left corner of the claim form data elements.

Field # Narrative Description

- 1 Enter your Medicaid ID provider number. **Make sure to include your location code.**
- 2 Enter the patient's last name and first name
- 3 Enter the 12-digit patient Medicaid ID number
- 4 Enter the patient's sex. M = Male, F = Female.
- 5 Enter the patient's birth date. Use MMDDCCYY format.
- 6 Enter the level of service code if appropriate. 01 = Patient consultation, 02 = Home delivery, 03 = Emergency, 04 = 24-hour service, 05 = Patient consultation regarding generic product selection.
- 7 Enter the days supply.
- 8 If this is an original prescription, enter 00. If this is a prescription refill, indicate the number of the refill. Valid values are 00 to 99.
- 9 Enter the Dispense as Written override code of "6" for prescriptions for which "Brand Necessary" is indicated in accordance with the law and Medicaid policy. The value should be used only when the prescribing physician certifies "Brand Necessary" in his or her own handwriting for a prescribed brand name drug that is generically available and substitutable under Virginia state law.
- 10 Enter the patient's location. Valid values are: 00 = Not specified, 01 = Home, 02 = Inter-Care, 03 = Nursing Home, 04 = Long Term/Extended Care, 05 = Rest Home, 06 = Boarding Home, 07 = Skilled Care Facility, 08 = Sub Acute Care Facility, 09 = Acute Care Facility, 10 = Outpatient, 11 = Hospice.
- 11 Use this field only if an adjustment or void is being requested. Enter the appropriate code if requesting the adjustment or void of a previously paid claim.
- 12 Use this field only if an adjustment or void is being requested. Enter the reference number of the claim that is to be voided or adjusted.
- 13 Enter the prescription's 7-digit Rx number.
- 14 Enter the date dispensed in MMDDYY format.
- 15 Enter the 11-digit National Drug Code (NDC), Health Related Item (HRI), or Universal Package Code (UPC) which corresponds to the product dispensed. Be certain all NDCs entered are current. Confirm refill NDCs are correct. NDC-specific use data is the basis of both reimbursement and the drug rebate program.
- 16 Indicate the metric decimal quantity (e.g., 2.5) of the product using the appropriate unit of measure (each, gram or milliliter).
- 17 Enter the appropriate unit dose code. Valid values are: 0 = Not specified, 1 = Not unit dose, 2 = Manufacturer's unit dose, 3 = Pharmacy unit dose.
- 18 Enter the exemption indicator if appropriate. 02 = Medical certification, 03 = EPSDT, 04 = Exemption from Co-pay, 05 = Exemption from prescription limits, 06 = Family planning indicator, 07 = AFDC, 08 = Payer defined exemption.
- 19 Enter the 11-digit prior authorization number if required.
- 20 Enter the prescriber's 10-digit state license number. **Please note: This field is required and may cause claim denial if not present.**
- 21 Enter the ICD-9CM diagnosis code if appropriate. **If using a 4 or 5-digit code number, do not enter the decimal point.**
- 22 Enter the amount billed for the product.
- 23 Enter the coordination of benefits code. Valid values are: 2 = No other insurance carrier, 3 = Payment has been received from a private carrier other than Medicare, 5 = There is another insurer and the primary carrier has denied payment.
- 24 Enter the dollar amount paid by the primary payer if coordination of benefits applies.
- 25 Enter the provider's name, address and telephone number. The address entered must correspond to the provider location code included with the provider I.D. in field 01.
- 26 Note the certification statement on the claim form and sign and date the claim form.

COMPOUND PRESCRIPTION PHARMACY CLAIM FORM COMPLETION

The following instructions describe each field by referencing the field number found in the left corner of the claim form data elements. Compounded prescriptions may be submitted electronically if the total cost of the prescription is less than \$10.00

Field # Narrative Description

- 1 Use this field only if an adjustment or void is being requested. Enter the appropriate code if requesting the adjustment or void of a previously paid claim.
- 2 Use this field only if an adjustment or void is being requested. Enter the reference number of the claim that is to be voided or adjusted.
- 3 Indicate the type of compound. Valid values are: 01 = TPN, 02 = Powder papers, Bulk powder, 03 = Suppositories, 04 = Topicals (ointments, creams, suspensions), 05 = Cassette, 06 = IV/Piggyback, 07 = Syringe/Injectable, 08 = Oral solids (troche, capsule, tablet), 09 = Oral Liquids, 10 = Ophthalmic/Otic.
- 4 Enter your Medicaid ID provider number. **Make sure to include the location code.**
- 5 Enter the level of service code if appropriate. 01 = Patient Consultation, 02 = Home Delivery, 03 = Emergency, 04 = 24 Hour Service, 05 = Patient Consultation Regarding Generic Product Selection.
- 6 Enter the ICD-9 diagnosis if appropriate. **If using the 4 or 5-digit diagnosis code number, do not add in the decimal point.**
- 7 Enter exemption indicator if appropriate. 02 = Medical Certification, 03 = EPSDT, 04 = Exemption from Co-Pay, 05 = Exemption from Prescription Limits, 06 = Family Planning Indicator, 07 = AFDC, 08 = Payer Defined Exemption.
- 8 Enter the 11-digit Prior Authorization number if required.
- 9 Enter the 12-digit recipient Medicaid ID number.
- 10 Enter the recipient's last name and first name.
- 11 Enter the recipient's sex. M = Male, F = Female.
- 12 Enter the recipient's birth date. Use MMDDCCYY format.
- 13 Enter the prescriber's 10-digit state license number. **Please note: This field is required and may cause claim denial if not present.**
- 14 Enter the prescription's 7-digit Rx number.
- 15 Enter the date dispensed in MMDDYY format.
- 16 Enter the days supply.
- 17 If this is an original prescription, enter 00. If this is a prescription refill, indicate the number of the refill. Valid values are 00 to 99.
- 18 Enter the patient's location. Valid values are: 00 = Not specified, 01 = Home, 02 = Inter-Care, 03 = Nursing Home, 04 = Long Term/Extended Care, 05 = Rest Home, 06 = Boarding Home, 07 = Skilled Care Facility, 08 = Sub-Acute Care Facility, 09 = Acute Care Facility, 10 = Outpatient, and 11 = Hospice.
- 19 Enter the 11-digit National Drug Code (NDC), Health Related Item code (HRI), or Universal Package Code (UPC) which corresponds to the ingredients in the compound. Be certain all NDCs entered are current. Confirm refill NDCs are correct. NDC-specific use data is the basis of both reimbursement and the drug rebate program.
- 20 Enter the Dispense as Written override code of "6" for prescriptions for which "Brand Necessary" is indicated in accordance with the law and Medicaid policy. The value should be used only when "Brand Necessary" has been properly indicated for a prescribed brand name drug that is generically available and substitutable under Virginia state law.
- 21 Enter a narrative description of the ingredient, if there is no NDC, HRI, or UPC for the ingredient used.
- 22 Indicate the metric decimal quantity (e.g., 2.5) of the ingredient using the appropriate unit of measure (each, gram, or milliliter).
- 23 Enter the coordination of benefits code, if known. Valid values are: 2 = Used when there is no other insurance carrier; 3 = Used when payment has been received from a private carrier other than Medicare; 5 = This indicates that there is another insurer and that the primary carrier has denied payment.
- 24 Enter the dollar amount paid by the primary payer if coordination of benefits applies.
- 25 Enter the usual and customary charge for the prescription. This field should include the dispensing fee.
- 26 Enter comments, if any.
- 27 Enter the provider's name, address, and telephone number. The address entered should correspond to the provider location code entered in field # 4.
- 28 Note the certification statement on the claim form, and sign and date the claim form.

GOVERNOR

EXECUTIVE ORDER NUMBER SIXTY-FIVE (96)

DECLARATION OF A STATE OF EMERGENCY THROUGHOUT THE COMMONWEALTH ARISING FROM HURRICANE BERTHA

Recent meteorological forecasts concerning Hurricane Bertha predict that the storm could cause storm surge, heavy rains, flooding, and high winds in the Commonwealth. The potential also exists for tornadoes which could be spawned as a collateral effect of the hurricane. Should the hurricane make landfall in those cities and counties which lie generally east of Interstate Highway 95 in "Tidewater Virginia," as defined in § 10.1-2101 of the *Code of Virginia*, flash flooding, storm surge damage, and wind damage are anticipated in those areas. Inland areas of the state could also be impacted by the residual destructive power of Hurricane Bertha.

The health and general welfare of the citizens of the localities which may be affected require that state action be taken to help prepare for, and should this destructive storm impact the Commonwealth, to alleviate the conditions which may result from this situation. I also find that these potential hurricane effects may constitute a natural disaster wherein human life and public and private property are imperiled, as described in § 44-146.16 of the *Code of Virginia*.

Therefore, by virtue of the authority vested in me by § 44-146.17 of the *Code of Virginia*, as Governor and as Director of Emergency Services, and by virtue of the authority vested in me by Article V, Section 7 of the Constitution of Virginia and by § 44-75.1 of the *Code of Virginia*, as Governor and Commander-in-Chief of the armed forces of the Commonwealth, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby declare that a state of emergency exists in the Commonwealth and direct that appropriate assistance be rendered by agencies of both state and local governments to prepare for and alleviate any conditions resulting from this hurricane, and to implement recovery and mitigation operations so as to return impacted areas to pre-event conditions in so far as possible. Pursuant to §§ 44-75.1 (3) and (4) of the *Code of Virginia*, I also direct that the Virginia National Guard and the Virginia Defense Force be called forth to state duty to assist in providing such aid. This shall include Virginia National Guard assistance to the Virginia State Police to direct traffic, prevent looting, and perform such other law enforcement functions as the Superintendent of State Police, in consultation with the Coordinator of Emergency Services and with the approval of the Secretary of Public Safety, may find necessary.

In order to marshal all public resources and appropriate preparedness, response and recovery measures to meet this potential threat and recovery from its effects, and in accordance with my authority contained in § 44-146.17 of the Emergency Services and Disaster Laws, I hereby order the following protective and restoration measures:

1. The full implementation by agencies of the state and local governments of Volume II, Virginia Emergency Operations Plan (COVEOP) for Peacetime Disasters, September 1988, as amended, along with its attendant

Annex I-FF, Virginia Hurricane Emergency Response Plan, and other appropriate state agency plans.

2. Full activation of the Virginia Emergency Operations Center (VEOC) and State Emergency Response Team (SERT), which is a multi-agency working group, to coordinate implementation of the COVEOP and to coordinate receipt and evaluation of information related to the effects of this storm. Furthermore, I am directing that the VEOC and SERT coordinate state operations in support of affected localities and the Commonwealth, to include issuing mission assignments to agencies designated in the COVEOP and others that may be identified by the Coordinator of Emergency Services, in consultation with the Secretary of Public Safety, which are needed to provide for the preservation of life, protection of property and implementation of recovery activities. The Coordinator of Emergency Services will work closely with involved agencies to identify sources of funding to cover costs related to the execution of mission assignments.

3. The authorization to assume control over the Commonwealth's telecommunications systems, as required by the State Coordinator of Emergency Services, in coordination with the Department of Information Technology and with the prior consent of the Secretary of Public Safety, making all systems assets available for use in providing adequate communications, intelligence and warning capabilities for the impending event, pursuant to § 44-146.18 of the *Code of Virginia*.

4. The preparation for and if necessary, the evacuation by low-lying localities, particularly in the coastal counties and the Eastern Shore, of citizens subject to the potential effects of this storm. Although I have the power to direct evacuation as authorized in § 44-146.17 (1) of the Emergency Services and Disaster Laws, I will defer to the authorities of the governing bodies of local jurisdictions as to exactly when and to what extent mandatory evacuation of their localities is implemented. I will retain the authority to implement mandatory evacuation, if warranted. The authority to issue local preventive evacuation orders is dependent upon the following procedures: (a) the declaration by the governing body of a local emergency as outlined in § 44-146.21 of the Emergency Services and Disaster Laws; (b) the judicious and timely use of the manual Decision Arc process, or any automated decision aids, device or process, as described in Annex I-FF, Virginia Hurricane Emergency Response Plan, to determine specific local evacuation start times; and (c) prior consultation and close coordination with the Virginia Emergency Operations Center (VEOC) in Richmond. Violations of any order to citizens to evacuate shall constitute a violation of this Executive Order and are punishable as a Class I misdemeanor.

5. The cessation of toll collection on evacuation routes. Coordination and timing of the application of this measure will be accomplished by the Virginia Department of Transportation, in conjunction with the toll road administrations, local jurisdictions, and the

Department of State Police. The general public will be informed of this action by the best means available.

6. The hosting of evacuees from affected localities by inland jurisdictions in their public shelters is authorized and encouraged. To assist host jurisdictions in this regard, the use of the Sum Sufficient, as defined in § 44-146.28 (a) of the Emergency Services and Disaster Laws, to defray authorized and justified expenses incurred by the host jurisdictions in opening and operating their public shelters is herewith authorized. Invoices and payments will be subject to such approvals and procedures as may be prescribed by the State Coordinator of Emergency Services in consultation with the State Comptroller.

7. The activation, implementation and coordination of appropriate mutual aid agreements and compacts, including the Emergency Management Assistance Compact, and the authorization of the State Coordinator of Emergency Services to enter into any other supplemental agreements, pursuant to §§ 44-146.17 (5) and 44-146.28:1, to provide for the evacuation and reception of injured and other persons and the exchange of medical, fire, police, National Guard personnel and equipment, public utility, reconnaissance, welfare, transportation and communications personnel, and equipment and supplies. The State Coordinator of Emergency Services is hereby designated as Virginia's authorized representative within the meaning of the Emergency Management Assistance Compact, § 44-146.28:1, *Code of Virginia*.

8. The authorization of the Departments of State Police, Transportation and Motor Vehicles to grant temporary overweight/registration/license exemptions to carriers transporting essential emergency relief supplies into and within the Commonwealth in order to support the disaster response and recovery, particularly as regards donation management.

The axle and gross weights shown below are the maximum allowed, unless otherwise posted.

Any One Axle	24,000 Pounds
Tandem Axles (more than 40 inches but not more than 96 inches spacing between axle centers)	44,000 Pounds
Single Unit (2 Axles)	44,000 Pounds
Single Unit (3 Axles)	54,500 Pounds
Tractor-Semitrailer (4 Axles)	64,500 Pounds
Tractor-Semitrailer (5 or more Axles)	90,000 Pounds
Tractor-Twin Trailers (5 or more Axles)	90,000 Pounds
Other Combinations (5 or more Axles)	90,000 Pounds
Per Inch of Tire Width in Contact with Road Surface	850 Pounds

In addition to described overweight transportation privileges, carriers are also exempt from registration with DMV. This includes the vehicles enroute and returning to their home base. The above cited agencies shall communicate this information to all staff responsible for permit issuance and truck legalization enforcement.

This authorization shall apply to hours worked by any carrier when transporting passengers, property,

equipment, food, fuel, construction materials and other critical supplies to or from any portion of the Commonwealth for purpose of providing relief or assistance as a result of this disaster, pursuant to § 52-8.4 of the *Code of Virginia*.

The foregoing overweight transportation privileges and the regulatory exemption provided by § 52-8.4.A of the *Code of Virginia*, and implemented in § 2.3.B of VR 545-01-1, "Motor Carrier Safety Regulations," shall remain in effect for sixty (60) days from the onset of the disaster, or until emergency relief is no longer necessary, as determined by the Secretary of Public Safety in consultation with the Secretary of Transportation, whichever is earlier.

9. The discontinuance of provisions authorized in paragraphs 5 and 8 may be implemented and disseminated by publication of administrative notice to all affected and interested parties by the authority I herewith delegate to the Secretary of Public Safety, after consultation with other affected Cabinet-level Secretaries.

10. If deemed necessary, the designation of a State Recovery Task Force under the leadership of the Secretary of Commerce and Trade to promote public, private and industrial redevelopment projects and help sustain long-term community economic vitality in the aftermath of the disaster. This task force will also assist in the restoration of critical public health and safety systems and will do so in close coordination with the Coordinator of Emergency Services as the individual responsible for ensuring implementation of short-term recovery programs.

11. The authorization of appropriate oversight boards, commissions and agencies to ease building code restrictions, and to permit emergency demolition, hazardous waste disposal, debris removal, emergency landfill siting and operations and other activities necessary to address immediate health and safety needs. This state of emergency constitutes a major medical emergency under the Rules and Regulations of the Board of Health Governing Emergency Medical Services, pursuant to Article 3.01 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1, Statewide Emergency Medical Services System and Services, and exemptions specified in the Rules and Regulations regarding patient transport and provider certification in disasters apply.

12. The costs incurred by state agencies and other agents of the Commonwealth as defined herein and in § 44-146.17, except as defined in paragraph 20, page 9, in performing these missions shall be paid out of the sum sufficient appropriation for Disaster Planning and Operations contained in Item 42 of Chapter 912 of the 1996 Acts of Assembly.

13. The implementation by public agencies under my supervision and control of their emergency assignments as directed in the COVEOP without regard to normal procedures pertaining to performances of public work, entering into contracts, incurring of obligations, or other logistical and support measures, as delineated in § 44-

Governor

146.28 (b) of the Emergency Services and Disaster Laws. § 44-146.24 also applies to the disaster activities of state agencies.

14. The immunity provisions of § 44-146.23 (a) apply to volunteer, auxiliary and reserve groups including search and rescue team members (SAR), Virginia Association of Volunteer Rescue Squad (VAVRS) personnel, Civil Air Patrol (CAP), member organizations of the Voluntary Organizations Active in Disasters (VOAD), Radio Amateur Civil Emergency Services (RACES), volunteer fire fighters and others when designated as agents of the Commonwealth for specific disaster-related mission assignments and identified by the Coordinator of Emergency Services.

The following conditions apply to the deployment of the Virginia National Guard and the Virginia Defense Force:

1. The Adjutant General of Virginia, after consultation with the State Coordinator of Emergency Services, shall make available on state active duty such units and members of the Virginia National Guard and Virginia Defense Force and such equipment as may be desirable to assist in pre-storm preparation and in alleviating the human suffering and damage to property as a result of Hurricane Bertha.

2. Pursuant to § 52-6 of the *Code of Virginia*, I authorize and direct the Superintendent of State Police to appoint any and all such Virginia Army and Air National Guard personnel called to state active duty as additional police officers. These police officers shall have the same powers and perform the same duties as the regular State Police officers appointed by the Superintendent. However, they shall nevertheless remain members of the Virginia National Guard, subject to military command as members of the State Militia. Any bonds and/or insurance required by § 52-7 of the *Code of Virginia* shall be provided for them at the expense of the Commonwealth.

3. In all instances, members of the Virginia Army National Guard and Virginia Defense Force shall remain subject to military command as prescribed by § 44-78.1 of the *Code of Virginia* and not subject to the civilian authorities of the state or local governments. This shall not be deemed to prohibit working in close cooperation with members of the Virginia Departments of State Police or Emergency Services or local law enforcement or emergency management authorities or receiving guidance from them in the performance of their duties.

4. Should service under this Executive Order result in the injury or death of any member of the Virginia National Guard, the following will be provided to the member and the member's dependents or survivors:

(a) Workers' Compensation benefits provided to members of the National Guard by the Virginia Workers' Compensation Act subject to the requirements and limitations thereof; and, in addition,

(b) The same benefits, or their equivalent, for injury, disability and/or death, as would be provided by the federal government if the member were serving on

federal active duty at the time of the injury or death. Any such federal-type benefits due to a member and his or her dependents or survivors during any calendar month shall be reduced by any payments due under the Virginia Workers' Compensation Act during the same month. If and when the time period for payment of Workers' Compensation benefits has elapsed, the member and his or her dependents or survivors shall thereafter receive full federal-type benefits for as long as they would have received such benefits if the member had been serving on federal active duty at the time of injury or death. Any federal-type benefits due shall be computed on the basis of military pay grade E-5 or the member's military grade at the time of injury or death, whichever produces the greater benefit amount. Pursuant to § 44-14 of the *Code of Virginia*, and subject to the concurrence of the Board of Military Affairs, and subject to the availability of future appropriations which may be lawfully applied to this purpose, I now approve of future expenditures out of appropriations to the Department of Military Affairs for such federal-type benefits as being manifestly for the benefit of the military service.

5. The following conditions apply to service by the Virginia Defense Force:

(a) Compensation shall be at a daily rate that is equivalent of base pay only for a National Guard Unit Training Assembly, commensurate with the grade and years of service of the member, not to exceed 20 years of service;

(b) Lodging and meals shall be provided by the Adjutant General or reimbursed at standard state per diem rates;

(c) All privately owned equipment, including, but not limited to, vehicles, boats, and aircraft, will be reimbursed for expense of fuel. Damage or loss of said equipment will be reimbursed, minus reimbursement from personal insurance, if said equipment was authorized for use by the Adjutant General in accordance with § 44-54.12 of the *Code of Virginia*; and

(d) In the event of death or injury, benefits shall be provided in accordance with the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof.

6. The costs incurred by the Department of Military Affairs and Virginia Defense Force in performing these missions shall be paid out of the sum sufficient appropriation for Disaster Planning and Operations contained in Item 493 of Chapter 912 of the 1996 Acts of Assembly.

This Executive Order shall be effective upon its signing, and shall remain in full force and effect until June 30, 1997, unless sooner amended or rescinded by further executive order. That portion providing for benefits for members of the National Guard and other agents of the Commonwealth herein provided for in the event of injury or death shall continue to remain in effect after termination of this Executive Order as a whole.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 11th day of July, 1996.

/s/ George Allen
Governor

VA.R. Doc. No. R97-162; Filed November 27, 1996, 10:27 a.m.

EXECUTIVE ORDER NUMBER SIXTY-SIX (96)

**DECLARATION OF A STATE OF EMERGENCY
THROUGHOUT THE COMMONWEALTH ARISING FROM
HURRICANE FRAN**

Recent meteorological forecasts concerning Hurricane Fran predict that the storm could cause storm surge, heavy rains, flooding, and high winds in the Commonwealth. The potential also exists for tornadoes which could be spawned as a collateral effect of the hurricane. The hurricane is projected to make landfall in an area between North Carolina and South Carolina, south of the Virginia coast. Should the hurricane make landfall as predicted, flash flooding, river flooding, and wind damage are anticipated statewide.

The health and general welfare of the citizens of the localities which may be affected require that state action be taken to help prepare for, and should this destructive storm impact the Commonwealth, to alleviate the conditions which may result from this situation. I also find that these potential hurricane effects may constitute a natural disaster wherein human life and public and private property are imperiled, as described in § 44-146.16 of the Code of Virginia.

Therefore, by virtue of the authority vested in me by § 44-146.17 of the Code of Virginia, as Governor and as Director of Emergency Services, and by virtue of the authority vested in me by Article V, Section 7 of the Constitution of Virginia and by § 44-75.1 of the Code of Virginia, as Governor and Commander-in-Chief of the armed forces of the Commonwealth, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby declare that a state of emergency exists in the Commonwealth and direct that appropriate assistance be rendered by agencies of both state and local governments to prepare for and alleviate any conditions resulting from this hurricane, and to implement recovery and mitigation operations and activities so as to return impacted areas to pre-event conditions insofar as possible. Pursuant to §§ 44-75.1 (3) and (4) of the Code of Virginia, I also direct that the Virginia National Guard and the Virginia Defense Force be called forth to state duty to assist in providing such aid. This shall include Virginia National Guard assistance to the Virginia State Police to direct traffic, prevent looting, and perform such other law enforcement functions as the Superintendent of State Police, in consultation with the State Coordinator of Emergency Services and the Adjutant General, and with the approval of the Secretary of Public Safety, may find necessary.

In order to marshal all public resources and appropriate preparedness, response and recovery measures to meet this potential threat and recovery from its effects, and in accordance with my authority contained in § 44-146.17 of the Emergency Services and Disaster Laws, I hereby order the following protective and restoration measures:

1. The full implementation by agencies of the state and local governments of Volume II, Virginia Emergency Operations Plan (COVEOP) for Peacetime Disasters, September 1988, as amended, along with its attendant Annex I-FF, Virginia Hurricane Emergency Response Plan, and other appropriate state agency plans.

2. Full activation of the Virginia Emergency Operations Center (VEOC) and State Emergency Response Team (SERT), which is a multi-agency working group, to coordinate implementation of the COVEOP and to coordinate receipt and evaluation of information related to the effects of this storm. Furthermore, I am directing that the VEOC and SERT coordinate state operations in support of affected localities and the Commonwealth, to include issuing mission assignments to agencies designated in the COVEOP and others that may be identified by the State Coordinator of Emergency Services, in consultation with the Secretary of Public Safety, which are needed to provide for the preservation of life, protection of property and implementation of recovery activities. The State Coordinator of Emergency Services will work closely with involved agencies to identify sources of funding to cover costs related to the execution of mission assignments.

3. The authorization to assume control over the Commonwealth's telecommunications systems, as required by the State Coordinator of Emergency Services, in coordination with the Department of Information Technology, and with the prior consent of the Secretary of Public Safety, making all systems assets available for use in providing adequate communications, intelligence and warning capabilities for the impending event, pursuant to § 44-146.18 of the Code of Virginia.

4. The preparation for and if necessary, the evacuation by low-lying areas subject to the potential effects of this storm. Although I have the power to direct evacuation as authorized in § 44-146.17 (1) of the Emergency Services and Disaster Laws, I will defer to the authorities of the governing bodies of local jurisdictions as to exactly when and to what extent mandatory evacuation of their localities is implemented. I will retain the authority to implement mandatory evacuation, if warranted. The authority to issue local preventive evacuation orders is dependent upon a declaration of a local emergency by the governing body as outlined in § 44-146.21 of the Emergency Services and Disaster Laws. Violations of any order to citizens to evacuate shall constitute a violation of this Executive Order and are punishable as a Class I misdemeanor.

5. The activation, implementation and coordination of appropriate mutual aid agreements and compacts, including the Emergency Management Assistance Compact, and the authorization of the State Coordinator of Emergency Services to enter into any other supplemental agreements, pursuant to §§ 44-146.17 (5) and 44-146.28:1, to provide for the evacuation and reception of injured and other persons and the exchange of medical, fire, police, National Guard personnel and equipment, public utility, reconnaissance, welfare, transportation and communications personnel, and

Governor

equipment and supplies. The State Coordinator of Emergency Services is hereby designated as Virginia's authorized representative within the meaning of the Emergency Management Assistance Compact, § 44-146.28:1, Code of Virginia.

6. The authorization of the Departments of State Police, Transportation and Motor Vehicles to grant temporary overweight/registration/license exemptions to carriers transporting essential emergency relief supplies into and within the Commonwealth in order to support the disaster response and recovery, particularly as regards donation management.

The axle and gross weights shown below are the maximum allowed, unless otherwise posted.

Any One Axle	24,000 Pounds
Tandem Axles (more than 40 inches but not more than 96 inches spacing between axle centers)	44,000 Pounds
Single Unit (2 Axles)	44,000 Pounds
Single Unit (3 Axles)	54,500 Pounds
Tractor-Semitrailer (4 Axles)	64,500 Pounds
Tractor-Semitrailer (5 or more Axles)	90,000 Pounds
Tractor-Twin Trailers (5 or more Axles)	90,000 Pounds
Other Combinations (5 or more Axles)	90,000 Pounds
Per Inch of Tire Width in Contact with Road Surface	850 Pounds

In addition to described overweight transportation privileges, carriers are also exempt from registration with DMV. This includes the vehicles enroute and returning to their home base. The above cited agencies shall communicate this information to all staff responsible for permit issuance and truck legalization enforcement.

This authorization shall apply to hours worked by any carrier when transporting passengers, property, equipment, food, fuel, construction materials and other critical supplies to or from any portion of the Commonwealth for purpose of providing relief or assistance as a result of this disaster, pursuant to § 52-8.4 of the Code of Virginia.

The foregoing overweight transportation privileges and the regulatory exemption provided by § 52-8.4.A of the Code of Virginia, and implemented in § 2.3.B of VR 545-01-1, "Motor Carrier Safety Regulations," shall remain in effect for sixty (60) days from the onset of the disaster, or until emergency relief is no longer necessary, as determined by the Secretary of Public Safety in consultation with the Secretary of Transportation, whichever is earlier.

7. The discontinuance of provisions authorized in paragraphs 6 above may be implemented and disseminated by publication of administrative notice to all affected and interested parties by the authority I herewith delegate to the Secretary of Public Safety, after consultation with other affected Cabinet-level Secretaries.

8. If deemed necessary, the designation of a State Recovery Task Force under the leadership of the Secretary of Commerce and Trade to promote public,

private and industrial redevelopment projects and help sustain long-term community economic vitality in the aftermath of the disaster. This task force will also assist in the restoration of critical public health and safety systems and will do so in close coordination with the State Coordinator of Emergency Services as the individual responsible for ensuring implementation of short-term recovery programs.

9. The authorization of appropriate oversight boards, commissions and agencies to ease building code restrictions, and to permit emergency demolition, hazardous waste disposal, debris removal, emergency landfill siting and operations and other activities necessary to address immediate health and safety needs. This state of emergency constitutes a major medical emergency under the Rules and Regulations of the Board of Health Governing Emergency Medical Services, pursuant to Article 3.01 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1, Statewide Emergency Medical Services System and Services, and exemptions specified in the Rules and Regulations regarding patient transport and provider certification in disasters apply.

10. The costs incurred by state agencies and other agents of the Commonwealth as defined herein and in § 44-146.17, except as defined in paragraph 6 below, in performing these missions shall be paid out of the sum sufficient appropriation for Disaster Planning and Operations contained in Item 42 of Chapter 912 of the 1996 Acts of Assembly.

11. The implementation by public agencies under my supervision and control of their emergency assignments as directed in the COVEOP without regard to normal procedures pertaining to performance of public work, entering into contracts, incurring of obligations, or other logistical and support measures, as delineated in § 44-146.28 (b) of the Emergency Services and Disaster Laws. § 44-146.24 also applies to the disaster activities of state agencies.

12. The immunity provisions of § 44-146.23 (a) apply to volunteer, auxiliary and reserve groups including search and rescue team members (SAR), Virginia Association of Volunteer Rescue Squad (VAVRS) personnel, Civil Air Patrol (CAP), member organizations of the Voluntary Organizations Active in Disasters (VOAD), Radio Amateur Civil Emergency Services (RACES), volunteer fire fighters and others when designated as agents of the Commonwealth for specific disaster-related mission assignments and identified by the State Coordinator of Emergency Services.

The following conditions apply to the deployment of the Virginia National Guard and the Virginia Defense Force:

1. The Adjutant General of Virginia, after consultation with the State Coordinator of Emergency Services, shall make available on state active duty such units and members of the Virginia National Guard and Virginia Defense Force and such equipment as may be desirable to assist in pre-storm preparations and in alleviating the human suffering and damage to property as a result of Hurricane Fran.

2. Pursuant to § 52-6 of the Code of Virginia, I authorize and direct the Superintendent of State Police to appoint any and all such Virginia Army and Air National Guard personnel called to state active duty as additional police officers. These police officers shall have the same powers and perform the same duties as the regular State Police officers appointed by the Superintendent. However, they shall nevertheless remain members of the Virginia National Guard, subject to military command as members of the State Militia. Any bonds and/or insurance required by § 52-7 of the Code of Virginia shall be provided for them at the expense of the Commonwealth.

3. In all instances, members of the Virginia National Guard and Virginia Defense Force shall remain subject to military command as prescribed by § 44-78.1 of the Code of Virginia and not subject to the civilian authorities of the state or local governments. This shall not be deemed to prohibit working in close cooperation with members of the Virginia Departments of State Police or Emergency Services or local law enforcement or emergency management authorities or receiving guidance from them in the performance of their duties.

4. Should service under this Executive Order result in the injury or death of any member of the Virginia National Guard, the following will be provided to the member and the member's dependents or survivors:

(a) Workers' Compensation benefits provided to members of the National Guard by the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof; and, in addition,

(b) The same benefits, or their equivalent, for injury, disability and/or death, as would be provided by the federal government if the member were serving on federal active duty at the time of the injury or death. Any such federal-type benefits due to a member and his or her dependents or survivors during any calendar month shall be reduced by any payments due under the Virginia Workers' Compensation Act during the same month. If and when the time period for payment of Workers' Compensation benefits has elapsed, the member and his or her dependents or survivors shall thereafter receive full federal-type benefits for as long as they would have received such benefits if the member had been serving on federal active duty at the time of injury or death. Any federal-type benefits due shall be computed on the basis of military pay grade E-5 or the member's military grade at the time of injury or death, whichever produces the greater benefit amount. Pursuant to § 44-14 of the Code of Virginia, and subject to the concurrence of the Board of Military Affairs, and subject to the availability of future appropriations which may be lawfully applied to this purpose, I now approve of future expenditures out of appropriations to the Department of Military Affairs for such federal-type benefits as being manifestly for the benefit of the military service.

5. The following conditions apply to service by the Virginia Defense Force:

(a) Compensation shall be at a daily rate that is equivalent of base pay only for a National Guard Unit Training Assembly, commensurate with the grade and years of service of the member, not to exceed 20 years of service;

(b) Lodging and meals shall be provided by the Adjutant General or reimbursed at standard state per diem rates;

(c) All privately owned equipment, including, but not limited to, vehicles, boats, and aircraft, will be reimbursed for expense of fuel. Damage or loss of said equipment will be reimbursed, minus reimbursement from personal insurance, if said equipment was authorized for use by the Adjutant General in accordance with § 44-54.12 of the Code of Virginia; and

(d) In the event of death or injury, benefits shall be provided in accordance with the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof.

6. The costs incurred by the Department of Military Affairs and Virginia Defense Force in performing these missions shall be paid out of the sum sufficient appropriation for Disaster Planning and Operations contained in Item 493 of Chapter 912 of the 1996 Acts of Assembly.

This Executive Order shall be effective upon its signing, and shall remain in full force and effect until June 30, 1997, unless sooner amended or rescinded by further executive order. That portion providing for benefits for members of the National Guard and other agents of the Commonwealth herein provided for in the event of injury or death shall continue to remain in effect after termination of this Executive Order as a whole.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 6th day of September, 1996.

/s/ George Allen
Governor

V.A.R. Doc. No. R97-163; Filed November 27, 1996, 10:27 a.m.

EXECUTIVE ORDER NUMBER SIXTY-SEVEN (96)

CREATING THE GOVERNOR'S COMMISSION ON SURPLUS PROPERTY

The extent to which the extensive real property of the Commonwealth is efficiently and effectively utilized must be a major concern of state government. This issue has been addressed over time, by the Department of General Services, the Governor's Commission on Government Reform (Blue Ribbon Strike Force), and the Governor's Commission on the Conversion of State-Owned Property.

Considerable progress has been made in determining specific properties that can be put to higher or better use. It is important not only to continue this progress, but in addition, to institutionalize a process that ensures comprehensive and systematic oversight on behalf of the citizens of the Commonwealth.

Governor

Accordingly, by virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and under the laws of the Commonwealth, including but not limited to § 2.1-51.36 of the Code of Virginia, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby create the Governor's Commission on Surplus Property.

The Commission is classified as a gubernatorial advisory commission in accordance with Section 2.1-51.35 and 9-6.25 of the Code of Virginia.

The Commission shall have the responsibility to provide the Governor with advice on the use of real property assets controlled by the agencies and institutions of the executive branch and on institutionalizing a program for real estate asset management. The Commission shall have the following specific responsibilities:

1. To evaluate real property assets controlled by executive branch agencies and institutions in a manner that takes into account their highest and best use on behalf of the Commonwealth at large, as well as the narrower interests of individual agencies and institutions.
2. To appraise the market value and potential of real property assets that should be considered for sale or other disposition, and to recommend assets that should be sold, used for other purposes, or otherwise disposed.
3. To examine the utility of such assets as they relate to the mission of the controlling agency or institution and to consider, as appropriate, alternative means to achieve agency missions with alternative assets.
4. To coordinate any specific recommendations that involve substantial policy and program change with the appropriate Governor's Secretary.
5. To recommend an approach to establish a comprehensive and systematic process for managing real estate assets in close coordination with the respective state agencies which control that property, and giving careful consideration to the potential role for the private sector and public/private partnerships.
6. To recommend incentives for state agencies and institutions to participate in a real property management program that pursues benefits on behalf of the Commonwealth as a whole, rather than only the narrower interests of a single agency or institution.

The Commission shall be comprised of fifteen members, including the Governor's Secretary of Administration and Secretary of Finance; appointed by and serving at the pleasure of the Governor. The Governor shall designate a Chair, or one or more Co-Chairs, from among the Commission members. Members shall serve without compensation, but may receive reimbursement for expenses incurred in the discharge of their official duties, with the approval of the Secretary of Administration.

Such staff support as is necessary for the conduct of the Commission's work during the term of its existence shall be furnished by the Department of General Services, the Commonwealth Competition Council, the Offices of the Governor's Secretaries, and such other executive agencies

with closely and definitely related purposes as the Governor may designate. An estimated 1,500 hours of staff support will be required to support the Commission. Such funding as is necessary during the Commission's existence shall be provided from sources authorized by Section 2.1-51.37 of the Code of Virginia, which have been appropriated for the same purposes as the Commission. Direct expenditures for the Commission's work are estimated to be \$35,000.

The Commission shall complete its examinations of these matters by October 1, 1997, and provide periodic progress reports and recommendations to the Governor on a schedule to be approved by the Secretary of Administration.

All agencies and institutions of the executive branch shall cooperate with the Commission and provide in a timely manner such information as the Commission may request. The Secretary of Administration periodically shall report to the Governor regarding the timeliness and completeness of responses by executive agencies and institutions to Commission requests.

This Executive Order shall be effective upon its signing and shall remain in full force and effect until October 1, 1997, unless amended or rescinded by further executive order.

Given under my hand and under the seal of the Commonwealth of Virginia this 4th day of October, 1996.

/s/ George Allen
Governor

VA.R. Doc. No. R97-164; Filed November 27, 1996, 10:27 a.m.

EXECUTIVE ORDER NUMBER SIXTY-EIGHT (96)

CONTINUING CERTAIN EMERGENCY DECLARATIONS DUE TO NATURAL DISASTERS IN THE COMMONWEALTH

By virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and under the laws of the Commonwealth, including but not limited to § 44-146.17 of the *Code of Virginia*, and subject always to my continuing and ultimate authority and responsibility to act in such matters, and to reserve powers, I hereby continue the states of emergency declared in the following executive orders:

Executive Order Number Six (94), Declaration of a State of Emergency Arising From a Severe Winter Storm Which Impacted the Commonwealth, as continued by Executive Orders Number Eighteen (94) and Fifty-one (95);

Executive Order Number Seven (94), Declaration of a State of Emergency Arising From Heavy Snowfall, Torrential Rains, and Icy Conditions Throughout the Commonwealth, as continued by Executive Orders Number Eighteen (94) and Fifty-one (95);

Executive Order Number Fifty-four (95), Declaration of a State of Emergency Arising From Heavy Rains, Flash Floods, and Mud Slides in Portions of the Commonwealth of Virginia; and

Executive Order Number Sixty (96), Declaration of a State of Emergency Throughout the Commonwealth

Arising From Massive Snow Storm With Blizzard Conditions.

This Executive Order shall be retroactively effective to July 1, 1996, upon its signing, and shall remain in full force and effect until June 30, 1997, unless sooner amended or rescinded by further executive order.

Given under my hand and under the seal of the Commonwealth of Virginia this 31st day of October, 1996.

/s/ George Allen
Governor

VA.R. Doc. No. R97-166; Filed November 27, 1996, 10:27 a.m.

EXECUTIVE ORDER NUMBER SIXTY-NINE (96)

THE VOLUNTEER VIRGINIA INITIATIVE: CONTINUING THE GOVERNOR'S COMMISSION ON COMMUNITY SERVICE AND VOLUNTEERISM

By virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and under the laws of the Commonwealth, including but not limited to § 2.1-51.36 of the *Code of Virginia*, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby continue the Governor's Commission on Community Service and Volunteerism.

The Commission is classified as a gubernatorial advisory commission in accordance with §§ 2.1-51.35 and 9-6.25 of the Code of Virginia.

The Commission shall advise the Governor on matters related to the application for federal funds for national service programs and the promotion and development of all types of citizen service and volunteerism in the Commonwealth of Virginia, including coordination of the VOLUNTEER VIRGINIA initiative. The Commission shall have the following specific duties:

1. To serve in an advisory capacity for national service programs in Virginia, fulfilling the responsibilities and duties prescribed by the federal Corporation for National Service;
2. To advise regarding the development, implementation, and evaluation of Virginia's state plan which outlines strategies for supporting and expanding voluntary service throughout the Commonwealth;
3. To advise regarding the adaptation of the Americorps national service program to meet the priorities of Virginia citizens, establishing a network which can address local community needs related to welfare reform, public safety matters, conservation of natural resources, education of youth, and other initiatives;
4. To serve as an advisory body to the Governor, the Secretary of Health and Human Resources, and to the Commissioner of the Department of Social Services for the purpose of strengthening all aspects of community volunteerism in Virginia; and

5. To recognize and call attention to the significant voluntary contributions of Virginia citizens and organizations.

The Commission shall be comprised of 15 to 25 voting members appointed by the Governor and serving at his pleasure. No more than 25 percent of voting members may be state employees. Additional persons may be appointed by the Governor as ex-officio non-voting members. The Chairperson shall be elected by the voting members of the Commission. Commission voting membership shall include representatives for the categories as outlined in federal regulations issued by the Corporation for National Service.

Such staff support as is necessary for the conduct of the Commission's work during the term of its existence shall be furnished by the Virginia Department of Social Services and other state agencies with closely and definitely related purposes as the Governor may designate. An estimated 8,000 hours of staff time will be required to support the work of the Commission. Funding necessary to support the Commission's work shall be provided from federal funds, private contributions, and state funds appropriated for the same purposes as the Commission, authorized by § 2.1-51.27 of the Code of Virginia. Direct expenditures for the Commission's work are estimated at \$15,000.

Members of the Commission shall serve without compensation and shall receive reimbursement for expenses incurred in the discharge of their official duties only upon the approval of the Commissioner of the Virginia Department of Social Services.

The Commission shall meet at least quarterly upon the call of the Chairperson. The Commission shall make a report to the Governor in June, 1997, and shall issue such other reports and recommendations as it deems necessary or as requested by the Governor.

This Executive Order shall be retroactively effective to April 1, 1996, upon its signing and shall remain in full force and effect until April 1, 1997, unless amended or rescinded by further executive order.

Given under my hand and under the seal of the Commonwealth of Virginia this 8th day of November, 1996.

/s/ George Allen
Governor

VA.R. Doc. No. R97-166; Filed November 27, 1996, 10:27 a.m.

EXECUTIVE ORDER NUMBER SEVENTY (96)

AMENDING THE DECLARATION OF EMERGENCY ARISING FROM HURRICANE FRAN

Hurricane Fran destroyed and damaged many trees in the Commonwealth and adjoining states, a situation that has resulted in a substantial increase in the risk of forest fires and the spread of plant diseases and undesirable insects. In addition, actions by North Carolina and South Carolina to allow trucks hauling trees damaged and destroyed by Hurricane Fran to exceed their normal weight limitations, have created a situation in which Virginia's trees which were

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destroyed and damaged by Hurricane Fran are being neglected by haulers.

Therefore, by virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and under the laws of the Commonwealth, including but not limited to § 44-146.17 of the *Code of Virginia*, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby amend Executive Order Number Sixty-Six (96), approved by me September 6, 1996, as set forth below.

The following paragraph numbered 13 shall follow paragraph 12 on page five of Executive Order Number Sixty-six (96):

13. The authorization of the State Forester, in consultation with the Departments of Transportation, State Police, and Motor Vehicles, to issue temporary special credentials to those hauling salvaged and damaged trees, logs and other usable materials located in the declared disaster areas, either inside or outside the Commonwealth, to forest manufacturing mills for the purpose of reducing the imminent risk of forest fire, the spread of disease, and undesirable insects. These temporary credentials shall waive restrictions on weight/registration/licenses to the extent called for in paragraph six above, but shall remain in effect for periods determined by the State Forester.

The Departments of State Police, Transportation, and Motor Vehicles shall communicate this information to all staff responsible for permit issuance and truck legalization enforcement.

This Executive Order shall be effective upon its signing and shall remain in full force and effect until June 30, 1997, unless sooner amended or rescinded by further executive order.

Given under my hand and under the seal of the Commonwealth of Virginia this 8th day of November, 1996.

/s/ George Allen
Governor

VA.R. Doc. No. R97-167; Filed November 27, 1996, 10:26 a.m.

EXECUTIVE MEMORANDUM 2-96

CENTURY DATE CHANGE INITIATIVE

Purpose

The purpose of this Executive Memorandum is to provide policy guidance to State agencies to resolve computer technology challenges associated with the century date change in the year 2000.

Applicability

All Executive Branch agencies and institutions.

Effective Date

December 1, 1996.

Introduction

By virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and the laws of the Commonwealth, including but not limited to, Chapter 5 of Title 2.1 of the *Code of Virginia*, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby establish the Century Date Change Initiative to resolve computer problems associated with the arrival of the year 2000.

Many computer programs and data files were developed using a two-digit representation for the year. State government computers are connected with the computer systems of other states, local governments, the federal government, banks, lending institutions, and various vendors.

In addition, many security systems, elevators, and heating and air conditioning systems run on time and date programs. As it becomes necessary to use the date of January 1, 2000 and beyond, computer programs and data files may fail or produce invalid results.

General Policy

The Secretary of Administration, with support from the Council on Information Management, the Department of Information Technology, and the Department of Planning and Budget, shall provide the necessary coordination and leadership to ensure that the Commonwealth's information systems successfully make the effective and efficient transition to the year 2000. Each agency or institution shall be primarily responsible for its own information systems but will coordinate its efforts through the Secretary of Administration. All agencies and institutions shall redirect their existing financial and personnel resources as necessary, to the extent allowed by law, to resolve the problem.

Responsibility of the Secretary of Administration

- Provide leadership for the Century Date Change Initiative (CDCI), including designation of a statewide CDCI coordinator.
- Create a CDCI coordinating committee, with representation from each Secretariat.
- Establish deadlines and milestones for the Initiative.
- Issue CDCI guidance and directives.
- Direct agencies and institutions, in consultation with the Department of Planning and Budget, to reallocate existing financial and personnel resources to resolve the century date change problems.
- Coordinate with other branches of Virginia government.
- Ensure effective coordination with other states, localities and the federal government.
- Provide periodic reports to the Governor and, as may be required, to the General Assembly.

Responsibilities of Other Secretariats

- Cooperate to the fullest extent with the Secretary of Administration.

- Resolve problems within their respective agencies and institutions.
- Ensure agency compliance with this Executive Memorandum and the deadlines, policies, and directives issued pursuant to it.

Responsibilities of State Agencies

- Be pro-active in identifying problems and offering solutions.
- Identify a single point of contact within the agency to coordinate century date change related activities.
- Comply with the deadlines, policies, and directives issued by the Secretary of Administration.
- Redirect existing financial and personnel resources to address the challenges.
- Make available to the CDCI Coordinator, for use by other agencies, any tools developed by an agency for use in their own internal checks.

This Executive Memorandum shall be effective December 1, 1996, and shall remain in full force and effect until superseded or rescinded by further executive action.

/s/ George Allen
Governor

VA.R. Doc. No. R97-161; Filed November 27, 1996, 10:27 a.m.

GOVERNOR'S COMMENTS ON PROPOSED REGULATIONS

STATE AIR POLLUTION CONTROL BOARD

Title of Regulation: 9 VAC 5-20-10 et seq. General Provisions.

Governor's Comment:

I have reviewed this proposed regulation on a preliminary basis. The regulation is needed to implement a federal mandate. While I reserve the right to take action authorized by the Administrative Process Act during the final adoption period, I have no objection to the proposed regulation based on the information and public comment currently available.

/s/ George Allen
Governor
Date: July 26, 1996

VA.R. Doc. No. R97-155; Filed November 22, 1996, 10:21 a.m.

DEPARTMENT OF REHABILITATIVE SERVICES

Title of Regulation: 22 VAC 30-10-10 et seq. Public Participation Guidelines.

Governor's Comment:

I have reviewed this proposed regulation on a preliminary basis. This regulation is mandated by state law. While I reserve the right to take action authorized by the

Administrative Process Act during the final adoption period, I have no objection to the proposed regulation based on the information and public comment currently available.

/s/ George Allen
Governor
Date: July 26, 1996

VA.R. Doc. No. R97-153; Filed November 22, 1996, 10:21 a.m.

BOARD OF SOCIAL WORK

Title of Regulation: 18 VAC 140-20-10 et seq. Regulations Governing the Practice of Social Work.

Governor's Comment:

I have reviewed this proposed regulation on a preliminary basis. While I reserve the right to take action authorized by the Administrative Process Act during the final adoption period, I have no objection to the proposed regulation based on the information and public comment currently available.

/s/ George Allen
Governor
Date: July 25, 1996

VA.R. Doc. No. R97-158; Filed November 26, 1996, 9:22 a.m.

COMMONWEALTH TRANSPORTATION BOARD

Title of Regulation: 24 VAC 30-70-10 et seq. Minimum Standards of Entrances to State Highways (REPEALING).

Title of Regulation: 24 VAC 30-71-10 et seq. Minimum Standards of Entrances to State Highways.

Governor's Comment:

I have reviewed this proposed regulation on a preliminary basis. While I reserve the right to take action authorized by the Administrative Process Act during the final adoption period, I have no objection to the proposed regulation based on the information and public comment currently available.

/s/ George Allen
Governor
Date: June 14, 1996

VA.R. Doc. No. R97-154; Filed November 22, 1996, 10:21 a.m.

GENERAL NOTICES/ERRATA

Symbol Key

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

GOVERNOR'S COMMISSION ON ENVIRONMENTAL STEWARDSHIP

Notice

The Governor's Commission on Environmental Stewardship will meet to present its final report on December 18, 1996, at 10 a.m. in House Room C, General Assembly Building, Capitol Square, Richmond, Virginia.

The commission is charged with examining Virginia's environmental programs and policies and making recommendations to improve the stewardship of Virginia's rich natural heritage. The commission is also specially charged by the Governor to study ways to foster growth of the environmental technologies industry in Virginia.

The commission is specifically directed to:

Examine Virginia's laws and policies related to pollution prevention, compliance and enforcement, and make appropriate findings and recommendations regarding strategies for improvement;

Evaluate and provide recommendations for enhancing the awareness, understanding, commitment, and active involvement of Virginia citizens in ensuring wise stewardship of the Commonwealth's natural resources, now and in the future, through education, volunteerism, public/private partnerships, and incentive programs;

Evaluate Virginia's laws, programs, and policies relating to conservation, recreation, parks, natural areas, open spaces, private property protection, and wildlife management, and make appropriate findings and recommendations for improvement;

Examine the development of advanced environmental technologies in Virginia, and make recommendations for fostering growth of the environmental technologies industry in Virginia, including development of markets and promotion of the use of such advanced environmental technologies in Virginia and regionally, nationally, and internationally;

Evaluate the laws, programs, and policies of the Commonwealth regarding waste management, litter control and recycling, and make appropriate findings and recommendations regarding strategies for improvement; and

Examine the role of citizen boards in the development, implementation and oversight of policies affecting natural resource conservation, environmental quality, and economic development, and make appropriate findings and recommendations for improvement.

The distinguished Virginians who comprise the commission have been selected broadly to represent the many constituencies, disciplines, interests and outlooks on

environmental matters, and to provide expertise to assist the commission in evaluating proposals and reaching consensus on environmental goals and strategies for the 21st century. The commission has also conducted public meetings and site visits throughout the Commonwealth, including Richmond, Salem, Hopewell, Gloucester, Augusta County, Fauquier County, Arlington, Abingdon, Herndon, and Virginia Beach. The commission has received presentations and comment, oral and written, from persons in the business and academic communities, environmental and civic organizations, volunteer groups, federal, state and local governments, and concerned citizens.

The commission's activities are reported on its Internet homepage at www.state.va.us/~greenva/gces.htm.

Contacts: David Nutter, Staff Director, Office of the Secretary of Natural Resources, 202 N. Ninth St., 7th Floor, Richmond, VA 23219, telephone (804) 786-0044, FAX (804) 371-8333, or Carl Josephson, Assistant Attorney General, Office of the Attorney General, 900 E. Main St., Richmond, VA 23219, telephone (804) 786-2444 or FAX (804) 786-0034.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Mailing Address: Our mailing address is: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219. You may FAX in your notice; however, we ask that you FAX two copies and do not follow up with a mailed copy. Our FAX number is: (804) 692-0625.

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

All agencies are required to use the appropriate forms when furnishing material and dates for publication in *The Virginia Register of Regulations*. The forms are supplied by the office of the Registrar of Regulations. If you do not have any forms or you need additional forms, please contact: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

FORMS:

NOTICE of INTENDED REGULATORY ACTION - RR01
NOTICE of COMMENT PERIOD - RR02
PROPOSED (Transmittal Sheet) - RR03
FINAL (Transmittal Sheet) - RR04
EMERGENCY (Transmittal Sheet) - RR05
NOTICE of MEETING - RR06
AGENCY RESPONSE TO LEGISLATIVE OBJECTIONS - RR08

ERRATA

DEPARTMENT OF LABOR AND INDUSTRY

Title of Regulation: 16 VAC 25-90-1910.1001. Asbestos Standard for General Industry (29 CFR 1910.1001).

Publication: 13:4 VA.R. 415 November 11, 1996

Correction to Final Regulation:

Page 415, last paragraph, line 2, change "16 VAC 25-175-1926.1101" to "16 VAC 25-90-1910.1001"

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulation: 12 VAC 30-120-360 et seq. State Plan for Medical Assistance: Part VI: Medallion II.

Publication: 13:5 VA.R. 629-637 November 25, 1996

Correction to Final Regulation:

Page 635, 12 VAC 30-120-410 B, line 2, change "Medallion II provider" to "HMO"

CALENDAR OF EVENTS

Symbol Key

- † Indicates entries since last publication of the *Virginia Register*
- ♿ Location accessible to handicapped
- ☎ Telecommunications Device for Deaf (TDD)/Voice Designation

NOTICE

Only those meetings which are filed with the Registrar of Regulations by the filing deadline noted at the beginning of this publication are listed. Since some meetings are called on short notice, please be aware that this listing of meetings may be incomplete. Also, all meetings are subject to cancellation and the *Virginia Register* deadline may preclude a notice of such cancellation.

For additional information on open meetings and public hearings held by the Standing Committees of the Legislature during the interim, please call Legislative Information at (804) 786-6530.

VIRGINIA CODE COMMISSION

EXECUTIVE

4917, telephone (804) 367-8590, FAX (804) 367-2474 or (804) 367-9753/TDD ☎

BOARD FOR ACCOUNTANCY

GOVERNOR'S ADVISORY BOARD ON AGING

January 6, 1997 - 10 a.m. -- Open Meeting
Germanna Community College, 2130 Germanna Highway, Room 100, Locust Grove, Virginia. ♿ (Interpreter for the deaf provided upon request)

January 20, 1997 - 6 p.m. -- Open Meeting
January 21, 1997 - 8 a.m. -- Open Meeting
Department for the Aging, 700 East Franklin Street, 10th Floor, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A meeting of the board's Executive Committee to discuss (i) RFP Specifications (Executive Session); (ii) Regulatory Review Committee report; (iii) 1997 legislation preparation; and (iv) other business needing action by the committee. This is a work session for the committee which consists of two board members and staff. All meetings are subject to cancellation. Call the board office 24 hours in advance of the scheduled meeting. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact the board at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

A meeting to conduct board business.

Contact: Kimlah Hyatt, Staff to the Board, Department for the Aging, 700 E. Franklin St., 10th Floor, Richmond, VA 23219-2327, telephone (804) 225-2801, FAX (804) 371-8381, toll-free 1-800-552-3402, or (804) 225-2271/TDD ☎

Contact: Nancy Taylor Feldman, Assistant Director, Board for Accountancy, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-2474 or (804) 367-9753/TDD ☎

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

January 21, 1997 - 10 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

Pesticide Control Board

January 15, 1997 - 1 p.m. -- Open Meeting
January 16, 1997 - 9 a.m. -- Open Meeting
Washington Building, 1100 Bank Street, Board Room, Room 204, Richmond, Virginia. ♿

A meeting to discuss regulatory review, committee reports, disciplinary cases, and other matters requiring board action. A public comment period will be held at the beginning of the meeting. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the board at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Committee meetings and a general business meeting. Portions of the meetings may be held in closed session pursuant to § 2.1-344 of the Code of Virginia. The public will have an opportunity to comment on any matter not on the board's agenda beginning at 1 p.m. on January 15. Any person who needs any accommodations in order to participate at the meeting should contact Dr. Marvin A. Lawson at least 10 days before the meeting date so that suitable arrangements can be made.

Contact: Dr. Marvin A. Lawson, Program Manager, Office of Pesticide Services, Department of Agriculture and Consumer Services, 1100 Bank St., Room 401, P.O. Box 1163, Richmond, VA 23218, telephone (804) 371-6558.

Contact: Nancy Taylor Feldman, Assistant Director, Board for Accountancy, 3600 W. Broad St., Richmond, VA 23230-

Virginia Plant Pollination Advisory Board

† February 7, 1997 - 10 a.m. -- Open Meeting
Washington Building, 1100 Bank Street, 4th Floor
Conference Room, Richmond, Virginia. ☎

A regular meeting.

Contact: Robert G. Wellemeyer, Secretary-Treasurer,
Department of Agriculture and Consumer Services, 234 West
Shirley Ave., Warrenton, VA 22186, telephone (540) 347-
6380, FAX (540) 347-6384, or (804) 371-6344/TDD ☎

STATE AIR POLLUTION CONTROL BOARD

December 31, 1996 -- Public comments may be submitted
until 4:30 p.m. on this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of
the Code of Virginia that the State Air Pollution Control
Board intends to amend regulations entitled: **9 VAC 5-
20-10 et seq. Regulations for the Control and
Abatement of Air Pollution: General Provisions.** 9
VAC 5-20-21 lists documents that are incorporated by
reference into the Regulations for the Control and
Abatement of Air Pollution. In addition to federal
documents (which include portions of the Code of Federal
Regulations as listed in Rules 5-5 and 6-1), a number of
technical documents are listed. These documents include
materials from the American Society for Testing and
Materials, the American Petroleum Institute, and the
National Fire Prevention Association. The regulation
amendments update the documents to include the most
current version available.

Request for Comments: The purpose of this notice is to
provide the public with the opportunity to comment on the
proposed regulation and the costs and benefits of the
proposal.

Localities Affected: There is no locality which will bear any
identified disproportionate material air quality impact due to
the proposed regulation which would not be experienced by
other localities.

Location of Proposal: The proposal, an analysis conducted
by the department (including a statement of purpose, a
statement of estimated impact and benefits of the proposed
regulation, an explanation of need for the proposed
regulation, an estimate of the impact of the proposed
regulation upon small businesses, identification of and
comparison with federal requirements, and a discussion of
alternative approaches) and any other supporting documents
may be examined by the public at the department's Office of
Air Program Development (Eighth Floor), 629 East Main
Street, Richmond, Virginia, and the department's regional
offices (listed below) between 8:30 a.m. and 4:30 p.m. of
each business day until the close of the public comment
period.

Southwest Regional Office
Department of Environmental Quality
355 Deadmore Street
Abingdon, Virginia
Ph: (540) 676-4800

West Central Regional Office
Department of Environmental Quality
Executive Office Park
3019 Peters Creek Road
Roanoke, Virginia
Ph: (540) 562-6700

Lynchburg Satellite Office
Department of Environmental Quality
7705 Timberlake Road
Lynchburg, Virginia
Ph: (804) 582-5120

Valley Regional Office
Department of Environmental Quality
116 North Main Street
Bridgewater, Virginia 22812
Ph: (540) 828-2595

Fredericksburg Satellite Office
Department of Environmental Quality
300 Central Road, Suite B
Fredericksburg, Virginia
Ph: (540) 899-4600

Piedmont Regional Office
Department of Environmental Quality
4949-A Cox Road
Innsbrook Corporate Center
Glen Allen, Virginia
Ph: (804) 527-5020

Tidewater Regional Office
Department of Environmental Quality
5636 Southern Boulevard
Virginia Beach, Virginia
Ph: (757) 518-2000

Springfield Satellite Office
Department of Environmental Quality
Springfield Corporate Center, Suite 310
6225 Brandon Avenue
Springfield, Virginia
Ph: (703) 644-0311

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

Public comments may be submitted until 4:30 p.m. December
31, 1996, to the Director, Office of Air Program Development,
Department of Environmental Quality, P.O. Box 10009,
Richmond, Virginia 23240.

Contact: Karen G. Sabasteanski, Policy Analyst, Office of
Air Program Development, Department of Environmental
Quality, P.O. Box 10009, Richmond, VA 23240, telephone
(804) 698-4426, FAX (804) 698-4510, (804) 698-
4021/TDD ☎, or toll-free 1-800-592-5482.

† January 8, 1997 - 10 a.m. -- Open Meeting
Location to be determined.

A regular meeting.

Contact: Cindy M. Berndt, Department of Environmental
Quality, P.O. Box 10009, Richmond, VA 23240, telephone
(804) 698-4378.

Calendar of Events

AUCTIONEERS BOARD

† **January 10, 1997 - 10 a.m.** -- Open Meeting
Omni Hotel, 100 South 12th Street, Richmond, Virginia. ☎

A meeting to conduct general board business. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact the department at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514 or (804) 367-9753/TDD ☎

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

† **February 20, 1997 - 9:30 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Richmond, Virginia. ☎

A general board meeting. Public comments will be received for 15 minutes at the beginning of the meeting.

Contact: Senita Booker, Program Support Technician Senior, Board of Audiology and Speech-Language Pathology, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-7390, FAX (804) 662-9943 or (804) 662-7197/TDD ☎

Legislative/Regulatory Committee

† **January 31, 1997 - 10 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Richmond, Virginia. ☎

A meeting to discuss proposed regulations of the board. No public comment will be received.

Contact: Senita Booker, Program Support Technician Senior, Board of Audiology and Speech-Language Pathology, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-7390, FAX (804) 662-9943 or (804) 662-7197/TDD ☎

BOARD FOR BARBERS

† **January 6, 1997 - 10 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ☎

A general business meeting of the Legislative Committee. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact the department at least two weeks prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Karen W. O'Neal, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8509, FAX (804) 367-2475 or (804) 367-9753/TDD ☎

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

Northern Area Review Committee

January 14, 1997 - 10 a.m. -- Open Meeting
February 11, 1997 - 10 a.m. -- Open Meeting
Chesapeake Bay Local Assistance Department, 805 East Broad Street, Suite 701, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to review Chesapeake Bay Preservation Area programs for the Northern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the meeting; however, written comments are welcome.

Contact: Carolyn J. Elliott, Executive Secretary, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440, FAX (804) 225-3447 or toll-free 1-800-243-7229/TDD ☎

Southern Area Review Committee

January 14, 1997 - 2 p.m. -- Open Meeting
February 11, 1997 - 2 p.m. -- Open Meeting
Chesapeake Bay Local Assistance Department, 805 East Broad Street, Suite 701, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to review Chesapeake Bay Preservation Area programs for the Southern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the meeting; however, written comments are welcome.

Contact: Carolyn J. Elliott, Executive Secretary, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440, FAX (804) 225-3447 or toll-free 1-800-243-7229/TDD ☎

STATE CHILD FATALITY REVIEW TEAM

† **January 22, 1997 - 10 a.m.** -- Open Meeting
State Corporation Commission, Tyler Building, 1300 East Main Street, 3rd Floor Conference Room, Richmond, Virginia. ☎

A meeting to (i) discuss the status of ongoing studies; (ii) review data collection and analysis issues; and (iii) update the team on any new legislative or administrative

matters. The second part of this meeting will be closed for specific case discussion.

Contact: Suzanne J. Keller, Coordinator, 9 N. 14th St., Richmond, VA 23219, telephone (804) 786-1048, FAX (804) 371-8595, or toll-free 1-800-447-1706.

COMMONWEALTH COMPETITION COUNCIL

† **January 6, 1997 - 10 a.m.** -- Open Meeting
General Assembly Building, 910 Capitol Square, 3rd Floor West Conference Room, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A regular meeting.

Contact: Peggy Robertson, Staff, Commonwealth Competition Council, James Monroe Bldg., 101 N. 14th St., 5th Floor, Richmond, VA 23219, telephone (804) 786-0240 or FAX (804) 786-1594.

DEPARTMENT OF CONSERVATION AND RECREATION

Appomattox Scenic River Advisory Board

January 14, 1997 - 7 p.m. -- Open Meeting
1801 Ramblewood Road, Petersburg, Virginia.

A meeting to discuss river issues.

Contact: Richard G. Gibbons, Environmental Program Manager, Department of Conservation and Recreation, Division of Planning and Recreation Resources, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-4132, FAX (804) 371-7899 or (804) 786-2121/TDD ♿

Virginia Cave Board

† **January 11, 1997 - 1 p.m.** -- Open Meeting
Radford University, Porterfield Hall, Room 180, Radford, Virginia.

A regularly scheduled meeting. A variety of issues relating to cave and karst conservation will be discussed. No public comment period has been set aside on the agenda.

Contact: Lawrence R. Smith, Natural Area Protection Manager, Department of Conservation and Recreation, Division of Natural Heritage, 1500 E. Main St., Suite 312, Richmond, VA 23219, telephone (804) 786-7951, FAX (804) 371-2674, or (804) 786-2121/TDD ♿

Falls of the James Scenic River Advisory Board

† **January 9, 1997 - Noon** -- Open Meeting
Parks and Recreation Conference Room, City Hall, 900 East Broad Street, 4th Floor, Richmond, Virginia.

† **February 6, 1997 - Noon** -- Open Meeting
Planning Commission Conference Room, City Hall, 900 East Broad Street, 5th Floor, Richmond, Virginia.

A meeting to discuss river issues and programs.

Contact: Richard G. Gibbons, Environmental Program Manager, Department of Conservation and Recreation, Division of Planning and Recreation Resources, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-4132, FAX (804) 371-7899, or (804) 786-2121/TDD ♿

Moormans Scenic River Advisory Board

† **January 8, 1997 - 1 p.m.** -- Open Meeting
† **February 12, 1997 - 1 p.m.** -- Open Meeting
Albemarle County Office, 401 McIntire Road, Charlottesville, Virginia.

A meeting to discuss river issues.

Contact: Richard G. Gibbons, Environmental Program Manager, Department of Conservation and Recreation, Division of Planning and Recreation Resources, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-4132, FAX (804) 371-7899, or (804) 786-2121/TDD ♿

Rappahannock Scenic River Advisory Board

† **February 19, 1997 - 6 p.m.** -- Open Meeting
Riverview Restaurant, 1101 Sophia Street, Fredericksburg, Virginia.

A meeting to discuss river issues.

Contact: Richard G. Gibbons, Environmental Program Manager, Department of Conservation and Recreation, Division of Planning and Recreation Resources, 203 Governor St., Richmond, VA 23219, telephone (804) 786-4132, FAX (804) 371-7899, or (804) 786-2121/TDD ♿

CONSERVATION AND RECREATION FOUNDATION

† **December 30, 1996 - 10 a.m.** -- Open Meeting
Lake Anna State Park Visitor's Center, 6800 Lawyers Road, Spotsylvania, Virginia. ♿

A general business meeting to include discussion of General Obligation Bond projects.

Contact: Ron Hedlund, Division Director, Planning and Recreation Resources, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-5054, FAX (804) 371-7899, or (804) 786-2121/TDD ♿

Calendar of Events

BOARD FOR CONTRACTORS

January 7, 1997 - 5 p.m. -- Public Hearing

Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Conference Room 4, Richmond, Virginia.

January 30, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Contractors intends to adopt regulations entitled: **18 VAC 50-30-10 et seq. Tradesman Certification Program Regulations.** The purpose of the proposed regulation is to provide for the certification of tradesmen by establishing fees, entry requirements, standards of practice and conduct, and other administrative procedures.

Statutory Authority: §§ 54.1-201 and 54.1-1102 of the Code of Virginia.

Contact: Steven L. Arthur, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2945.

Disciplinary Committee

† February 4, 1997 - 9 a.m. -- Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A meeting to review board member reports and summaries from informal fact-finding conferences held pursuant to the Administrative Process Act, and to review consent order offers in lieu of further disciplinary proceedings. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact the department at least two weeks prior to the meeting so that suitable arrangements can be made. The board fully complies with the Americans with Disabilities Act.

Contact: Michelle Couch, Legal Assistant, Board for Contractors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8524.

DEPARTMENT OF CORRECTIONAL EDUCATION

January 17, 1997 - 10 a.m. -- Open Meeting

Department of Correctional Education, James Monroe Building, 101 North 14th Street, 7th Floor, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A monthly meeting to discuss general business.

Contact: Patty Ennis, Board Clerk, Department of Correctional Education, James Monroe Bldg., 101 N. 14th St., 7th Floor, Richmond, VA 23219-3678, telephone (804) 225-3314.

BOARD FOR COSMETOLOGY

† January 6, 1997 - 10 a.m. -- Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A general business meeting. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact Karen W. O'Neal. Please notify the department of your request at least two weeks in advance. The department fully complies with the Americans with Disabilities Act.

Contact: Karen W. O'Neal, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8509, FAX (804) 367-2475 or (804) 367-9753/TDD 

BOARD OF EDUCATION

† January 9, 1997 - 9 a.m. -- Open Meeting

James Monroe Building, 101 North 14th Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

The Board of Education and the Board of Vocational Education will hold a regularly scheduled meeting. Business will be conducted according to items listed on the agenda. The agenda is available upon request.

Contact: James E. Laws, Jr., Administrative Assistant to the Superintendent for Board Relations, Department of Education, P.O. Box 2120, Richmond, VA 23218-2120, telephone (804) 225-2540 or toll-free 1-800-292-3820.

DEPARTMENT OF ENVIRONMENTAL QUALITY

† January 7, 1997 - 7 p.m. -- Public Hearing

Town Council Chambers, 502 Vancey Street, South Boston, Virginia.

A public hearing to receive comments on the proposed major modification on the Resource Conservation and Recovery Act (RCRA) Post-Closure for Teledyne Allvac located in South Boston.

Contact: Richard Criqui, Office of Permitting Management, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4013.

Virginia Ground Water Protection Steering Committee

† January 21, 1997 - 9 a.m. -- Open Meeting

State Corporation Commission, Tyler Building, 1300 East Main Street, 8th Floor Conference Room, Richmond, Virginia. 

A meeting concerning ground water protection issues. All interested persons are welcome to attend. Meeting minutes and agenda are available from Mary Ann Massie.

Contact: Mary Ann Massie, Environmental Program Planner, Department of Environmental Quality, P. O. Box 10009, Richmond, VA 23240-0009, telephone (804) 698-4042 or FAX (804) 698-4032.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

† **January 9, 1997 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, Richmond, Virginia. ☎

A general board meeting. Public comments will be received for 15 minutes at the beginning of the meeting. Formal hearings will follow.

Contact: Elizabeth Young Kirksey, Executive Director, Board of Funeral Directors and Embalmers, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9907, FAX (804) 662-9943, or (804) 662-7197/TDD ☎

BOARD OF GAME AND INLAND FISHERIES

† **January 9, 1997 - 9 a.m.** -- Open Meeting
† **January 10, 1997 - 9 a.m.** -- Open Meeting
Department of Game and Inland Fisheries, 4010 West Broad Street, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to discuss general and administrative issues. The board may hold an executive session beginning at 9 a.m., on January 9. If the board completes its entire agenda on January 9, it may not convene on January 10.

Contact: Phil Smith, Policy Analyst Senior, Department of Game and Inland Fisheries, 4010 W. Broad St., Richmond, VA 23230, telephone (804) 367-8341 or FAX (804) 367-2427.

DEPARTMENT OF GENERAL SERVICES

Design/Build Construction Management Review Board

January 17, 1997 - 10 a.m. -- Open Meeting
February 21, 1997 - 10 a.m. -- Open Meeting
Department of General Services, 805 East Broad Street, Room 116, Richmond, Virginia. ☎

A meeting of the board to conduct general business and review any submissions by local governing bodies for proposed use of design/build construction management for specific construction projects. The board meets the third Friday of each month.

Contact: Nathan I. Broocke, Director, Division of Engineering and Buildings, Department of General Services, 805 E. Broad St., Room 101, Richmond, VA 23219, telephone (804) 786-3263 or (804) 786-6152/TDD ☎

STATE HAZARDOUS MATERIALS TRAINING ADVISORY COMMITTEE

† **January 11, 1997 - 10 a.m.** -- Open Meeting
Department of Emergency Services, 310 Turner Road, Training Room, Richmond, Virginia. ☎

A meeting to discuss curriculum course development and review existing hazardous materials courses. Individuals with a disability, as defined in the Americans with Disabilities Act of 1990, desiring to attend the meeting should contact the Department of Emergency Services 10 days prior to the meeting so appropriate accommodations can be made.

Contact: George B. Gotschalk, Jr., Department of Criminal Justice Services, 805 E. Broad St., Richmond, VA 23219, telephone (804) 786-6001.

BOARD FOR HEARING AID SPECIALISTS

January 13, 1997 - 8:30 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 3, Richmond, Virginia. ☎

A routine business meeting. A public comment period will be held at the beginning of the meeting. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact David Dick at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8507, FAX (804) 367-2475 or (804) 367-9753/TDD ☎

HOPEWELL INDUSTRIAL SAFETY COUNCIL

January 7, 1997 - 9 a.m. -- Open Meeting
† **February 4, 1997 - 9 a.m.** -- Open Meeting
† **March 4, 1997 - 9 a.m.** -- Open Meeting
Hopewell Community Center, Second and City Point Road, Hopewell, Virginia. ☎ (Interpreter for the deaf provided upon request)

Local Emergency Preparedness Committee Meeting on emergency preparedness as required by SARA Title III.

Contact: Robert Brown, Emergency Services Coordinator, 300 N. Main St., Hopewell, VA 23860, telephone (804) 541-2298.

Calendar of Events

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

January 10, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Housing and Community Development intends to repeal regulations entitled: **13 VAC 5-20-10 et seq., Virginia Certification Standards/1993** and adopt regulations entitled: **13 VAC 5-21-10 et seq. Virginia Certification Standards**. The purpose of this proposal is (i) to delete the tradesmen certification requirements since regulatory authority for tradesmen certification was transferred to the Department of Professional and Occupational Regulation, and (ii) to transfer the blaster certification requirements from this regulation to the Virginia Statewide Fire Prevention Code.

Statutory Authority: §§ 36-98.3 and 36-137 of the Code of Virginia.

Contact: Norman R. Crumpton, Associate Director, Department of Housing and Community Development, The Jackson Center, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7170 or FAX (804) 371-7092.

January 10, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Housing and Community Development intends to repeal regulations entitled: **13 VAC 5-30-10 et seq., Virginia Amusement Device Regulations/1993** and adopt regulations entitled: **13 VAC 5-31-10 et seq. Virginia Amusement Device Regulations**. The Virginia Amusement Device Regulations provide statewide standards for the construction, maintenance, inspection and operation of amusement devices. The proposed changes update this regulation to reflect current nationally approved standards.

Statutory Authority: § 36-98.3 of the Code of Virginia.

Contact: Norman R. Crumpton, Associate Director, Department of Housing and Community Development, The Jackson Center, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7170 or FAX (804) 371-7092.

January 10, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Housing and Community Development intends to repeal regulations entitled: **13 VAC 5-50-10 et seq., Virginia Statewide**

Fire Prevention Code/1993 and adopt regulations entitled: **13 VAC 5-51-10 et seq. Virginia Statewide Fire Prevention Code**. The proposed regulation sets forth performance requirements for the use of explosives, and the maintenance and use of structures with regard to fire safety. The proposed regulation has been updated to reflect current nationally approved safety standards, blaster certification requirements have been deleted from the Virginia Certification Standards and incorporated into this regulation, and the format of the regulation has been changed to make it more understandable to the regulated community

Statutory Authority: § 27-97 of the Code of Virginia.

Contact: Norman R. Crumpton, Associate Director, Department of Housing and Community Development, The Jackson Center, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7170 or FAX (804) 371-7092.

January 10, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Housing and Community Development intends to repeal regulations entitled: **13 VAC 5-60-10 et seq., Virginia Uniform Statewide Building Code, Volume I - New Construction Code/1993**, and **13 VAC 5-70-10 et seq., Virginia Uniform Statewide Building Code, Volume II - New Construction Code/1993**, and adopt regulations entitled: **13 VAC 5-61-10 et seq., Virginia Uniform Statewide Building Code**. The Building Code prescribes standards for construction, maintenance and use of buildings and structures and their equipment. This proposal consolidates Volumes I and II of the USBC into a single regulation and updates the latest construction and maintenance model codes and standards.

Statutory Authority: § 36-98 of the Code of Virginia.

Contact: Norman R. Crumpton, Associate Director, Department of Housing and Community Development, The Jackson Center, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7170 or FAX (804) 371-7092.

January 10, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Housing and Community Development intends to repeal regulations entitled: **13 VAC 5-90-10 et seq., Virginia Industrialized Building and Manufactured Home and Safety Regulations/1993**, and adopt regulations entitled: **13 VAC 5-91-10 et seq., Virginia Industrialized Building Safety Regulations**. The proposed amendments update documents incorporated

by reference to reflect current nationally approved safety standards and transfer requirements regarding manufactured home safety standards from this regulation to the Virginia Manufactured Home Safety Regulations (13 VAC 5-95-10 et seq.).

Statutory Authority: § 36-73 of the Code of Virginia.

Contact: Norman R. Crumpton, Associate Director, Department of Housing and Community Development, The Jackson Center, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7170 or FAX (804) 371-7092.

January 10, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Housing and Community Development intends to adopt regulations entitled: **13 VAC 5-95-10 et seq., Virginia Manufactured Home Safety Regulations.** The Virginia Manufactured Home Safety Regulations provide for the administration and enforcement of uniform, statewide, and safety standards for manufactured homes, wherever produced.

Statutory Authority: §§ 36-85.7 of the Code of Virginia.

Contact: Norman R. Crumpton, Associate Director, Department of Housing and Community Development, The Jackson Center, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7170 or FAX (804) 371-7092.

STATEWIDE INDEPENDENT LIVING COUNCIL

† **January 23, 1997 - 10 a.m.** -- Open Meeting
Department for the Visually Handicapped, 397 Azalea Avenue, Library and Resource Center, Richmond, Virginia. ♿
(Interpreter for the deaf provided upon request)

A meeting to conduct regular business.

Contact: Jim Rothrock, Statewide Independent Living Council Staff, 1802 Marroit Rd., Richmond, VA 23229, telephone (804) 673-0119, FAX (804) 282-7112, toll-free 1-800-552-5019/TDD and Voice, or e:mail jarothrock@aol.com.

DEPARTMENT OF LABOR AND INDUSTRY

Safety and Health Codes Board

† **January 23, 1997 - 10 a.m.** -- Public Hearing
Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, Virginia.

† **February 28, 1997** -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Safety and Health Codes Board intends to adopt regulations entitled: **16 VAC 25-**

35-10 et seq. Regulation Concerning Certified Lead Contractor Notification, Lead Project Permits and Permit Fees. The proposed regulation requires all certified lead contractors who engage in lead abatement projects in Virginia with a contract value of \$2,000 or more to notify the Department of Labor and Industry in writing at least 20 days before the beginning of such lead project. Such notification shall be provided on a department form accompanied by the payment of a lead project permit fee. The regulation also requires filing of amended notifications prior to changes in or cancellation of lead abatement projects.

Statutory Authority: §§ 40.1-22(5) and 40.1-51.20 of the Code of Virginia.

Public comments may be submitted until February 28, 1997, to Bonnie H. Robinson, Regulatory Coordinator, Department of Labor and Industry, 13 South 13th Street, Richmond, VA 23219.

Contact: Clarence H. Wheeling, Director of Occupational Health Compliance, Department of Labor and Industry, 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-0574, FAX (804) 786-8418, or (804) 786-2376/TDD ☎

VIRGINIA INSURANCE COUNSELING AND ADVOCACY PROJECT ADVISORY COUNCIL

† **January 29, 1997 - 10 a.m.** -- Open Meeting
Department for the Aging, 700 East Franklin Street, 10th Floor, Richmond, Virginia.

A meeting to conduct advisory council business.

Contact: Kimlah Hyatt, Program Coordinator, Department for the Aging, 700 E. Franklin St., 10th Floor, Richmond, VA 23219, telephone (804) 225-2801, FAX (804) 371-8381, toll-free 1-800-552-3402, or (804) 225-2271/TDD ☎

LIBRARY BOARD

January 6, 1997 - 10:30 a.m. -- Open Meeting
The Library of Virginia, 11th Street at Capitol Square, 3rd Floor, Supreme Court Room, Richmond, Virginia. ♿

A meeting to discuss matters related to the Library of Virginia and its board.

Contact: Jean H. Taylor, Secretary to the State Librarian, The Library of Virginia, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

Automation and Networking Committee

January 6, 1997 - 9 a.m. -- Open Meeting
The Library of Virginia, 11th Street at Capitol Square, Office of the Division Director, Richmond, Virginia. ♿

A meeting to discuss automation and networking matters.

Calendar of Events

Contact: Jean H. Taylor, Secretary to the State Librarian, The Library of Virginia, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

Facilities Committee

January 5, 1997 - 5 p.m. -- Open Meeting
Omni Richmond Hotel, 100 South 12th Street, Richmond, Virginia. ☎

A meeting to discuss matters pertaining to the new Library of Virginia building, the status of the Records Center, and the current Library of Virginia facilities.

Contact: Jean H. Taylor, Secretary to the State Librarian, The Library of Virginia, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

Legislative and Finance Committee

January 5, 1997 - 4 p.m. -- Open Meeting
Omni Richmond Hotel, 100 South 12th Street, Richmond, Virginia. ☎

A meeting to discuss legislative and financial matters.

Contact: Jean H. Taylor, Secretary to the State Librarian, The Library of Virginia, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

Publications and Cultural Affairs Committee

January 6, 1997 - 8 a.m. -- Open Meeting
The Library of Virginia, 11th Street at Capitol Square, Office of the Division Director, Richmond, Virginia. ☎

A meeting to discuss matters related to the Publications and Cultural Affairs Division and The Library of Virginia.

Contact: Jean H. Taylor, Secretary to the State Librarian, The Library of Virginia, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

Public Library Development Committee

January 5, 1997 - 5 p.m. -- Open Meeting
Omni Richmond Hotel, 100 South 12th Street, Richmond, Virginia. ☎

A meeting to discuss matters pertaining to public library development and The Library of Virginia.

Contact: Jean H. Taylor, Secretary to the State Librarian, The Library of Virginia, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

Records Management Committee

January 6, 1997 - 9 a.m. -- Open Meeting
The Library of Virginia, 11th Street at Capitol Square, Conference Room B, Richmond, Virginia. ☎

A meeting to discuss matters pertaining to records management.

Contact: Jean H. Taylor, Secretary to the State Librarian, The Library of Virginia, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

Research and Information Services Committee

January 6, 1997 - 8 a.m. -- Open Meeting
The Library of Virginia, 11th Street at Capitol Square, Conference Room B, Richmond, Virginia. ☎

A meeting to discuss research and information services.

Contact: Jean H. Taylor, Secretary to the State Librarian, The Library of Virginia, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

LITTER CONTROL AND RECYCLING FUND ADVISORY BOARD

January 10, 1997 - 1:30 p.m. -- Open Meeting
Plantation House, 1108 East Main Street, 2nd Floor Conference Center, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to (i) promote the control, prevention, and elimination of litter from the Commonwealth and encourage recycling; and (ii) advise the Director of the Department of Environmental Quality on other litter control and recycling matters. For details call Paddy Katzen or e-mail pmkatzen@deq.state.va.us.

Contact: Paddy Katzen, Special Assistant to the Secretary of Natural Resources, Department of Environmental Quality, 629 E. Main St., Richmond, VA 23219, telephone (804) 698-4488 or FAX (804) 698-4453.

VIRGINIA MANUFACTURED HOUSING BOARD

† **January 15, 1997 - 10 a.m.** -- Open Meeting
Department of Housing and Community Development, The Jackson Center, 501 North 2nd Street, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A regular monthly meeting of the board.

Contact: Curtis L. McIver, Associate Director, Department of Housing and Community Development, Manufactured Housing Office, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7160 or (804) 371-7089/TDD ☎

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

† **February 21, 1997** -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending

regulations entitled: 12 VAC 30-70-10 et seq. **Methods and Standards for Establishing Payment Rates--Inpatient Hospital Services** and 12 VAC 30-80-10 et seq. **Methods and Standards for Establishing Payment Rates--Other Types of Care**. The purpose of the proposed action is to promulgate a new reimbursement methodology (diagnosis related groupings) for inpatient hospital services to replace the current per diem methodology.

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

Public comments may be submitted until February 21, 1997, to Scott Crawford, Division of Financial Operations, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

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

† **February 21, 1997** -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Medical Assistance Services intends to consider adopting regulations entitled: 12 VAC 30-100-250 through 12 VAC 30-100-370 et seq. **HIV Premium Assistance Program**. The purpose of the proposed regulation is to promulgate permanent regulations for the administration of the HIV Premium Assistance Program consistent with § 32.1-330.1 of the Code of Virginia.

Statutory Authority: §§ 32.1-325 and 32.1-330.1 of the Code of Virginia.

Public comments may be submitted until February 21, 1997, to Michael Lupien, Division of Program Delivery Systems, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

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

Medicaid Drug Utilization Review Board

† **January 9, 1997 - 2 p.m.** -- Open Meeting
Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Board Room, Richmond, Virginia. ☎

A meeting to conduct routine business.

Contact: Marianne R. Rollins, Medical Support, Division of Program Operations, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-8056.

Medicaid Pharmacy Prior Authorization Advisory Committee

† **January 9, 1997 - 10 a.m.** -- Open Meeting
Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Board Room, Richmond, Virginia. ☎

A meeting to conduct routine business.

Contact: Marianne R. Rollins, Medical Support, Division of Program Operations, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-8056.

BOARD OF MEDICINE

Informal Conference Committee

January 8, 1997 - 9 a.m. -- Open Meeting
Roanoke Airport Marriott, 2801 Hershberger Road, Roanoke, Virginia.

† **January 14, 1997 - 9 a.m.** -- Open Meeting
Sheraton Inn, 2801 Plank Road, Fredericksburg, Virginia.

† **January 16, 1997 - 8:30 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, Richmond, Virginia.

January 24, 1997 - 9 a.m. -- Open Meeting
Marriott Hotel, 50 Kingsmill Road, Williamsburg, Virginia.

The Informal Conference Committee, composed of three members of the board, will inquire into allegations that certain practitioners may have violated laws and regulations governing the practice of medicine and other healing arts in Virginia. The committee will meet in open and closed sessions pursuant to § 2.1-344 A 7 and A 15 of the Code of Virginia. Public comment will not be received.

Contact: Lorraine McGehee, Acting Deputy Executive Director, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-7693, FAX (804) 662-9943 or (804) 662-7197/TDD ☎

Advisory Board on Occupational Therapy

† **January 9, 1997 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 4, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to review public comments and make recommendations to the board regarding the regulatory review of 18 VAC 85-80-10 et seq., Regulations for Certification of Occupational Therapists, and such other issues which may be presented. The board will entertain public comment during the first 15 minutes on agenda items.

Contact: Warren W. Koontz, M.D., Executive Director, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond,

Calendar of Events

VA 23230-1717, telephone (804) 662-9960, FAX (804) 662-9943 or (804) 662-7197/TDD ☎

Advisory Board on Physical Therapy

† **January 10, 1997 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 4, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to review public comments and make recommendations to the board regarding the regulatory review of 18 VAC 85-30-10 et seq., Regulations Governing the Practice of Physical Therapy, and such other issues which may be presented. The board will entertain public comment during the first 15 minutes on agenda items.

Contact: Warren W. Koontz, M.D., Executive Director, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9960, FAX (804) 662-9943 or (804) 662-7197/TDD ☎

Advisory Board on Physician's Assistants

† **January 10, 1997 - 1 p.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 4, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to review public comments and make recommendations to the board regarding the regulatory review of 18 VAC 85-50-10 et seq. Regulations Governing the Practice of Physician's Assistants, and such other issues which may be presented. The committee will entertain public comment during the first 15 minutes on agenda items.

Contact: Warren W. Koontz, M.D., Executive Director, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9960, FAX (804) 662-9943 or (804) 662-7197/TDD ☎

Advisory Board on Respiratory Therapy

† **January 9, 1997 - 1 p.m.** -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 4, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to review public comments and make recommendations to the board regarding the regulatory review of 18 VAC 85-40-10 et seq., Regulations Governing the Practice of Respiratory Therapy Practitioners, and such other issues which may be presented. The board will entertain public comment during the first 15 minutes on agenda items.

Contact: Warren W. Koontz, M.D., Executive Director, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond,

VA 23230-1717, telephone (804) 662-9960, FAX (804) 662-9943 or (804) 662-7197/TDD ☎

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

† **January 8, 1997 - Time to be announced** -- Open Meeting
Location to be announced.

The Case Rate Workgroup will meet to identify issues and develop recommendations related to the development of a case rate. The workgroup will report to the Priority Populations/Case Rate Funding Subcommittee of the Pilot Leadership Team.

Contact: Brenda Mantio, Division of Administration and Finance, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-5025 or FAX (804) 371-0090.

† **January 15, 1997 - 1:30 p.m.** -- Open Meeting
Department for the Visually Handicapped (tentative location).

A meeting of the Priority Populations/Case Rate Funding Subcommittee of the Pilot Leadership Team to discuss consultation services and hear the report of the Case Rate Workgroup.

Contact: Cheryl Crawford, Administrative Staff Specialist, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-5682 or FAX (804) 371-6638.

Pilot Leadership Team

January 9, 1997 - 10:30 a.m. -- Open Meeting
Locations to be announced.

A meeting to continue the development of plans for mental health, mental retardation and substance abuse system reform pilot projects. The team will hear the reports of the Priority Populations/Case Rate Funding Subcommittee; the Consumer and Family Involvement Subcommittee; and the POMS Subcommittee.

Contact: Marion Greenfield, Policy Analyst, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-6431 or FAX (804) 786-0092.

STATE MILK COMMISSION

† **February 19, 1997 - 10:30 a.m.** -- Open Meeting
900 Natural Resources Drive, 2nd Floor Board Room, Charlottesville, Virginia. ☎

A regular meeting to (i) discuss industry issues, distributor licensing, Virginia base transfers, Virginia baseholding license amendments, regulations, and fiscal matters and (ii) receive reports from the staff of the Milk Commission. The commission may consider other matters pertaining to its responsibilities. Any persons who require accommodations in order to participate in

the meeting should contact Edward C. Wilson, Jr., at least five days prior to the meeting date so that suitable arrangements can be made.

Contact: Edward C. Wilson, Jr., Deputy Administrator, State Milk Commission, 200 N. 9th St., Suite 1015, Richmond, VA 23219-3414, telephone (804) 786-2013 or (804) 786-2013/TDD ☎

GOVERNOR'S MINED LAND RECLAMATION ADVISORY BOARD

January 16, 1997 - 10 a.m. -- Open Meeting
Department of Mines, Minerals and Energy, Buchanan-Smith Building, Route 23, Big Stone Gap, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to review and discuss recent Interstate Mining Compact Commission issues associated with the coal industry.

Contact: Danny Brown, Division Director, Department of Mines, Minerals and Energy, Division of Mined Land Reclamation, P.O. Drawer 900, Big Stone Gap, VA 24219, telephone (540) 523-8152, FAX (540) 523-8163 or toll-free 1-800-828-1120 (VA Relay Center).

VIRGINIA MUSEUM OF FINE ARTS

Buildings and Ground Committees

† January 9, 1997 - Noon -- Open Meeting
Virginia Museum of Fine Arts, 2800 Grove Avenue, Conference Room, Richmond, Virginia. ☎

A meeting to discuss renovation of the Center for Education and Outreach, and ongoing projects. Public comment will not be received at the meeting.

Contact: Emily C. Robertson, Secretary of the Museum, Virginia Museum of Fine Arts, 2800 Grove Ave., Richmond, VA 23221-2466, telephone (804) 367-0553.

Communications and Marketing Committee

† January 8, 1997 - 10:30 a.m. -- Open Meeting
Virginia Museum of Fine Arts, 2800 Grove Avenue, Auditorium, Richmond, Virginia. ☎

A meeting to discuss communication and marketing issues for the museum. This is the initial meeting of the year. Public comment will not be received at the meeting.

Contact: Emily C. Robertson, Secretary of the Museum, Virginia Museum of Fine Arts, 2800 Grove Ave., Richmond, VA 23221-2466, telephone (804) 367-0553.

Finance Committee

† January 16, 1997 - 11 a.m. -- Open Meeting
Virginia Museum of Fine Arts, 2800 Grove Avenue, Conference Room, Richmond, Virginia. ☎

A meeting to review budgets and reports on enterprise operations. Public comment will not be received at the meeting.

Contact: Emily C. Robertson, Secretary of the Museum, Virginia Museum of Fine Arts, 2800 Grove Ave., Richmond, VA 23221-2466, telephone (804) 367-0553.

Board of Trustees

† January 7, 1997 - 8 a.m. -- Open Meeting
Virginia Museum of Fine Arts, 2800 Grove Avenue, Conference Room, Richmond, Virginia. ☎

A monthly briefing of the officers of the Board of Trustees with the director and deputy director. Public comment will not be received at the meeting.

Contact: Emily C. Robertson, Secretary of the Museum, Virginia Museum of Fine Arts, 2800 Grove Ave., Richmond, VA 23221-2466, telephone (804) 367-0553.

† January 16, 1997 - Noon -- Open Meeting
Virginia Museum of Fine Arts, 2800 Grove Avenue, Auditorium, Richmond, Virginia. ☎

A regularly scheduled bimonthly meeting to review budgets and receive staff and committee reports. Public comment will not be received at the meeting.

Contact: Emily C. Robertson, Secretary of the Museum, Virginia Museum of Fine Arts, 2800 Grove Ave., Richmond, VA 23221-2466, telephone (804) 367-0553.

BOARD OF NURSING

† January 7, 1997 - 8 a.m. -- Open Meeting
Carroll County Library, 101 Beaversdam Road, Hillsville, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to conduct informal conferences with certified nurse aides. Public comment will not be received.

Contact: Nancy K. Durrett, R.N., Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909, FAX (804) 662-9943 or (804) 662-7197/TDD ☎

BOARD OF NURSING HOME ADMINISTRATORS

† January 8, 1997 - 9:30 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Richmond, Virginia. ☎

A general board meeting. Public comments will be heard for 15 minutes prior to the meeting.

Calendar of Events

Contact: Senita Booker, Program Support Technician Senior, Board of Nursing Home Administrators, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9911, FAX (804) 662-9943, or (804) 662-7197/TDD ☎

BOARD FOR OPTICIANS

January 10, 1997 - 10 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A meeting to discuss regulatory review and other matters requiring board action, including disciplinary cases. A public comment period will be held at the beginning of the meeting. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the board at least 10 days prior to the meeting so that suitable arrangements can be made for appropriate accommodations. The department fully complies with the Americans with Disabilities Act.

Contact: Nancy Taylor Feldman, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-2474 or (804) 367-9753/TDD ☎

BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

January 24, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Professional Counselors and Marriage and Family Therapists intends to amend regulations entitled: **18 VAC 115-40-10 et seq. Regulations Governing the Certification of Rehabilitation Providers.** The purpose of the proposed amendment is to establish educational and experience requirements for certification.

Statutory Authority: §§ 54.1-2400 and 54.1-3505 of the Code of Virginia.

Contact: Janet Delorme, Deputy Executive Director, Department of Health Professions, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9575 or FAX (804) 662-9943.

DEPARTMENT OF REHABILITATIVE SERVICES (BOARD OF)

December 27, 1996 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Rehabilitative Services intends to amend regulations entitled: **22 VAC**

30-10-10 et seq. Public Participation Guidelines. The purpose of the proposed amendment is to make the department's regulations more representative of public needs and views through greater public participation in the regulatory process and make changes mandated by 1993 amendments to the Administrative Process Act.

Statutory Authority: §§ 9-6.14:7.1 and 51.5-14 of the Code of Virginia.

Contact: Mary C. Lutkenhaus, Policy Analyst, Department of Rehabilitative Services, 8004 Franklin Farms Dr., Richmond, VA 23288-0300, telephone (804) 662-7610, FAX (804) 662-7696, toll-free 1-800-552-5019, or toll-free 1-800-464-9950/TDD ☎

† January 23, 1997 - 10 a.m. -- Open Meeting
Department of Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A quarterly business meeting of the board.

Contact: John R. Vaughn, Commissioner, Department of Rehabilitative Services, 8004 Franklin Farms Dr., Richmond, VA 23230, telephone (804) 662-7010, toll-free 1-800-552-5019/TDD and Voice or (804) 662-9040/TDD ☎

VIRGINIA RESOURCES AUTHORITY

January 14, 1997 - 9:30 a.m. -- Open Meeting
The Mutual Building, 909 East Main Street, Suite 607, Board Room, Richmond, Virginia.

The board will meet to approve minutes of the meeting of the prior month, to review the authority's operations for the prior months, and to consider other matters and take other actions as it may deem appropriate. The planned agenda of the meeting will be available at the offices of the authority one week prior to the date of the meeting. Public comments will be received at the beginning of the meeting.

Contact: Shockley D. Gardner, Jr., Virginia Resources Authority, 909 E. Main St., Suite 607, Mutual Building, Richmond, VA 23219, telephone (804) 644-3100 or FAX (804) 644-3109.

BOARD OF SOCIAL WORK

† January 10, 1997 - 8:15 a.m. -- Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia. ☎

A meeting of the Regulatory Committee to plan for 1997 regulatory/legislative review.

Contact: Janet Delorme, Deputy Executive Director, Board of Social Work, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9575, FAX (804) 662-9943, or (804) 662-7197/TDD ☎

VIRGINIA SOIL AND WATER CONSERVATION BOARD

† **January 16, 1997 - 9 a.m.** -- Open Meeting
Colonial Farm Credit, 6526 Mechanicsville Turnpike,
Mechanicsville, Virginia.

A regular bimonthly business meeting.

Contact: Linda J. Cox, Administrative Staff Assistant,
Virginia Soil and Water Conservation Board, 203 Governor
St., Suite 302, Richmond, VA 23219, telephone (804) 786-
2123 or FAX (804) 786-6141.

COMMONWEALTH TRANSPORTATION BOARD

December 27, 1996 -- Public comments may be submitted
until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of
the Code of Virginia that the Commonwealth
Transportation Board intends to **repeal** regulations
entitled: **24 VAC 30-70-10 et seq. Minimum
Standards of Entrances to State Highways**; and **adopt**
regulations entitled: **24 VAC 30-71-10 et seq.
Minimum Standards of Entrances to State Highways**.
The purpose of the proposed action is to repeal the
existing regulation and promulgate a new regulation
concerning state highway entrances. The proposal is
intended to make the regulation less restrictive to all
users.

Statutory Authority: §§ 33.1-12, 33.1-197, and 33.1-198 of
the Code of Virginia.

Contact: Steve Edwards, Transportation Engineer,
Department of Transportation, 1401 E. Broad St., Richmond,
VA 23219, telephone (804) 786-0121 or Virginia Relay
Center 1-800-828-1120/TDD

† **January 15, 1997 - 2 p.m.** -- Open Meeting
Department of Transportation, 1401 East Broad Street,
Richmond, Virginia. (Interpreter for the deaf provided upon
request)

A work session of the board and the Department of
Transportation staff.

Contact: Robert E. Martinez, Secretary of Transportation,
1401 E. Broad St., Richmond, VA 23219, telephone (804)
786-8032.

† **January 16, 1997 - 10 a.m.** -- Open Meeting
Department of Transportation, 1401 East Broad Street,
Richmond, Virginia. (Interpreter for the deaf provided upon
request)

A monthly meeting of the board to vote on proposals
presented regarding bids, permits, additions and
deletions to the highway system, and any other matters
requiring board approval. Public comment will be
received at the outset of the meeting on items on the
meeting agenda for which the opportunity for public
comment has not been afforded the public in another
forum. Remarks will be limited to five minutes. Large

groups are asked to select one individual to speak for
the group. The board reserves the right to amend these
conditions. Separate committee meetings may be held
on call of the chairman. Contact Department of
Transportation Public Affairs at (804) 786-2715 for
schedule.

Contact: Robert E. Martinez, Secretary of Transportation,
1401 E. Broad St., Richmond, VA 23219, telephone (804)
786-8032.

TREASURY BOARD

January 16, 1997 - 9 a.m. -- Open Meeting
February 20, 1997 - 9 a.m. -- Open Meeting
James Monroe Building, 101 North 14th Street, Treasury
Board Room, 3rd Floor, Richmond, Virginia. (Interpreter for the deaf provided upon request)

In January and February, 1997, the board will meet on
the third Thursday rather than the third Wednesday.

Contact: Gloria J. Hatchel, Administrative Assistant,
Department of the Treasury, James Monroe Bldg., 101 N.
14th St., Richmond, VA 23219, telephone (804) 371-6011.

DEPARTMENT FOR THE VISUALLY HANDICAPPED (BOARD OF)

January 22, 1997 - 1:30 p.m. -- Open Meeting
Department for the Visually Handicapped, Administrative
Headquarters, 397 Azalea Avenue, Richmond, Virginia. (Interpreter for the deaf provided upon request)

The board is responsible for advising the Governor, the
Secretary of Health and Human Resources, the
Commissioner, and the General Assembly on the
delivery of public services to the blind and the protection
of their rights. The board also reviews and comments on
policies, budgets and requests for appropriations for the
department. At this regular quarterly meeting, the board
members will receive information regarding department
activities and operations, review expenditures from the
board's institutional fund, and discuss other issues
raised by board members.

Contact: Katherine C. Proffitt, Executive Secretary Senior,
Department for the Visually Handicapped, 397 Azalea Ave.,
Richmond, VA 23227, telephone (804) 371-3140, toll-free 1-
800-622-2155, or (804) 371-3140/TDD

VIRGINIA VOLUNTARY FORMULARY BOARD

† **February 6, 1997 - 10:30 a.m.** -- Open Meeting
Washington Building, 1100 Bank Street, 2nd Floor, Board
Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A meeting to review public hearing comments and new
product data for drug products pertaining to the Virginia
Voluntary Formulary.

Contact: James K. Thomson, Director, Bureau of Pharmacy
Services, Virginia Voluntary Formulary, James Monroe Bldg.,

Calendar of Events

101 N. 14th St., Room S-45, Richmond, VA 23219, telephone (804) 786-4326.

STATE WATER CONTROL BOARD

January 21, 1997 - 11 a.m. -- Public Hearing
City of Lexington Municipal Building, 300 East Washington Street, 2nd Floor Conference Room, Lexington, Virginia.

January 22, 1997 - 11 a.m. -- Public Hearing
Prince William County Administration Center, 1 County Complex, McCoart Building, Board Chambers, Prince William, Virginia.

January 23, 1997 - 11 a.m. -- Public Hearing
James City County Board of Supervisors Room, 101 C. Mounts Bay Road, Building C, Williamsburg, Virginia.

February 10, 1997 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to adopt regulations entitled: **9 VAC 25-193-10 et seq. General Virginia Pollutant Discharge Elimination System (VPDES) Permit for Ready-Mixed Concrete Plants.** The proposed regulation establishes a general permit for the ready-mixed concrete plant category of wastewater discharges under the Virginia Pollutant Discharge Elimination System.

Question and Answer Period: A question and answer period will be held one half hour prior to the public hearing at the same location. Interested citizens will have an opportunity to ask questions pertaining to the proposal at that time.

Accessibility to Persons with Disabilities: The public hearing will be held at facilities believed to be accessible to persons with disabilities. Any person with questions should contact Ms. Lily Choi at the address given below. Persons needing interpreter services for the deaf should notify Ms. Choi no later than January 10, 1997.

Request for Comments: The board is seeking written comments from interested persons on both the proposed regulatory action and the draft permit, as well as comments regarding the costs and benefits of the proposal or any other alternatives. Written comments on the proposed issuance of the permit and on the proposed regulation must be received no later than 4 p.m. on February 10, 1997, and should be submitted to Ms. Choi. Comments shall include the name, address, and telephone number of the writer, and shall contain a complete, concise statement of the factual basis for comments. Only those comments received within this period will be considered by the board.

Other Information: The department has conducted analyses on the proposed regulation related to the basis, purpose, substance, issues and estimated impacts. These are available upon request from Ms. Choi at the address below.

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

Contact: Lily Choi, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4054.

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

January 9, 1997 - 8:30 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Richmond, Virginia. ☎
(Interpreter for the deaf provided upon request)

A meeting to discuss regulatory review, disciplinary cases, and other matters requiring board action. A public comment period will be held at the beginning of the meeting. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact the board at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Nancy Taylor Feldman, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-2474 or (804) 367-9753/TDD ☎

CHRONOLOGICAL LIST

OPEN MEETINGS

December 30

† Conservation and Recreation Foundation

January 5, 1997

Library Board

- Facilities Committee
- Legislative and Finance Committee
- Public Library Development Committee

January 6

Accountancy, Board for

† Barbers, Board for

† Competition Council, Commonwealth

† Cosmetology, Board for

Library Board

- Automation and Networking Committee
- Publications and Cultural Affairs Committee
- Records Management Committee
- Research and Information Services Committee

January 7

Hopewell Industrial Safety Council

† Museum of Fine Arts, Virginia

- Board of Trustees

† Nursing, Board of

January 8

† Air Pollution Control Board, State

† Conservation and Recreation, Department of

- Moormans Scenic River Advisory Board

Medicine, Board of

† Mental Health, Mental Retardation and Substance

Abuse Services, Department of

† Museum of Fine Arts, Virginia

- Communication and Marketing Committee

Calendar of Events

† Nursing Home Administrators, Board of

January 9

† Conservation and Recreation, Department of
- Falls of the James Scenic River Advisory Board
† Education, Board of
† Funeral Directors and Embalmers, Board of
† Game and Inland Fisheries, Board of
† Medical Assistance Services, Department of
- Medicaid Drug Utilization Review Board
- Medicaid Pharmacy Prior Authorization Advisory
Committee
† Medicine, Board of
- Advisory Board on Occupational Therapy
- Advisory Board on Respiratory Therapy
Mental Health, Mental Retardation and Substance Abuse
Services, Department of
- Pilot Leadership Team
† Museum of Fine Arts, Virginia
Waterworks and Wastewater Works Operators, Board
for

January 10

† Auctioneers Board
† Game and Inland Fisheries, Board of
Litter Control and Recycling Fund Advisory Board
† Medicine, Board of
- Advisory Board on Physical Therapy
- Advisory Committee on Physician's Assistant
Opticians, Board for
† Social Work, Board of

January 11

† Conservation and Recreation, Department of
- Virginia Cave Board
† Hazardous Materials Training Advisory Committee,
State

January 13

Hearing Aid Specialists, Board for

January 14

Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
- Southern Area Review Committee
Conservation and Recreation, Department of
- Appomattox Scenic River Advisory Board
† Medicine, Board of
Resources Authority, Virginia

January 15

Agriculture and Consumer Services, Department of
- Pesticide Control Board
† Manufactured Housing Board, Virginia
† Mental Health, Mental Retardation and Substance
Abuse Services, Department of
- Priority Populations/Case Rate Funding
Subcommittee of the Pilot Leadership Team
† Transportation Board, Commonwealth

January 16

Agriculture and Consumer Services, Department of
- Pesticide Control Board
† Medicine, Board of
Mined Land Reclamation Advisory Board, Governor's

† Museum of Fine Arts, Virginia

- Finance Committee
- Board of Trustees
† Soil and Water Conservation Board, Virginia
† Transportation Board, Commonwealth
Treasury Board

January 17

Correctional Education, Board of
General Services, Department of
- Design/Build Construction Management Review
Board

January 20

Aging, Governor's Advisory Board on

January 21

Accountancy, Board for
Aging, Governor's Advisory Board on
† Environmental Quality, Department of
- Virginia Ground Water Protection Steering
Committee

January 22

† Child Fatality Review Team, State
Visually Handicapped, Board for the

January 23

† Independent Living Council, Statewide
† Rehabilitative Services, Board of

January 24

Medicine, Board of

January 29

† Aging, Department for the
- Virginia Insurance Counseling and Advocacy Project
Advisory Council

January 31

† Audiology and Speech-Language Pathology, Board of
- Legislative/Regulatory Committee

February 4

† Contractors, Board for
- Disciplinary Committee
† Hopewell Industrial Safety Council

February 6

† Conservation and Recreation, Department of
- Falls of the James Scenic River Advisory Board
† Voluntary Formulary Board, Virginia

February 7

† Agriculture and Consumer Services, Department of
- Virginia Plant Pollination Advisory Board

February 11

Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
- Southern Area Review Committee

February 12

† Conservation and Recreation, Department of
- Moormans Scenic River Advisory Board

Calendar of Events

February 19

- † Conservation and Recreation, Department of
- Rappahannock Scenic River Advisory Board
- † Milk Commission, State

February 20

- † Audiology and Speech Language Pathology, Board of
Treasury Board

February 21

- General Services, Department of
- Design/Build Construction Management Review
Board

March 4

- † Hopewell Industrial Safety Council

PUBLIC HEARINGS

January 7, 1997

- Contractors, Board for
† Environmental Quality, Department of

January 21

- Water Control Board, State

January 22

- Water Control Board, State

January 23

- † Labor and Industry, Department of
- Safety and Health Codes Board
- Water Control Board, State