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Title 4. Conservation and Natural Resources			
4 VAC 3-10-10	Amended	22:5 VA.R. 706	12/14/05
4 VAC 3-10-20	Amended	22:5 VA.R. 707	12/14/05
4 VAC 3-10-30	Amended	22:5 VA.R. 707	12/14/05
4 VAC 3-10-40	Repealed	22:5 VA.R. 709	12/14/05
4 VAC 5-15-10	Amended	22:7 VA.R. 1000	1/11/06
4 VAC 5-15-40	Amended	22:7 VA.R. 1004	1/11/06
4 VAC 5-15-60	Amended	22:7 VA.R. 1004	1/11/06
4 VAC 5-15-80	Amended	22:7 VA.R. 1005	1/11/06
4 VAC 5-15-100	Amended	22:7 VA.R. 1005	1/11/06
4 VAC 5-15-110	Amended	22:7 VA.R. 1006	1/11/06
4 VAC 5-15-130	Repealed	22:7 VA.R. 1006	1/11/06
4 VAC 5-15-140	Amended	22:7 VA.R. 1006	1/11/06
4 VAC 5-15-150	Amended	22:7 VA.R. 1008	1/11/06
4 VAC 15-20-210	Added	22:6 VA.R. 888	1/1/06
4 VAC 15-30-40	Amended	22:6 VA.R. 888	12/1/05
4 VAC 15-90-293	Amended	22:6 VA.R. 891	11/1/05
4 VAC 15-380-70	Amended	22:6 VA.R. 891	3/1/06
4 VAC 15-380-71	Added	22:6 VA.R. 892	3/1/06
4 VAC 15-430-60	Amended	22:6 VA.R. 892	3/1/06
4 VAC 15-430-160	Amended	22:6 VA.R. 892	3/1/06
4 VAC 20-70-30	Amended	22:4 VA.R. 575	12/1/05
4 VAC 20-70-70	Amended	22:4 VA.R. 575	12/1/05
4 VAC 20-70-140	Amended	22:4 VA.R. 576	12/1/05
4 VAC 20-80-30	Amended	21:25 VA.R. 3469	7/29/05
4 VAC 20-110-60	Amended	22:4 VA.R. 576	12/1/05
4 VAC 20-150-60	Amended	22:4 VA.R. 576	12/1/05
4 VAC 20-230-30	Amended	22:4 VA.R. 576	12/1/05
4 VAC 20-230-50	Amended	22:4 VA.R. 576	12/1/05
4 VAC 20-252-30 emer	Amended	22:4 VA.R. 627	9/29/05-10/28/05
4 VAC 20-252-30	Amended	22:7 VA.R. 1013	11/14/05
4 VAC 20-252-90	Amended	22:1 VA.R. 81	9/1/05
4 VAC 20-252-100	Amended	22:1 VA.R. 81	9/1/05
4 VAC 20-252-135	Amended	22:7 VA.R. 1013	11/14/05
4 VAC 20-252-160	Amended	22:7 VA.R. 1014	11/14/05
4 VAC 20-270-30	Amended	21:25 VA.R. 3469	7/29/05
4 VAC 20-310-15	Added	22:4 VA.R. 582	10/1/05
4 VAC 20-310-20	Amended	22:4 VA.R. 582	10/1/05
4 VAC 20-310-40	Amended	22:4 VA.R. 583	10/1/05
4 VAC 20-310-50	Amended	22:4 VA.R. 583	10/1/05
4 VAC 20-566-10 through 4 VAC 20-566-50 emer	Added	21:25 VA.R. 3552	8/16/05-9/14/05
4 VAC 20-566-10 through 4 VAC 20-566-50	Added	22:1 VA.R. 81-82	9/15/05
4 VAC 20-610-40	Amended	22:4 VA.R. 576	12/1/05
4 VAC 20-610-50	Amended	22:4 VA.R. 577	12/1/05
4 VAC 20-650-10 through 4 VAC 20-650-40 emer	Amended	22:4 VA.R. 628	10/1/05-10/30/05

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4 VAC 20-650-20	Amended	22:6 VA.R. 893	10/28/05
4 VAC 20-670-20	Amended	22:4 VA.R. 577	12/1/05
4 VAC 20-670-30	Amended	21:25 VA.R. 3470	7/29/05
4 VAC 20-670-50	Amended	21:25 VA.R. 3470	7/29/05
4 VAC 20-720-20	Amended	22:4 VA.R. 584	10/1/05
4 VAC 20-720-40	Amended	22:4 VA.R. 585	10/1/05
4 VAC 20-720-50	Amended	22:4 VA.R. 586	10/1/05
4 VAC 20-720-60	Amended	22:4 VA.R. 586	10/1/05
4 VAC 20-720-70	Amended	22:4 VA.R. 586	10/1/05
4 VAC 20-720-75	Amended	22:4 VA.R. 587	10/1/05
4 VAC 20-720-80	Amended	22:4 VA.R. 587	10/1/05
4 VAC 20-720-100	Amended	22:4 VA.R. 587	10/1/05
4 VAC 20-730-20	Repealed	22:4 VA.R. 577	12/1/05
4 VAC 20-751-20	Amended	22:6 VA.R. 893	11/1/05
4 VAC 20-890-25	Amended	22:4 VA.R. 577	12/1/05
4 VAC 20-900-30	Amended	22:4 VA.R. 578	12/1/05
4 VAC 20-920-30	Amended	22:4 VA.R. 578	12/1/05
4 VAC 20-920-40	Amended	22:4 VA.R. 578	12/1/05
4 VAC 20-950-46 emer	Amended	22:4 VA.R. 628	10/1/05-10/30/05
4 VAC 20-950-46	Amended	22:6 VA.R. 894	11/1/05
4 VAC 20-950-48 emer	Amended	22:4 VA.R. 629	10/1/05-10/30/05
4 VAC 20-950-48	Amended	22:6 VA.R. 894	11/1/05
4 VAC 20-950-48.2 emer	Added	22:4 VA.R. 629	10/1/05-10/30/05
4 VAC 20-950-48.2	Added	22:6 VA.R. 895	11/1/05
4 VAC 20-950-49 emer	Amended	22:4 VA.R. 630	10/1/05-10/30/05
4 VAC 20-950-49	Amended	22:6 VA.R. 895	11/1/05
4 VAC 20-1090-10 through 4 VAC 20-1090-40	Added	22:4 VA.R. 579-582	12/1/05
4 VAC 25-10-90	Added	22:6 VA.R. 896	12/28/05
4 VAC 25-20 (Forms)	Amended	22:5 VA.R. 720	--
4 VAC 25-130-816.11	Amended	21:26 VA.R. 3706	8/10/05-8/9/06
4 VAC 25-130-816.64	Amended	21:26 VA.R. 3707	8/10/05-8/9/06
Title 6. Criminal Justice and Corrections			
6 VAC 20-230-10 through 6 VAC 20-230-350	Added	21:26 VA.R. 3680-3691	10/5/05
6 VAC 20-230-160	Erratum	22:2 VA.R. 296	--
6 VAC 20-230-210	Erratum	22:2 VA.R. 296	--
Title 8. Education			
8 VAC 20-21-80	Amended	21:25 VA.R. 3471	9/22/05
8 VAC 20-21-90	Amended	21:25 VA.R. 3473	9/22/05
8 VAC 20-21-660	Amended	21:25 VA.R. 3473	9/22/05
8 VAC 20-21-680	Amended	21:25 VA.R. 3474	9/22/05
8 VAC 40-30	Repealed	22:6 VA.R. 925	11/8/05-11/7/06
8 VAC 40-31-10 through 8 VAC 40-31-320	Added	22:6 VA.R. 925-939	11/8/05-11/7/06
Title 9. Environment			
9 VAC 5-50-400	Amended	22:4 VA.R. 588	12/1/05
9 VAC 5-60-60	Amended	22:4 VA.R. 588	12/1/05
9 VAC 5-60-90	Amended	22:4 VA.R. 588	12/1/05
9 VAC 5-60-100	Amended	22:4 VA.R. 588	12/1/05
9 VAC 10-10-10	Amended	22:5 VA.R. 709	12/14/05
9 VAC 10-10-20	Amended	22:5 VA.R. 710	12/14/05
9 VAC 10-10-30	Amended	22:5 VA.R. 710	12/14/05
9 VAC 20-80-60	Amended	21:26 VA.R. 3691	10/5/05
9 VAC 20-80-400	Amended	21:26 VA.R. 3694	10/5/05
9 VAC 20-80-480	Amended	21:26 VA.R. 3697	10/5/05
9 VAC 20-80-485	Amended	21:26 VA.R. 3698	10/5/05
9 VAC 20-80-485	Erratum	22:2 VA.R. 296	--

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9 VAC 20-80-790	Amended	22:1 VA.R. 104	12/19/05
9 VAC 25-40-10	Amended	22:3 VA.R. 370	11/16/05
9 VAC 25-40-20	Repealed	22:3 VA.R. 370	11/16/05
9 VAC 25-40-25	Added	22:3 VA.R. 370	11/16/05
9 VAC 25-40-30	Amended	22:3 VA.R. 371	11/16/05
9 VAC 25-40-40	Amended	22:3 VA.R. 371	11/16/05
9 VAC 25-40-50	Amended	22:3 VA.R. 371	11/16/05
9 VAC 25-40-70	Added	22:3 VA.R. 371	11/16/05
9 VAC 25-110-10	Amended	22:4 VA.R. 595	11/30/05
9 VAC 25-110-20	Amended	22:4 VA.R. 595	11/30/05
9 VAC 25-110-60	Amended	22:4 VA.R. 596	11/30/05
9 VAC 25-110-70	Amended	22:4 VA.R. 596	11/30/05
9 VAC 25-110-80	Amended	22:4 VA.R. 597	11/30/05
9 VAC 25-180-10 through 9 VAC 25-180-70	Repealed	22:4 VA.R. 605	11/30/05
9 VAC 25-260-30	Amended	22:3 VA.R. 381	*
9 VAC 25-260-310	Amended	22:7 VA.R. 1015	**
9 VAC 25-260-410	Amended	22:7 VA.R. 1017	**
9 VAC 25-260-530	Amended	22:7 VA.R. 1018	**
9 VAC 25-630-50	Amended	22:2 VA.R. 229	11/2/05
9 VAC 25-720-10	Amended	22:3 VA.R. 372	11/16/05
9 VAC 25-720-30	Amended	22:3 VA.R. 374	11/16/05
9 VAC 25-720-40	Amended	22:3 VA.R. 374	11/16/05
9 VAC 25-720-50	Amended	22:2 VA.R. 236	11/2/05
9 VAC 25-720-50	Amended	22:3 VA.R. 376	11/16/05
9 VAC 25-720-50	Amended	22:6 VA.R. 896	12/28/05
9 VAC 25-720-60	Amended	22:7 VA.R. 1019	1/11/06
9 VAC 25-720-70	Amended	22:3 VA.R. 378	11/16/05
9 VAC 25-720-80	Amended	22:6 VA.R. 897	12/28/05
9 VAC 25-720-90	Amended	22:2 VA.R. 237	11/2/05
9 VAC 25-720-90	Amended	22:6 VA.R. 899	12/28/05
9 VAC 25-720-110	Amended	22:3 VA.R. 380	11/16/05
9 VAC 25-720-120	Amended	22:7 VA.R. 1021	1/11/06
9 VAC 25-720-130	Amended	22:2 VA.R. 238	11/2/05
9 VAC 25-720-130	Amended	22:6 VA.R. 900	12/28/05
9 VAC 25-750-10 through 9 VAC 25-750-50	Repealed	22:4 VA.R. 605	11/30/05
9 VAC 25-780-10 through 9 VAC 25-780-190	Added	22:2 VA.R. 238-246	11/2/05
9 VAC 25-780-30	Erratum	22:4 VA.R. 660	--
9 VAC 25-780-50	Erratum	22:4 VA.R. 660	--
9 VAC 25-780-90	Erratum	22:4 VA.R. 660	--
9 VAC 25-780-140	Erratum	22:4 VA.R. 660	--
Title 10. Finance and Financial Institutions			
10 VAC 5-20-50	Added	22:3 VA.R. 383	9/30/05
Title 11. Gaming			
11 VAC 15-22-10 through 11 VAC 15-22-120	Amended	22:6 VA.R. 901-915	12/28/05
11 VAC 15-22-35	Added	22:6 VA.R. 906	12/28/05
11 VAC 15-31-10	Amended	22:6 VA.R. 915	1/1/06
11 VAC 15-31-20	Amended	22:6 VA.R. 917	1/1/06
11 VAC 15-31-30	Amended	22:6 VA.R. 919	1/1/06
11 VAC 15-31-50	Amended	22:6 VA.R. 922	1/1/06
11 VAC 15-31-60	Amended	22:6 VA.R. 922	1/1/06
Title 12. Health			
12 VAC 5-70-10 through 12 VAC 5-70-50 emer	Repealed	22:5 VA.R. 713	3/1/06-2/28/07

* Effective upon filing notice of approval by U.S. EPA.

** Effective upon submittal of notice of EPA approval to the Registrar of Regulations.

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12 VAC 5-71-10 through 12 VAC 5-71-170 emer	Added	22:5 VA.R. 713-719	3/1/06-2/28/07
12 VAC 5-371-180	Amended	22:7 VA.R. 1023	1/11/06
12 VAC 5-371-210	Amended	22:7 VA.R. 1024	1/11/06
12 VAC 5-371-240	Amended	22:7 VA.R. 1024	1/11/06
12 VAC 5-371-300	Amended	22:7 VA.R. 1025	1/11/06
12 VAC 5-371-320	Amended	22:7 VA.R. 1025	1/11/06
12 VAC 5-371-340	Amended	22:7 VA.R. 1025	1/11/06
12 VAC 5-371-350	Repealed	22:7 VA.R. 1026	1/11/06
12 VAC 5-371-360	Amended	22:7 VA.R. 1026	1/11/06
12 VAC 5-371-370	Amended	22:7 VA.R. 1027	1/11/06
12 VAC 5-371-410	Amended	22:7 VA.R. 1027	1/11/06
12 VAC 5-371-425	Added	22:7 VA.R. 1028	1/11/06
12 VAC 5-371-430 through 12 VAC 5-371-560	Repealed	22:7 VA.R. 1028-1031	1/11/06
12 VAC 5-380	Repealed	22:3 VA.R. 388	1/1/06
12 VAC 5-381-10 through 12 VAC 5-381-360	Added	22:3 VA.R. 388-406	1/1/06
12 VAC 5-381-120	Erratum	22:4 VA.R. 659	--
12 VAC 5-500-10 through 12 VAC 5-500-350	Repealed	22:3 VA.R. 407	1/1/06
12 VAC 5-501-10 through 12 VAC 5-501-350	Added	22:3 VA.R. 407-413	1/1/06
12 VAC 30-80-40	Amended	22:3 VA.R. 414	11/16/05
12 VAC 30-120-1600 through 12 VAC 30-120-1660 emer	Added	22:2 VA.R. 255-261	9/14/05-9/13/06
12 VAC 30-141-10 emer	Amended	21:25 VA.R. 3553	8/1/05-7/31/06
12 VAC 30-141-10 emer	Amended	21:25 VA.R. 3561	8/1/05-7/31/06
12 VAC 30-141-40 emer	Amended	21:25 VA.R. 3555	8/1/05-7/31/06
12 VAC 30-141-100 emer	Amended	21:25 VA.R. 3555	8/1/05-7/31/06
12 VAC 30-141-100 emer	Amended	21:25 VA.R. 3563	8/1/05-7/31/06
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12 VAC 30-141-160 emer	Amended	21:25 VA.R. 3557	8/1/05-7/31/06
12 VAC 30-141-170 emer	Repealed	21:25 VA.R. 3557	8/1/05-7/31/06
12 VAC 30-141-175 emer	Added	21:25 VA.R. 3559	8/1/05-7/31/06
12 VAC 30-141-200 emer	Amended	21:25 VA.R. 3560	8/1/05-7/31/06
12 VAC 30-141-810 through 12 VAC 30-141-1660 emer	Added	21:25 VA.R. 3566-3573	8/1/05-7/31/06
Title 13. Housing			
13 VAC 5-21-10 through 13 VAC 5-21-70	Amended	22:3 VA.R. 416-419	11/16/05
13 VAC 5-21-45	Added	22:3 VA.R. 418	11/16/05
13 VAC 5-21-61	Erratum	22:5 VA.R. 734	--
13 VAC 5-31-20	Amended	22:3 VA.R. 420	11/16/05
13 VAC 5-31-40	Amended	22:3 VA.R. 420	11/16/05
13 VAC 5-31-50	Amended	22:3 VA.R. 421	11/16/05
13 VAC 5-31-80	Amended	22:3 VA.R. 421	11/16/05
13 VAC 5-31-100	Amended	22:3 VA.R. 422	11/16/05
13 VAC 5-31-190	Amended	22:3 VA.R. 422	11/16/05
13 VAC 5-31-200	Added	22:3 VA.R. 422	11/16/05
13 VAC 5-31-210	Added	22:3 VA.R. 422	11/16/05
13 VAC 5-51-21	Amended	22:3 VA.R. 422	11/16/05
13 VAC 5-51-31	Amended	22:3 VA.R. 423	11/16/05
13 VAC 5-51-41	Amended	22:3 VA.R. 423	11/16/05
13 VAC 5-51-51	Amended	22:3 VA.R. 424	11/16/05
13 VAC 5-51-51	Erratum	22:5 VA.R. 734	--
13 VAC 5-51-61	Amended	22:3 VA.R. 425	11/16/05
13 VAC 5-51-81	Amended	22:3 VA.R. 425	11/16/05
13 VAC 5-51-91	Amended	22:3 VA.R. 432	11/16/05
13 VAC 5-51-121	Amended	22:3 VA.R. 433	11/16/05
13 VAC 5-51-130	Amended	22:3 VA.R. 434	11/16/05
13 VAC 5-51-131	Amended	22:3 VA.R. 434	11/16/05
13 VAC 5-51-132	Amended	22:3 VA.R. 435	11/16/05

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
13 VAC 5-51-133	Amended	22:3 VA.R. 435	11/16/05
13 VAC 5-51-133.5	Added	22:3 VA.R. 436	11/16/05
13 VAC 5-51-134	Added	22:3 VA.R. 436	11/16/05
13 VAC 5-51-135	Amended	22:3 VA.R. 436	11/16/05
13 VAC 5-51-135.5	Added	22:3 VA.R. 437	11/16/05
13 VAC 5-51-136	Repealed	22:3 VA.R. 437	11/16/05
13 VAC 5-51-145	Added	22:3 VA.R. 437	11/16/05
13 VAC 5-51-150	Amended	22:3 VA.R. 438	11/16/05
13 VAC 5-51-152	Added	22:3 VA.R. 442	11/16/05
13 VAC 5-51-154	Added	22:3 VA.R. 442	11/16/05
13 VAC 5-51-155	Amended	22:3 VA.R. 443	11/16/05
13 VAC 5-62-10 through 13 VAC 5-62-480	Repealed	22:3 VA.R. 444	11/16/05
13 VAC 5-63-10 through 13 VAC 5-63-550	Added	22:3 VA.R. 444-497	11/16/05
13 VAC 5-63-120	Erratum	22:5 VA.R. 734	--
13 VAC 5-63-210	Erratum	22:5 VA.R. 734	--
13 VAC 5-63-270	Erratum	22:5 VA.R. 734	--
13 VAC 5-63-300	Erratum	22:5 VA.R. 734	--
13 VAC 5-91-10	Amended	22:3 VA.R. 498	11/16/05
13 VAC 5-91-20	Amended	22:3 VA.R. 499	11/16/05
13 VAC 5-91-40	Amended	22:3 VA.R. 499	11/16/05
13 VAC 5-91-50	Amended	22:3 VA.R. 499	11/16/05
13 VAC 5-91-70	Amended	22:3 VA.R. 499	11/16/05
13 VAC 5-91-80	Amended	22:3 VA.R. 499	11/16/05
13 VAC 5-91-90	Amended	22:3 VA.R. 499	11/16/05
13 VAC 5-91-110 through 13 VAC 5-91-220	Amended	22:3 VA.R. 499-501	11/16/05
13 VAC 5-91-245 through 13 VAC 5-91-270	Amended	22:3 VA.R. 502	11/16/05
13 VAC 5-112-10 through 13 VAC 5-112-560 emer	Added	22:4 VA.R. 630-649	9/30/05-9/29/06
13 VAC 10-160-10	Amended	22:7 VA.R. 1032	12/1/05
13 VAC 10-160-30	Amended	22:7 VA.R. 1033	12/1/05
13 VAC 10-160-55	Amended	22:7 VA.R. 1034	12/1/05
13 VAC 10-160-60	Amended	22:7 VA.R. 1034	12/1/05
13 VAC 10-160-80	Amended	22:7 VA.R. 1035	12/1/05
13 VAC 10-160-90	Amended	22:7 VA.R. 1035	12/1/05
Title 14. Insurance			
14 VAC 5-170-20 through 14 VAC 5-170-105	Amended	21:25 VA.R. 3477-3490	8/15/05
14 VAC 5-170-120	Amended	21:25 VA.R. 3490	8/15/05
14 VAC 5-170-130	Amended	21:25 VA.R. 3492	8/15/05
14 VAC 5-170-150	Amended	21:25 VA.R. 3493	8/15/05
14 VAC 5-170-150	Erratum	22:1 VA.R. 114	--
14 VAC 5-170-160	Amended	21:25 VA.R. 3525	8/15/05
14 VAC 5-170-190 Appendices A through D	Amended	21:25 VA.R. 3527-3548	8/15/05
Title 16. Labor and Employment			
16 VAC 15-21-20	Amended	22:4 VA.R. 606	12/1/05
16 VAC 15-21-30	Amended	22:4 VA.R. 606	12/1/05
Title 18. Professional and Occupational Licensing			
18 VAC 47-20-10 emer	Amended	21:25 VA.R. 3574	8/1/05-7/31/06
18 VAC 47-20-35 emer	Added	21:25 VA.R. 3575	8/1/05-7/31/06
18 VAC 47-20-70 emer	Amended	21:25 VA.R. 3575	8/1/05-7/31/06
18 VAC 47-20-70	Amended	22:6 VA.R. 923	1/1/06
18 VAC 47-20-140 emer	Amended	21:25 VA.R. 3575	8/1/05-7/31/06
18 VAC 47-20-140	Amended	22:6 VA.R. 923	1/1/06
18 VAC 47-20-240 emer	Repealed	21:25 VA.R. 3575	8/1/05-7/31/06
18 VAC 47-20-250 emer	Added	21:25 VA.R. 3576	8/1/05-7/31/06
18 VAC 47-20-260 emer	Added	21:25 VA.R. 3576	8/1/05-7/31/06
18 VAC 47-20-270 emer	Added	21:25 VA.R. 3576	8/1/05-7/31/06

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
18 VAC 60-20-10 emer	Amended	22:1 VA.R. 106	9/1/05-8/31/06
18 VAC 60-20-20 emer	Amended	22:1 VA.R. 107	9/1/05-8/31/06
18 VAC 60-20-71 emer	Amended	22:1 VA.R. 107	9/1/05-8/31/06
18 VAC 60-20-105 emer	Amended	22:1 VA.R. 107	9/1/05-8/31/06
18 VAC 60-20-106 emer	Amended	22:1 VA.R. 108	9/1/05-8/31/06
18 VAC 60-20-210 emer	Amended	22:1 VA.R. 108	9/1/05-8/31/06
18 VAC 60-20-230 emer	Amended	22:1 VA.R. 109	9/1/05-8/31/06
18 VAC 76-20-20 emer	Amended	21:25 VA.R. 3577	7/25/05-7/24/06
18 VAC 76-20-30 emer	Amended	21:25 VA.R. 3577	7/25/05-7/24/06
18 VAC 76-20-50 emer	Amended	21:25 VA.R. 3577	7/25/05-7/24/06
18 VAC 76-20-60 emer	Amended	21:25 VA.R. 3577	7/25/05-7/24/06
18 VAC 76-20-70 emer	Added	21:25 VA.R. 3578	7/25/05-7/24/06
18 VAC 85-20	Erratum	22:1 VA.R. 114	--
18 VAC 85-20-25	Added	22:1 VA.R. 82	10/19/05
18 VAC 85-20-26	Added	22:1 VA.R. 83	10/19/05
18 VAC 85-20-27	Added	22:1 VA.R. 83	10/19/05
18 VAC 85-20-28	Added	22:1 VA.R. 83	10/19/05
18 VAC 85-20-29	Added	22:1 VA.R. 84	10/19/05
18 VAC 85-20-30	Amended	22:1 VA.R. 84	10/19/05
18 VAC 85-20-40	Amended	22:1 VA.R. 84	10/19/05
18 VAC 85-20-50	Amended	22:1 VA.R. 84	10/19/05
18 VAC 85-20-80	Amended	22:1 VA.R. 84	10/19/05
18 VAC 85-20-90	Amended	22:1 VA.R. 84	10/19/05
18 VAC 85-20-100	Amended	22:1 VA.R. 85	10/19/05
18 VAC 85-20-105	Amended	22:1 VA.R. 85	10/19/05
18 VAC 85-40-66	Amended	22:7 VA.R. 1036	1/11/06
18 VAC 85-40-85 through 18 VAC 85-40-91	Added	22:1 VA.R. 87-89	10/19/05
18 VAC 85-50-175 through 18 VAC 85-50-184	Added	22:1 VA.R. 89-91	10/19/05
18 VAC 85-80-120 through 18 VAC 85-80-125	Added	22:1 VA.R. 92-93	10/19/05
18 VAC 85-80-120 through 18 VAC 85-80-125	Erratum	22:4 VA.R. 659	--
18 VAC 85-101-161 through 18 VAC 85-101-166	Added	22:1 VA.R. 94-95	10/19/05
18 VAC 85-110-175 through 18 VAC 85-110-183	Added	22:1 VA.R. 95-98	10/19/05
18 VAC 85-120-50	Amended	22:2 VA.R. 254	12/17/05
18 VAC 85-120-155 through 18 VAC 85-120-162	Added	22:1 VA.R. 98-100	10/19/05
18 VAC 105-20-5	Added	22:4 VA.R. 607	11/30/05
18 VAC 105-20-10	Amended	22:4 VA.R. 607	11/30/05
18 VAC 105-20-15	Amended	22:4 VA.R. 607	11/30/05
18 VAC 105-20-16	Added	22:4 VA.R. 608	11/30/05
18 VAC 105-20-20	Amended	22:4 VA.R. 608	11/30/05
18 VAC 105-20-70	Amended	22:4 VA.R. 608	11/30/05
18 VAC 105-30-10 through 18 VAC 105-30-120	Repealed	22:4 VA.R. 606	11/30/05
18 VAC 110-20-20	Amended	22:2 VA.R. 246	11/2/05
18 VAC 110-20-320	Amended	22:7 VA.R. 1037	1/11/06
18 VAC 112-20-135	Amended	22:1 VA.R. 100	10/19/05
18 VAC 112-20-150	Amended	22:1 VA.R. 101	10/19/05
18 VAC 112-20-151	Repealed	22:1 VA.R. 101	10/19/05
18 VAC 115-20-20	Amended	22:2 VA.R. 249	1/14/06
18 VAC 115-20-130	Amended	22:7 VA.R. 1039	1/11/06
18 VAC 115-20-140	Amended	22:7 VA.R. 1040	1/11/06
18 VAC 115-20-150	Amended	22:7 VA.R. 1041	1/11/06
18 VAC 115-30-30	Amended	22:2 VA.R. 250	1/21/06
18 VAC 115-50-110	Amended	22:7 VA.R. 1041	1/11/06
18 VAC 115-50-120	Amended	22:7 VA.R. 1042	1/11/06
18 VAC 115-50-130	Amended	22:7 VA.R. 1043	1/11/06
18 VAC 115-60-130	Amended	22:7 VA.R. 1043	1/11/06
18 VAC 115-60-140	Amended	22:7 VA.R. 1045	1/11/06

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
18 VAC 115-60-150	Amended	22:7 VA.R. 1045	1/11/06
18 VAC 150-20-100	Amended	21:26 VA.R. 3701	10/5/05
Title 20. Public Utilities and Telecommunications			
20 VAC 5-400-80	Repealed	22:4 VA.R. 612	11/1/05
20 VAC 5-427-10	Erratum	22:1 VA.R. 114	--
20 VAC 5-427-10 through 20 VAC 5-427-170	Added	22:4 VA.R. 613-625	11/1/05
20 VAC 5-427-100	Erratum	22:1 VA.R. 114	--
20 VAC 5-427-110	Erratum	22:1 VA.R. 114	--
20 VAC 5-427-130	Erratum	22:1 VA.R. 114	--
Title 22. Social Services			
22 VAC 40-71-10 emer	Amended	22:2 VA.R. 261	12/28/05-12/27/06
22 VAC 40-71-50 emer	Amended	22:2 VA.R. 266	12/28/05-12/27/06
22 VAC 40-71-55 emer	Added	22:2 VA.R. 266	12/28/05-12/27/06
22 VAC 40-71-60 emer	Amended	22:2 VA.R. 267	12/28/05-12/27/06
22 VAC 40-71-65 emer	Added	22:2 VA.R. 269	12/28/05-12/27/06
22 VAC 40-71-80 emer	Amended	22:2 VA.R. 269	12/28/05-12/27/06
22 VAC 40-71-120 emer	Amended	22:2 VA.R. 270	12/28/05-12/27/06
22 VAC 40-71-130 emer	Amended	22:2 VA.R. 270	12/28/05-12/27/06
22 VAC 40-71-150 emer	Amended	22:2 VA.R. 270	12/28/05-12/27/06
22 VAC 40-71-400 emer	Amended	22:2 VA.R. 274	12/28/05-12/27/06
22 VAC 40-71-485 emer	Added	22:2 VA.R. 277	12/28/05-12/27/06
22 VAC 40-71-485	Erratum	22:4 VA.R. 659	--
22 VAC 40-71-630 emer	Amended	22:2 VA.R. 278	12/28/05-12/27/06
22 VAC 40-71-630	Erratum	22:4 VA.R. 660	--
22 VAC 40-71-650 emer	Amended	22:2 VA.R. 279	12/28/05-12/27/06
22 VAC 40-71-660 emer	Repealed	22:2 VA.R. 280	12/28/05-12/27/06
22 VAC 40-71-670 emer	Amended	22:2 VA.R. 280	12/28/05-12/27/06
22 VAC 40-71-700 emer	Amended	22:2 VA.R. 281	12/28/05-12/27/06
22 VAC 40-80-120 emer	Amended	22:2 VA.R. 285	12/28/05-12/27/06
22 VAC 40-80-340 emer	Amended	22:2 VA.R. 286	12/28/05-12/27/06
22 VAC 40-80-345 emer	Added	22:2 VA.R. 287	12/28/05-12/27/06
22 VAC 40-730-10	Amended	22:2 VA.R. 251	11/2/05
22 VAC 40-730-115	Amended	22:2 VA.R. 252	11/2/05

NOTICES OF INTENDED REGULATORY ACTION

Symbol Key

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

TITLE 2. AGRICULTURE

VIRGINIA PESTICIDE CONTROL BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Virginia Pesticide Control Board intends to consider amending regulations entitled **2 VAC 20-20, Rules and Regulations for Enforcement of the Virginia Pesticide Law**, and promulgating regulations entitled **2 VAC 20-25, Rules and Regulations for the Registration of Pesticides and Pesticide Products Under Authority of the Virginia Pesticide Control Act**. The purpose of the proposed action is to promulgate a new regulation that deals solely with all processes and procedures relating to the registration and subsequent sale and use of pesticides and pesticide products in Virginia as well as to review 2 VAC 20-20 for effectiveness and continued need. The agency invites comment on whether there should be an advisor.

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

Statutory Authority: § 3.1-249.30 of the Code of Virginia.

Public comments may be submitted until January 20, 2006.

Contact: Dr. W. Wayne Surles, Program Manager, Virginia Pesticide Control Board, P.O. Box 1163, Richmond, VA 23218, telephone (804) 371-6558, FAX (804) 786-9149 or e-mail wayne.surles@vdacs.virginia.gov.

VA.R. Doc. No. R06-110; Filed November 8, 2005, 3:51 p.m.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

VIRGINIA SOIL AND WATER CONSERVATION BOARD

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Virginia Soil and Water Conservation Board intends to consider amending regulations entitled **4 VAC 50-20, Impounding Structure Regulations**. The purpose of the proposed action is to (i) establish an alternative procedure (decision matrix) that would allow for the evaluation of spillway design floods (SDF) less than the probable maximum flood (PMF) where there would be unreasonable or significant increase in hazard to life and property; (ii) establish alteration permit requirements similar to construction permit

requirements; (iii) expand the requirements of an emergency action plan to meet federal requirements; (iv) amend references to new and existing dams to clarify that the regulations refer to all dams unless otherwise specified; (v) improve the applicability and consistency of Table 1 in 4 VAC 50-20-50 and improve the risk classification system; (vi) establish permit application fees for the administration of the dam safety program; (vii) amend or remove the forms that are incorporated by reference; (viii) clarify the meanings of terminologies such as "significantly," "appropriate," and "reasonable" as well as the threshold at which "probable" becomes "possible"; and (ix) revise the regulations as needed to improve the administration and implementation of the Virginia Dam Safety Program.

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

Statutory Authority: § 10.1-604 of the Code of Virginia.

Public comments may be submitted until February 24, 2006.

Contact: David C. Dowling, Policy, Planning and Budget Director, Department of Conservation and Recreation, 203 Governor St., Suite 302, Richmond, VA 23219, telephone (804) 786-2291, FAX (804) 786-6141 or e-mail david.dowling@dcr.virginia.gov.

VA.R. Doc. No. R06-130; Filed December 7, 2005, 9:51 a.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Virginia Soil and Water Conservation Board intends to consider amending regulations entitled **4 VAC 50-60, Stormwater Management Regulations**. The Virginia Stormwater Management Program was created by Chapter 372 of the 2004 Virginia Acts of Assembly (HB1177) and this action transferred the responsibility of the permitting programs for MS4s and construction activities from the State Water Control Board and DEQ to the Virginia Soil and Water Conservation Board and DCR. The law authorized the board to delegate to the department or to an approved locality any of the powers and duties vested in it except the adoption and promulgation of regulations. The purpose of this proposed action is to consider the development and adoption of revised regulations to establish minimal criteria of a local stormwater management program and board approval procedures for the delegation of the stormwater management program for construction activities, or parts thereof, to localities per §10.1-603.3 of the Code of Virginia; and to revise the regulation, as needed, to improve the administration and implementation of the Virginia Stormwater Management Act (§ 10.1-603.2 et seq.) per the requirements set forth in the federal Clean Water Act and its attendant regulations.

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

Notices of Intended Regulatory Action

Statutory Authority: §§ 10.1-107 and 10.1-603.4 of the Code of Virginia.

Public comments may be submitted until February 24, 2006.

Contact: David C. Dowling, Policy, Planning and Budget Director, Department of Conservation and Recreation, 203 Governor St., Suite 302, Richmond, VA 23219, telephone (804) 786-2291, FAX (804) 786-6141 or e-mail david.dowling@dcr.virginia.gov.

VA.R. Doc. No. R06-128; Filed December 7, 2005, 10:04 a.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Virginia Soil and Water Conservation Board intends to consider amending regulations entitled **4 VAC 50-60, Stormwater Management Regulations**. The purpose of the proposed action is to consider the development and adoption of regulations that establish or revise the statewide stormwater permit fees at a level sufficient to carry out the stormwater management program per § 10.1-603.4.5 of the Code of Virginia; and to revise the related provisions in the regulations, as needed, to improve the administration and implementation of fees under the Virginia Stormwater Management Act (§ 10.1-603.2 et seq.).

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

Statutory Authority: §§ 10.1-107 and 10.1-603.4 of the Code of Virginia.

Public comments may be submitted until February 24, 2006.

Contact: David C. Dowling, Policy, Planning and Budget Director, Department of Conservation and Recreation, 203 Governor St., Suite 302, Richmond, VA 23219, telephone (804) 786-2291, FAX (804) 786-6141 or e-mail david.dowling@dcr.virginia.gov.

VA.R. Doc. No. R06-129; Filed December 7, 2005, 10:04 a.m.

TITLE 6. CRIMINAL JUSTICE AND CORRECTIONS

STATE BOARD OF JUVENILE JUSTICE

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Juvenile Justice intends to consider promulgating regulations entitled **6 VAC 35-180, Regulations Governing Mental Health Services Transition Plans for Incarcerated Juveniles**. The purpose of the proposed action is to ensure continuity of necessary treatment and services for juveniles being released from incarceration.

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

Statutory Authority: § 16.1-293.1 of the Code of Virginia.

Public comments may be submitted until December 30, 2005.

Contact: Donald R. Carignan, Regulatory Coordinator, Department of Juvenile Justice, 700 E. Franklin St., P.O. Box 1110, Richmond, VA 23218-1110, telephone (804) 371-0743, FAX (804) 371-0773 or e-mail don.carignan@djj.virginia.gov.

VA.R. Doc. No. R06-104; Filed November 3, 2005, 12:55 p.m.

TITLE 8. EDUCATION

STATE BOARD OF EDUCATION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Education intends to consider amending regulations entitled **8 VAC 20-160, Regulations Governing Secondary School Transcripts**. The purpose of the proposed action is to provide definitions, format options for transcripts and profile data sheets, and the elements for weighing advanced, accelerated, advanced placement and honors level courses. The proposed revisions remove the 1988-89 effective date provisions, revise the definitions as necessary to comport with those in other Board of Education regulations, and revise the format options for the transcript and profile data sheets to reflect both Board of Education regulations and state and federal law. The sections concerning class rankings, advanced placement courses and the elements of weighing advanced, accelerated, advanced placement, and honors level courses also need to be reviewed to ensure that they comport with best instructional practices, as well as other state requirements.

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

Statutory Authority: §§ 22.1-16 and 22.1-253.13:3 of the Code of Virginia.

Public comments may be submitted until December 29, 2005.

Contact: Dr. Margaret N. Roberts, Office of Policy and Communications, Department of Education, P.O. Box 2120, 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524 or e-mail margaret.roberts@doe.virginia.gov.

VA.R. Doc. No. R06-111; Filed November 9, 2005, 9:50 a.m.

Notices of Intended Regulatory Action

TITLE 9. ENVIRONMENT

STATE AIR POLLUTION CONTROL BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Air Pollution Control Board intends to consider amending regulations entitled **9 VAC 5-50, New and Modified Stationary Sources** and **9 VAC 5-80, Permits for Stationary Sources (Rev. H05)**. The purpose of the proposed action is to simplify the minor new source review program requirements and reduce the complexity of the permit program as well as revise program requirements based on implementation experience. This action replaces Rev. K04 that was withdrawn.

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

Statutory Authority: §§ 10.1-1308 of the Code of Virginia; §§ 110, 112, 165, 173, 182 and Title V of the Clean Air Act; 40 CFR Parts 51, 61, 63, 70 and 72.

Public comments may be submitted until January 5, 2006.

Contact: Gary Graham, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4103, FAX (804) 698-4510 or e-mail gegraham@deq.virginia.gov.

VA.R. Doc. No. R06-106; Filed November 7, 2005, 2:11 p.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Withdrawal of Notice of Intended Regulatory Action

The State Board of Health has **withdrawn** the Notice of Intended Regulatory Action for 12 VAC 5-610, Sewage Handling and Disposal Regulations, that was published 17: 21 VA.R. 2970 July 2, 2001, which relates to new site and soil requirements for onsite sewage systems utilizing secondary and advanced secondary treatment, (ii) new design and construction criteria using the concept of a minimum footprint; and (iii) requirements for operating, maintaining, and monitoring onsite wastewater systems.

VA.R. Doc. No. R01-193; Filed December 12, 2005, 11:28 a.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance

Services intends to consider amending regulations entitled **12 VAC 30-30, Groups Covered and Agencies Responsible for Eligibility Determinations; 12 VAC 30-30, Eligibility Conditions and Requirements; and 12 VAC 30-50, Amount, Duration and Scope of Medical and Remedial Care Services**. The purpose of the proposed action is to implement a new program for prescription drug coverage for Medicaid/Medicare dual eligibles.

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

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public comments may be submitted until January 27, 2006.

Contact: Jack Quigley, Policy and Research Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-1300, FAX (804) 786-1680 or e-mail jack.quigley@dmas.virginia.gov.

VA.R. Doc. No. R06-132; Filed December 7, 2005, 9:51 a.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending regulations entitled **12 VAC 30-80, Methods and Standards for Establishing Payment Rates; Other Types of Care**.

The purpose of the proposed action is to implement a new supplemental payment method for faculty in dental pediatric residency programs.

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

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public comments may be submitted until January 25, 2006.

Contact: William Lessard, Provider Reimbursement Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 225-4593, FAX (804) 786-1680 or e-mail william.lessard@dmas.virginia.gov.

VA.R. Doc. No. R06-125; Filed December 2, 2005, 4:36 p.m.

STATE MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES BOARD

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Mental Health, Mental Retardation And Substance Abuse Services Board intends to consider amending regulations entitled **12 VAC 35-45, Regulations for Providers of Mental Health, Mental Retardation and Substance Abuse Residential Services for Children**. The purpose of the proposed action is to add

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provisions for issuing an order of summary suspension of the license to operate a group home or residential facility for children.

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

Statutory Authority: § 37.2-203 of the Code of Virginia.

Public comments may be submitted until January 25, 2006.

Contact: Leslie Anderson, Director, Office of Licensing, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 371-6885, FAX (804) 692-0066 or e-mail leslie.anderson@co.dmhmrzas.virginia.gov.

VA.R. Doc. No. R06-123; Filed December 2, 2005, 11:27 a.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Social Services intends to consider repealing regulations entitled **22 VAC 40-20, Food Stamp Program - Income Conversion Method**. The purpose of the proposed action is to repeal 22 VAC 40-20, which requires local social services workers to use conversion factors of 4.3 for weekly income amounts and 2.15 for biweekly amounts when calculating income to determine eligibility and benefit level for the Food Stamp Program. The provisions of this regulation will be included in a proposed new regulation, 22 VAC 40-601, Food Stamp Program.

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

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

Public comments may be submitted until January 25, 2006.

Contact: Celestine Jackson, Program Specialist, Division of Benefit Programs, Department of Social Services, 7 N. 8th St., Richmond, VA 23219, telephone (804) 726-7376, FAX (804) 726-7356 or e-mail celestine.jackson@dss.virginia.gov.

VA.R. Doc. No. R06-135; Filed December 7, 2005, 10:32 a.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Social Services intends to consider adopting regulations entitled **22 VAC 40-221, Interstate Compact on the Placement of Children**. The purpose of the proposed action is to promulgate regulations that shall be used as authority for judges, licensed placing agencies and other interested parties when addressing issues related to children who are placed across state lines for foster care or adoption.

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

Statutory Authority: § 63.2-1105 of the Code of Virginia.

Public comments may be submitted until December 14, 2005.

Contact: RoseMarie Keith, Program Administration Manager III, Department of Social Services, 7 N. 8th St., Richmond, VA 23219, telephone (804) 726-7581, FAX (804) 726-7498 or e-mail rosemarie.keith@dss.virginia.gov.

VA.R. Doc. No. R06-89; Filed October 18, 2005, 1:22 p.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Social Services intends to consider repealing regulations entitled **22 VAC 40-540, Allowance of Telephone Costs in the Food Stamp Program**. The purpose of the proposed action is to repeal 22 VAC 40-20, which requires local social services workers to use a standard telephone amount when calculating shelter expenses to determine eligibility and benefit level for the Food Stamp Program. The provisions of this regulation will be included in a proposed new regulation, 22 VAC 40-601, Food Stamp Program.

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

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

Public comments may be submitted until January 25, 2006.

Contact: Celestine Jackson, Program Specialist, Division of Benefit Programs, Department of Social Services, 7 N. 8th St., Richmond, VA 23219, telephone (804) 726-7376, FAX (804) 726-7356 or e-mail celestine.jackson@dss.virginia.gov.

VA.R. Doc. No. R06-136; Filed December 7, 2005, 10:32 a.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Social Services intends to consider repealing regulations entitled **22 VAC 40-600, Food Stamp Program - Administrative Disqualification Hearings**. The purpose of the proposed action is to repeal 22 VAC 40-600, which establishes an administrative process to determine if an individual has committed an intentional act against the Food Stamp Program. The provisions of this regulation will be included in a proposed new regulation, 22 VAC 40-601, Food Stamp Program.

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

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

Public comments may be submitted until January 25, 2006.

Contact: Celestine Jackson, Program Specialist, Division of Benefit Programs, Department of Social Services, 7 N. 8th St., Richmond, VA 23219, telephone (804) 726-7376, FAX (804) 726-7356 or e-mail celestine.jackson@dss.virginia.gov.

Notices of Intended Regulatory Action

VA.R. Doc. No. R06-137; Filed December 7, 2005, 10:32 a.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Social Services intends to consider adopting regulations entitled **22 VAC 40-601, Food Stamp Program**. The purpose of the proposed action is to promulgate a new regulation for determining eligibility and benefit level for the Food Stamp Program. The new regulation will establish calculation methods for determining monthly income, require use of a standard amount for telephone expenses, and establish a process for administrative hearings to determine when intentional acts have been committed. 22 VAC 40-20, 22 VAC 40-540, and 22 VAC 40-600 will be repealed and provisions incorporated into the proposed regulation, 22 VAC 40-601.

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

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

Public comments may be submitted until January 25, 2006.

Contact: Celestine Jackson, Program Specialist, Division of Benefit Programs, Department of Social Services, 7 N. 8th St., Richmond, VA 23219, telephone (804) 726-7376, FAX (804) 726-7356 or e-mail celestine.jackson@dss.virginia.gov.

VA.R. Doc. No. R06-138; Filed December 7, 2005, 10:32 a.m.



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.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Withdrawal of Proposed Regulation

Title of Regulation: 12 VAC 5-610. Sewage Handling and Disposal Regulations (amending 12 VAC 5-610-120 and 12 VAC 5-610-490; adding 12 VAC 5-610-449 and 12 VAC 5-610-449.1).

Statutory Authority: § 32.1-12 and 32.1-164 of the Code of Virginia.

The State Board of Health has **withdrawn** the proposed amendments to 12 VAC 5-610, Sewage Handling and Disposal Regulations, that were published in 18:23 VA.R. 2999-3011 July 29, 2002.

Agency Contact: Donald J. Alexander, Director, Division of Onsite Sewage and Water Services, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7452, FAX (804) 864-7475 or e-mail don.alexander@vdh.virginia.gov.

VA.R. Doc. No. R00-207 and R01-192; Filed December 12, 2005, 2:49 p.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Titles of Regulations: 12 VAC 30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12 VAC 30-60-40; adding 12 VAC 30-60-350).

12 VAC 30-90. Methods and Standards for Establishing Payment Rates for Long-Term Care (amending 12 VAC 30-90-41).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public Hearing Date: N/A -- Public comments may be submitted until February 24, 2006.

(See Calendar of Events section for additional information)

Agency Contact: Teja Stokes, Project Manager, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-0527, FAX (804) 786-1680, or e-mail teja.stokes@dmas.virginia.gov.

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

Security Act (42 USC 1396a) provides governing authority for payments for services.

Item 326 RR of Chapter 4 of the 2004 Acts of the Assembly directed DMAS to provide an additional \$10 per day reimbursement to nursing facilities for residents who require a specialized treatment bed due to their having at least one treatable Stage IV pressure ulcer.

Purpose: The purpose of this action is to provide additional reimbursement (\$10 per day) to nursing facilities (NF) for residents who require specialized treatment beds due to their having at least one treatable Stage IV pressure ulcer. The cost to NFs of providing specialized treatment beds frequently exceeds what is covered through the current NF reimbursement methodology. The additional \$10 per day reimbursement for specialized treatment beds is intended to help defray the cost to NFs of providing these beds to residents with Stage IV pressure ulcers.

Substance: Pressure ulcers are caused by unrelieved pressure on skin over bony prominences such as hips, sacrum, and heels in residents with limited mobility. Pressure ulcers are graded by the degree of observable tissue damage from Stage I, being least severe, to Stage IV, being most severe.

NFs have established policies for the prevention and treatment of pressure ulcers. Standard interventions include ongoing assessment of the patient and the ulcer including a nutritional assessment; management of pressure and friction through positioning and the use of support surfaces; care of the ulcer including debridement, cleansing, and dressing; medications to treat infections; operative repair of the ulcer; patient and caregiver education; and quality improvement programs.

Providing proper support surfaces such as specialized treatment beds for residents with Stage IV pressure ulcers is one component of a comprehensive pressure ulcer treatment plan. In FY 2002, a total of 1,147 residents at 204 NFs had at least one Stage IV pressure ulcer during at least one quarter of the fiscal year. This figure represents approximately 4.2% of the total Medicaid recipients who received nursing facility care in FY 2002. The additional \$10 per day reimbursement is intended to help defray the cost to NFs of providing specialized treatment beds to residents with Stage IV pressure ulcers. These costs are related to direct patient care, and in the nursing facility payment system all direct patient care costs are adjusted for inflation each year. Therefore to be consistent with the provisions of the payment system, this payment will also be adjusted for inflation.

DMAS staff reviewed proposed policy options with representatives of health care provider organizations. The feedback from providers was used in developing the emergency regulations and will also be used in developing the

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preauthorization process for the additional \$10 per day reimbursement.

Issues: The primary advantage of these regulations is that the additional reimbursement will help to defray the cost to nursing facilities of providing specialized treatment beds to residents with at least one treatable Stage IV pressure ulcer. There are no known disadvantages of these regulations to the agency, public or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H 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 impacts.

Summary of the proposed regulation. Pursuant to Item 326 RR of Chapter 4 of the 2004 Acts of the Assembly, the proposed regulations permanently increase Medicaid payments to nursing homes by \$10 per recipient per day for residents who require a specialized treatment bed for a Stage IV pressure ulcer. The proposed changes have been in effect since July 2005 under emergency regulations.

Estimated economic impact. Pursuant to Item 326 RR of the 2004 Acts of the Assembly, the proposed changes increase Medicaid reimbursement rates to nursing homes by \$10 per recipient per day for residents requiring a special treatment bed for at least one treatable Stage IV pressure ulcer.¹

Nursing facilities provide special treatment beds to recipients with pressure ulcers. The proposed additional \$10 per day for recipients with pressure ulcers is intended to help cover the additional costs of providing these special beds. In fiscal year 2002, there were 1,147 nursing facility residents who had at least one Stage IV pressure ulcer during at least one quarter of the year. Based on this data, the proposed changes are estimated to increase nursing facility payments by approximately \$1 million annually. The Commonwealth will finance approximately one half of this amount and the other half will be financed by federal matching dollars.

The impact on nursing homes will be a net increase in their revenues. Increased revenues may or may not improve services as this depends on how the monies are spent. This reimbursement increase could also benefit private payers if nursing homes use the additional revenues to subsidize them. Nursing homes can shift costs between private payers and Medicaid under the current institutional structure. While this rate increase may help improve access to special treatment

beds, it is unlikely that nursing homes would have refused to serve patients with Stage IV pressure ulcer if they had not been awarded the \$10 increase.

The net impact on Virginia's economy is likely to be positive because of the federal match. While one half of the funds will come from state resources, the other half will come from the federal government. Thus, the federal match will be a net injection into the state's economy as it does not have a corresponding offset elsewhere and will have a net positive impact on state output.

Businesses and entities affected. The proposed regulations will increase Medicaid reimbursement rates for nursing homes for recipients with pressure ulcers. Currently, there are 280 nursing homes in Virginia.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The proposed nursing home rate increase for pressure ulcers will likely have an expansionary effect on the state economy. To the extent increased funding, particularly the federal portion of the increase, is directed toward purchase of goods and services within the state, there could be a positive effect on demand for labor.

Effects on the use and value of private property. The proposed regulations are likely to improve revenues and the future profit streams of nursing homes. An increase in profits would, in turn, increase their asset values.

Small businesses: costs and other effects. The proposed regulations are not anticipated to have an adverse impact on small businesses.

Small businesses: alternative method that minimizes adverse impact. The proposed regulations are not anticipated to have an adverse impact on small businesses.

Agency's Response to the 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 Standards Established and Methods Used to Assure High Quality Care, Methods and Standards for Establishing Payment Rates for Long-Term Care: Additional NF Reimbursement for Treatment of Stage IV Pressure Ulcers (12 VAC 30-60-40, 12 VAC 30-60-350, and 12 VAC 30-90-41).

Summary:

The proposed amendments provide additional reimbursement of \$10 per day to nursing facilities (NF) for residents who require specialized treatment beds due to their having at least one treatable Stage IV pressure ulcer.

12 VAC 30-60-40. Utilization control: Nursing facilities.

A. Long-term care of residents in nursing facilities will be provided in accordance with federal law using practices and procedures that are based on the resident's medical and social needs and requirements. All nursing facility services, including specialized care, shall be provided in accordance

¹ Pressure ulcers are caused by unrelieved pressure on skin over bony prominences such as hips, sacrums, and heels and commonly referred to as "bed sores."

with guidelines found in the Virginia Medicaid Nursing Home Manual.

B. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

C. The Department of Medical Assistance Services shall periodically conduct a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided. The survey will be composed of a sample of Medicaid residents and will include review of both current and closed medical records.

D. Nursing facilities must submit to the Department of Medical Assistance Services resident assessment information at least every six months for utilization review. If an assessment completed by the nursing facility does not reflect accurately a resident's capability to perform activities of daily living and significant impairments in functional capacity, then reimbursement to nursing facilities may be adjusted during the next quarter's reimbursement review. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties.

E. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in 12 VAC 30-60-300 (Nursing facility criteria). *In order for the additional \$10 per day reimbursement to be made to the nursing facility for a recipient requiring a specialized treatment bed, the recipient must meet criteria as described in 12 VAC 30-60-350. Nursing facilities must obtain prior authorization for the reimbursement. DMAS shall provide the additional \$10 per day reimbursement for recipients meeting criteria for no more than 246 days annually. Nursing facilities may receive the reimbursement for up to 82 days per new occurrence of a Stage IV ulcer. There must be at least 30 days between each reimbursement period. Limits are per recipient, regardless of the number of providers rendering services. Nursing facilities are not eligible to receive this reimbursement for recipients enrolled in the specialized care program.*

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in 12 VAC 30-60-320 (Adult ventilation/tracheostomy specialized care criteria) or 12 VAC 30-60-340 (Pediatric and adolescent specialized care criteria). Reimbursement for specialized care must be preauthorized by the Department of Medical Assistance Services. In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis. Further specialized care services requirements are set forth below.

In each case for which payment for nursing facility services is made under the State Plan, a physician must recommend at

the time of admission, or if later, the time at which the individual applies for medical assistance under the State Plan, that the individual requires nursing facility care.

F. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

G. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged.

H. Specialized care services.

1. Providers must be nursing facilities certified by the Division of Licensure and Certification, State Department of Health, and must have a current signed participation agreement with the Department of Medical Assistance Services to provide nursing facility care. Providers must agree to provide care to at least four residents who meet the specialized care criteria for children/adolescents or adults.

2. Providers must be able to provide the following specialized services to Medicaid specialized care recipients:

a. Physician visits at least once weekly (after initial physician visit, subsequent visits may alternate between physician and physician assistant or nurse practitioner);

b. Skilled nursing services by a registered nurse available 24 hours a day;

c. Coordinated multidisciplinary team approach to meet the needs of the resident;

d. Infection control;

e. For residents under age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of 90 minutes each day, five days per week;

f. Ancillary services related to a plan of care;

g. Respiratory therapy services by a board-certified therapist (for ventilator patients, these services must be available 24 hours per day);

h. Psychology services by a licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric related to a plan of care;

i. Necessary durable medical equipment and supplies as required by the plan of care;

j. Nutritional elements as required;

k. A plan to assure that specialized care residents have the same opportunity to participate in integrated nursing facility activities as other residents;

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- I. Nonemergency transportation;
- m. Discharge planning; and
- n. Family or caregiver training.

3. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medicaid specialized care recipients who are under the age of 21.

12 VAC 30-60-350. Criteria for coverage of specialized treatment beds.

A. DMAS will pay \$10 per day toward the cost of specialized treatment beds for eligible NF recipients who have at least one treatable Stage IV pressure ulcer. Specialized treatment bed means either an air-fluidized bed or a low-air-loss bed. To be approved for this service, the following criteria must be met:

1. The individual must have at least one Stage IV pressure ulcer as documented on the MDS.
2. The individual must require the use of a specialized treatment bed as ordered by a physician for the treatment of at least one Stage IV pressure ulcer.
3. The nursing facility must obtain authorization by submitting the authorization request to DMAS or the preauthorization agent.

B. Nursing facilities shall not be eligible to receive this additional payment for residents who are enrolled in the specialized care program.

C. Limits. DMAS shall provide the additional \$10 per day reimbursement for recipients meeting criteria for no more than 246 days annually. Nursing facilities may receive the reimbursement for up to 82 days per new occurrence of a Stage IV ulcer. There must be at least 30 days between each reimbursement period. Limits are per recipient, regardless of the number of providers rendering services.

12 VAC 30-90-41. Nursing facility reimbursement formula.

A. Effective on and after July 1, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group-III (RUG-III) System as defined in Appendix IV (12 VAC 30-90-305 through 12 VAC 30-90-307)." RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG-III groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 12 VAC 30-90-305 through 12 VAC 30-90-307 for details on the Resource Utilization Groups.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.
2. Direct and indirect group ceilings and rates.
 - a. In accordance with 12 VAC 30-90-20 C, direct patient care operating cost peer groups shall be established for

the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in 12 VAC 30-90-271.

- b. Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, for the rest of the state for facilities with less than 61 licensed beds, and for the rest of the state for facilities with more than 60 licensed beds.

3. Each facility's average case-mix index shall be calculated based upon data reported by that nursing facility to the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA) Minimum Data Set (MDS) System. See 12 VAC 30-90-306 for the case-mix index calculations.

4. The normalized facility average Medicaid CMI shall be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NFs subsequent fiscal year. See 12 VAC 30-90-306 D 2 for the calculation of the normalized facility average Medicaid CMI.

- a. A NFs direct patient care operating cost prospective ceiling shall be the product of the NFs peer group direct patient care ceiling and the NFs normalized facility average Medicaid CMI. A NFs direct patient care operating cost prospective ceiling will be calculated semiannually.

- b. A CMI rate adjustment for each semiannual period of a nursing facility's prospective fiscal year shall be applied by multiplying the nursing facility's normalized facility average Medicaid CMI applicable to each prospective semiannual period by the nursing facility's case-mix neutralized direct patient care operating cost base rate for the preceding cost reporting period (see 12 VAC 30-90-307).

- c. See 12 VAC 30-90-307 for the applicability of case-mix indices.

5. Effective for services on and after July 1, 2002, the following changes shall be made to the direct and indirect payment methods.

- a. The direct patient care operating ceiling shall be set at 112% of the respective peer group day-weighted median of the facilities' case-mix neutralized direct care operating costs per day. The calculation of the medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group direct patient care operating ceilings shall be revised and case-mix neutralized every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

- b. The indirect patient care operating ceiling shall be set at 103.9% of the respective peer group day-weighted median of the facility's specific indirect operating cost per day. The calculation of the peer group medians shall be based on cost reports from freestanding nursing homes

for provider fiscal years ending in the most recent base year. The medians used to set the peer group indirect operating ceilings shall be revised every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

6. Reimbursement for use of specialized treatment beds. Effective for services on and after July 1, 2005, nursing facilities shall be reimbursed an additional \$10 per day for those recipients who require a specialized treatment bed due to their having at least one Stage IV pressure ulcer. Recipients must meet criteria as outlined in 12 VAC 30-60-350, and the additional reimbursement must be preauthorized as provided in 12 VAC 30-60-40. Nursing facilities shall not be eligible to receive this reimbursement for individuals whose services are reimbursed under the specialized care methodology. Beginning July 1, 2005, this additional reimbursement shall be subject to adjustment for inflation in accordance with 12 VAC 30-90-41 B, except that the adjustment shall be made at the beginning of each state fiscal year, using the inflation factor that applies to provider years beginning at that time. This additional payment shall not be subject to direct or indirect ceilings and shall not be adjusted at year-end settlement.

EDITOR'S NOTE: Subsection B through J are not being amended in this regulatory action; therefore, the text of these subsections is not set out here.

VA.R. Doc. No. R05-198; Filed December 7, 2005, 10:01 a.m.

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Titles of Regulations: 12 VAC 30-70. **Methods and Standards for Establishing Payment Rates; Inpatient Hospital Care (amending 12 VAC 30-70-425; repealing 12 VAC 30-70-426).**

12 VAC 30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12 VAC 30-80-20 and 12 VAC 30-80-30).

12 VAC 30-90. Methods and Standards for Establishing Payment Rates for Long-Term Care (amending 12 VAC 30-90-19).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public Comment Period: N/A -- Public comments may be submitted until February 24, 2006.

(See Calendar of Events section for additional information)

Agency Contact: William Lessard, Project Manager, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 225-4593, FAX (804) 786-1680, or e-mail william.lessard@dmas.virginia.gov.

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia authorizes the

Director of DMAS to administer and amend the Plan for Medical Assistance according to the board's requirements. The Medicaid authority as established by § 1902 (a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

Item 326 O of the 2005 Appropriation Act provides that DMAS shall modify state regulations and the State Plan for Medical Assistance Services as they relate to supplemental payments to nonstate public nursing homes, hospitals and clinics, and state hospitals and clinics as necessary to comply with changes negotiated with the Centers for Medicare and Medicaid Services. The state budget also provides for the authority to enact emergency regulations.

The Department of Medical Assistance Services (DMAS) was directed by the federal Medicaid authority, the Centers for Medicaid and Medicare Services (CMS), to modify or eliminate the use of intergovernmental transfers (IGTs) to finance supplemental payments by the end of SFY2005. In return, CMS agreed to provide federal matching funds for existing supplemental payments financed by IGTs through the end of SFY2005. To comply with its agreement with CMS, DMAS has decided to repeal certain supplemental payments and to modify others.

Purpose: The purpose of this action is to comply with recent CMS restrictions on the financing of supplemental payments for services provided by nonstate public hospitals, nursing homes and clinics, and state hospitals and clinics. In past years, DMAS has successfully generated additional federal reimbursement by making supplemental payments financed by intergovernmental transfers (IGTs). Beginning in January 2004, CMS began to defer federal matching funds for these payments. As a result of negotiations with CMS, CMS agreed to provide federal matching funds for all existing supplemental payments financed by IGTs through the end of FY2005 if DMAS agreed to sunset the use of IGTs to finance these supplemental payments after that date. To comply with this arrangement, DMAS implemented an emergency regulation effective July 1, 2005, to modify supplemental payments for inpatient services provided by nonstate public hospitals and nursing homes and outpatient services provided by nonstate public clinics, and to repeal all other supplemental payments. This proposed regulation would make the emergency regulation permanent.

Substance: The proposed regulations discontinue supplemental payments made to state hospitals for inpatient and outpatient services, state clinics and nonstate public hospitals for outpatient services; modify the payments made to nonstate public hospitals for inpatient services, nonstate public clinics for outpatient services, and nonstate public nursing homes.

Issues: DMAS used supplemental payments financed by IGTs to generate additional federal funds (approximately \$10 million in FY05) without spending additional state general funds. For the most part, the public providers/local governments did not keep the supplemental payments except for a small participation incentive for their cooperation. Since CMS has indicated to all states that it will no longer pay federal matching funds on these transaction, DMAS needed to make

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changes to the supplemental payment regulations. The loss of revenue to the Commonwealth and to a smaller extent to local governments is unavoidable. DMAS was able to revise either the payment or the financing for some of the supplemental payments such that the Commonwealth will continue to generate approximately \$2 million annually in net revenue.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H 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 impacts.

Summary of the proposed regulation. Pursuant to a policy change by the Centers for Medicaid and Medicare Services, the proposed regulations discontinue supplemental payments made to state hospitals for inpatient and outpatient services, state clinics and nonstate public hospitals for outpatient services; modify the payments made to nonstate public hospitals for inpatient services, nonstate public clinics for outpatient services, and nonstate public nursing homes. The proposed changes have been effective since July 2005 under the emergency regulations.

Estimated economic impact. Prior to July 2005, Medicaid reimbursements rates for public providers were up to the maximum allowed under federal law and regulations. Local and state government entities financed the supplemental payments through intergovernmental transfers and the Commonwealth claimed additional federal matching funds to supplement the Medicaid operating budget. However, the Centers for Medicaid and Medicare Services has recently imposed restrictions and indicated to all states that it will no longer pay federal matching funds on these types of supplemental financing transactions.

In order to comply with the new federal policy, the Department of Medical Assistance Services implemented emergency regulations on July 1, 2005, to discontinue supplemental payments made to state hospitals for inpatient and outpatient services, state clinics and nonstate public hospitals for outpatient services and agreed to modify the payments made to nonstate public hospitals for inpatient services, nonstate public clinics for outpatient services, and nonstate public nursing homes.

As a result of the proposed changes, the Commonwealth will lose approximately \$8 million in net revenues from the federal government. The loss of federal matching funds represents a net economic loss to the Commonwealth as it reduces injections to the state economy. The size of the net economic loss to the state will likely be greater than the original \$8

million when this loss ripples through Virginia's economy. It is well known that a dollar taken out of an economy reduces the economic activity more than the original amount over several years. The exact economic impact and the entities affected, however, will depend on precisely how the Commonwealth responds to this loss of revenue. For example, expenditures may be reduced in Medicaid operating budget or elsewhere or funds may be maintained by using existing or new sources. This information is not available at this time.

Also, public Medicaid providers were receiving a small participation incentive prior to this change. Of the \$8 million, approximately \$420,000 will be lost by public providers in terms of incentive payments received from the state. Similarly, the net economic effect on the public providers will depend on whether or not and how the revenue loss is made up.

Businesses and entities affected. The proposed changes affect six nonstate public nursing homes, two nonstate public hospitals, two state hospitals, 130 state clinics, and 40 community services boards.

Localities particularly affected. The proposed changes apply throughout the Commonwealth.

Projected impact on employment. As a net reduction in Virginia's economic activity results, a net reduction in demand for labor in the Commonwealth should be expected.

Effects on the use and value of private property. The proposed changes apply to public providers. Thus, no direct effect on the use and value of private property is expected.

Small businesses: costs and other effects. The proposed regulations do not apply to private businesses.

Small businesses: alternative method that minimizes adverse impact. The proposed regulations do not apply to private businesses.

Agency's Response to the 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 Services, Other Types of Care, and Long-Term Care: Modifications to Supplemental Payment Methods for Medicaid Public Providers (12 VAC 30-70-425 and 12 VAC 30-70-426, 12 VAC 30-80-20 and 12 VAC 30-80-30, and 12 VAC 30-90-19).

Summary:

The proposed regulations discontinue supplemental payments made to state hospitals for inpatient and outpatient services, state clinics and nonstate public hospitals for outpatient services; modify the payments made to nonstate public hospitals for inpatient services, nonstate public clinics for outpatient services, and nonstate public nursing homes. The proposed changes have been effective since July 2005 under the emergency regulations.

12 VAC 30-70-425. Supplemental payments to Certified public expenditures for nonstate government-owned hospitals for inpatient services.

A. ~~DMAS shall provide lump sum supplemental payments to participating nonstate government-owned hospitals for furnished inpatient services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to all nonstate government-owned hospitals for services to Medicaid patients and the maximum amount allowable under applicable federal regulations in accordance with 42 CFR 447.272. A participating hospital is one with respect to which a transfer agreement has been made and implemented. In addition to payments made elsewhere, effective July 1, 2005, DMAS shall draw down federal funds to cover unreimbursed Medicaid costs for inpatient services provided by nonstate government-owned hospitals as certified by the provider through cost reports.~~

B. ~~A nonstate government-owned hospital is owned or operated by a unit of government other than a state. The payment amount for a participating hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's Medicaid days provided during the most recent fiscal year by the total Medicaid days provided by all participating nonstate government-owned hospitals for the same fiscal year.~~

C. ~~A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified in 42 CFR 447.271 or the limit specified in 42 USC § 1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other participating hospitals in the same manner and subject to the same limitations as set forth above.~~

D. ~~For the period from December 16, 2001, through May 13, 2002, aggregate payments to nonstate government-owned hospitals shall not exceed 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. For the period beginning May 14, 2002, aggregate payments to these hospitals shall not exceed 100% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles.~~

E. ~~To determine the reasonable estimate of the amount that would be payable under Medicare payment principles, a hospital-specific per diem will be determined by dividing all inpatient hospital costs for acute, psychiatric and rehabilitation services by the total number of patient days. The hospital-specific per diem will be multiplied by the hospital's Medicaid bed days. The reasonable estimate will be the sum of the calculations for all hospitals. The calculation will use data from the last settled cost report for all nonstate government-owned hospitals at the beginning of the state fiscal year for which calculations are made. However, for state fiscal year 2002, only data from the last settled cost report at the beginning of state fiscal year 2003 will be used. Charges and Medicaid payments will be trended forward using~~

~~the Virginia-specific DRI hospital inflation factors. Medicare payments will be trended forward using CMS Medicare inflators. Additional adjustments will be made for any statutory changes in Medicare or Medicaid payments. The most recently available Medicaid DSH data will be used.~~

12 VAC 30-70-426. Supplemental payments to state government-owned hospitals for inpatient services. (Repealed.)

A. ~~In addition to payments for inpatient hospital services provided for elsewhere in this State Plan, DMAS makes supplemental payments to state government-owned or operated hospitals for services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment, the hospital must be part of a state academic health system or part of an academic health system that operates under a state authority.~~

B. ~~The amount of the supplemental payment made to each qualifying state government-owned or operated hospital is determined by:~~

~~1. Calculating for each hospital the annual difference between the upper payment limit attributed to each qualifying hospital calculated according to subsection D of this section and the amount otherwise actually paid for the services by the Medicaid program;~~

~~2. Dividing the difference determined in subdivision 1 of this subsection for each qualifying hospital by the aggregate difference for all such qualifying hospitals; and~~

~~3. Multiplying the proportion determined in subdivision 2 of this subsection by the aggregate upper payment limit amount for all such hospitals as determined in accordance with 42 CFR 447.272 less all payments made to such hospitals other than under this section.~~

C. ~~Payments under this section may be made in one or more installments at such time, within the fiscal year or thereafter, as is determined by DMAS.~~

D. ~~To determine the aggregate upper payment limit amount as referred to in subdivision B 3 of this section, the following methodology will be used. For cost-reimbursed hospitals, the upper payment limit is costs. By definition, cost-reimbursed hospitals have no net impact on the upper payment limit and will be excluded from the calculation. For Medicaid DRG-reimbursed hospitals, a ratio will be calculated for each hospital by dividing its Medicare payments by Medicare charges. This Medicare payment-to-charge ratio will be multiplied by Medicaid charges for each DRG-reimbursed hospital. The upper payment limit will be the sum of the product of that multiplication for all DRG-reimbursed hospitals. The calculation will use data from the last settled cost report for all state government-owned hospitals at the beginning of the state fiscal year for which calculations are made. Charges will be trended forward using hospital-specific data if available. If not available, charges will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any program changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.~~

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12 VAC 30-80-20. Services that are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision D 2 d. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform 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), and a statement of changes in financial position;
4. Schedules that reconcile financial statements and trial balance to expenses claimed in the cost report;
5. Depreciation schedule or summary;
6. Home office cost report, if applicable; and
7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

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

D. The services that are cost reimbursed are:

1. Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals.
2. Outpatient hospital services excluding laboratory.
 - a. Definitions. The following words and terms when used in this regulation shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

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

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

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

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

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

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services, including those obstetric and pediatric procedures contained in 12 VAC 30-80-160, rendered in emergency departments that DMAS determines were nonemergency care.

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

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

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

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

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

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

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

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

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

c. Limitation to 80% of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at 80% of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, 2003, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date. Operating costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Capital costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Operating and capital costs of Type One hospitals shall continue to be reimbursed at 94.2% and 90% of cost respectively.

d. Outpatient reimbursement methodology prior to July 1, 2003. DMAS shall continue to reimburse for outpatient hospital services, with the exception of direct graduate medical education for interns and residents, at 100% of reasonable costs less a 10% reduction for allowable capital costs and a 5.8% reduction for allowable operating costs. This methodology shall continue to be in effect after July 1, 2003, for Type One hospitals.

e. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12 VAC 30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

3. Rehabilitation agencies operated by community services boards. For reimbursement methodology applicable to other rehabilitation agencies, see 12 VAC 30-80-200. 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.

4. Comprehensive outpatient rehabilitation facilities.

5. Rehabilitation hospital outpatient services.

~~6. Supplemental payments to nonstate government-owned hospitals for outpatient services.~~

~~a. The department provides lump sum supplemental payments to participating nonstate government-owned hospitals for furnished outpatient services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to all nonstate government-owned hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321. A participating hospital is one with respect to which a transfer agreement has been made and implemented.~~

~~b. A nonstate government-owned hospital is owned or operated by a unit of government other than a state. The payment amount for a participating hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all participating nonstate government-owned hospitals for the same fiscal year.~~

~~c. A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified in 42 USC § 1396r 4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other participating hospitals in the same manner and subject to the same limitations as set forth above.~~

~~d. For the period from December 16, 2001, through May 13, 2002, aggregate payments to nonstate government-owned hospitals shall not exceed 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. For the period beginning May 14, 2002, aggregate payments to these hospitals shall not exceed 100% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles.~~

~~e. To determine the reasonable estimate of the amount that would be paid under Medicare payment principles, each hospital's outpatient cost to charge ratio will be calculated and applied to its Medicaid outpatient charges. The reasonable estimate will be the sum of the calculations for all hospitals. The calculation will use data from the last settled cost report for all nonstate government-owned hospitals at the beginning of the state fiscal year for which calculations are made. However, for~~

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~~state fiscal year 2002, only data from the last settled cost report at the beginning of state fiscal year 2003 will be used. Charges and Medicaid payments will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any statutory changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.~~

~~7. Supplemental payments to state government-owned hospitals for outpatient services.~~

~~a. In addition to payments for services set forth elsewhere in this State Plan, DMAS provides supplemental payments to qualifying state government-owned or operated hospitals for outpatient services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment, the hospital must be part of a state academic health system or part of an academic health system that operates under a state authority.~~

~~b. The amount of the supplemental payment made to each qualifying hospital is determined by:~~

~~(1) Calculating for each hospital the annual difference between the upper payment limit attributed to each qualifying hospital calculated according to this subdivision 7d and the amount otherwise actually paid for the services by the Medicaid program;~~

~~(2) Dividing the difference determined in subdivision 7 b (1) for each qualifying hospital by the aggregate difference for all such qualifying hospitals; and~~

~~(3) Multiplying the proportion determined in subdivision 7 b (2) by the aggregate upper payment limit amount for all state owned or operated hospitals as determined in accordance with 42 CFR 447.321 less all payments made to such hospitals other than under this section.~~

~~(4) A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified at 42 USC § 1396r 4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other qualifying hospitals in the same manner and subject to the same limitations as set forth above.~~

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

~~d. To determine the aggregate upper payment limit amount referred to in subdivision 7 b (3), the following methodology will be used. A ratio will be calculated for each hospital by dividing its Medicare payments by Medicare charges. This Medicare payment to charge ratio will be multiplied by the Medicaid charges for each hospital. The upper payment limit will be the sum of the product of that multiplication for all hospitals. The calculation will use data from the most recently settled cost report for all state government-owned hospitals at the beginning of the state fiscal year for which calculations are made. Charges will be trended forward~~

~~using hospital-specific data if available. If not available, charges will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any program changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.~~

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

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12 VAC 30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services (12 VAC 30-80-160 has obstetric/pediatric fees). Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public), except that reimbursement rates for designated physician services when performed in hospital outpatient settings shall be 50% of the reimbursement rate established for those services when performed in a physician's office. The following limitations shall apply to emergency physician services.

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

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

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

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

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

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

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in 12 VAC 30-80-160, rendered in emergency departments that DMAS determines are nonemergency care.

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

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

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

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

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

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

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

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

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

2. Dentists' services.

3. Mental health services including: (i) community mental health services; (ii) services of a licensed clinical psychologist; or (iii) mental health services provided by a physician.

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

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

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME).

a. The rate paid for all items of durable medical equipment except nutritional supplements shall be the lower of the state agency fee schedule that existed prior to July 1, 1996, less 4.5%, or the actual charge.

b. The rate paid for nutritional supplements shall be the lower of the state agency fee schedule or the actual charge.

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

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12 VAC 30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

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

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in

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units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services, including services paid to local school districts.
8. Laboratory services (other than inpatient hospital).
9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).
10. X-Ray services.
11. Optometry services.
12. Medical supplies and equipment.
13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12 VAC 30-80-180.
14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.
15. Clinic services, as defined under 42 CFR 440.90.
16. Supplemental payments to state government-owned or operated clinics.

a. ~~In addition to payments for clinic services specified elsewhere in this state plan, DMAS provides supplemental payments for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Supplemental payments will be made to Children's Specialty Services, a state government-owned and operated clinic.~~

b. ~~The amount of the supplemental payment made to Children's Specialty Services is determined by calculating for all state government-owned or operated clinics the annual difference between the aggregate upper payment limit specified in 42 CFR 447.321 and determined according to the method described in subdivision 16 d and the amount otherwise actually paid for the services by the Medicaid program.~~

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

d. ~~To determine the aggregate upper payment limit, Medicaid payments to state government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12 VAC 30-80-190 B) in regard to the~~

~~state agency fee schedule for Resource Based Relative Value Scale (RBRVS). Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.~~

17. Supplemental payments for services provided by Type I physicians.
18. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. *Effective July 1, 2005, a qualifying clinic is a clinic with estimated Medicaid payments in 2003 (including primary payments and copayments) of more than \$100,000 other than under this section and that serve areas covered by managed care prior to January 1, 1998 operated by a community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.*

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

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 18 d and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 18 b (1) for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision (2) of this subdivision 18 b by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

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

d. To determine the aggregate upper payment limit referred to in subdivision 18 b (3), Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12 VAC 30-80-190 B) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year

adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

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

12 VAC 30-90-19. Additional reimbursement Certified public expenditures for locally-owned nursing facilities.

~~A. Subject to legislative authorization as required and the availability of local, state, and federal funds, and based upon a transfer agreement and the subsequent transfer of funds, DMAS makes additional payments to local government nursing facilities. A local government nursing facility is defined as a provider owned or operated by a county, city, or other local government agency, instrumentality, authority or commission. In addition to payments made elsewhere, effective July 1, 2005, DMAS shall draw down federal funds to cover unreimbursed Medicaid costs for inpatient services provided by nonstate government-owned nursing homes as certified by the provider through cost reports. A local government nursing facility is defined as a provider owned or operated by a county, city, or other local government agency, instrumentality, authority or commission.~~

~~B. DMAS uses the following methodology to calculate the additional Medicaid payments to local government nursing facilities:~~

- ~~1. For each state fiscal year, DMAS calculates the maximum additional payments that it can make to the local government nursing facilities in conformance with 42 CFR 447.272 (a).~~
- ~~2. DMAS determines a total additional payment amount to be made in a manner not to exceed the maximum additional payment amount calculated in subdivision 1 of this subsection.~~
- ~~3. Using the latest fiscal period for which the local government nursing facilities have completed cost reports on file with DMAS, the department determines the total Medicaid days reported by each local government nursing facility for that fiscal period.~~
- ~~4. DMAS divides the total Medicaid days for each local government nursing facility by the total Medicaid days for all local government nursing facilities to determine the supplementation factor for each.~~
- ~~5. For each local government nursing facility, the department multiplies the local government nursing facility's supplementation factor determined in subdivision 4 of this subsection by the total additional payment amount identified in subdivision 2 of this subsection to determine the additional payment to be made to each local government nursing facility.~~

VA.R. Doc. No. R05-249; Filed December 7, 2005, 10 a.m.

TITLE 16. LABOR AND EMPLOYMENT

SAFETY AND HEALTH CODES BOARD

Title of Regulation: **16 VAC 25-55. Financial Responsibility of Boiler and Pressure Vessel Contract Fee Inspectors (adding 16 VAC 25-55-10 and 16 VAC 25-55-20).**

Statutory Authority: § 40.1-51.9:2 of the Code of Virginia.

Public Hearing Date: N/A -- Public comments may be submitted until February 25, 2006.

(See Calendar of Events section for additional information)

Agency Contact: Fred P. Barton, Director, Boiler Safety Compliance, Department of Labor and Industry, Powers Taylor Building, 13 South Thirteenth Street, Richmond, VA 23219, telephone (804) 786-3169, FAX (804) 371-2324, or e-mail fred.barton@doli.virginia.gov.

Basis: The Safety and Health Codes Board is authorized by § 40.1-51.9:2 C of the Code of Virginia to "...promulgate regulations requiring contract fee inspectors, as a condition of their doing business in the Commonwealth, to demonstrate financial responsibility sufficient to comply with the requirements of this chapter. Regulations governing the amount of any financial responsibility required by the contract fee inspector shall take into consideration the type, capacity and number of boilers or pressure vessels inspected or certified."

Purpose: The purpose of the proposed regulation is to set minimum aggregate limits for coverage or other means provided for in the Code of Virginia and approved by the board to ensure the financial responsibility of boiler and pressure vessel contract fee inspectors operating in the Commonwealth. The intent of this financial responsibility is to assure additional protection to the public, including compensation to third parties, in cases where there is bodily injury and property damage resulting from, or directly relating to, a contract fee inspector's negligent inspection or recommendation for certification of a boiler or pressure vessel.

Substance: This regulation provides financial requirements for certified contract fee inspectors that include documentation of financial responsibility; failure of the contract fee inspector to provide such documentation; approval of required documentation by the Chief Inspector; notification of Chief Inspector by contract fee inspector before the effective date of a change, expiration, or cancellation of any instrument of insurance, guaranty or surety or self-insurance. Provisions are also included concerning the expiration of acceptance of proof of financial responsibility and for application for renewal of acceptance of proof of financial responsibility.

Issues: Employers, employees and the general public would be compensated up to the level of the required financial responsibility in cases of bodily injury and property damage resulting from or directly related to a contract fee inspector's

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negligent inspection or recommendation for certification of a boiler or pressure vessel. It is anticipated that any additional costs to the contract fee inspector as a result of the requirements of this proposed regulation would be passed on to the boiler or pressure vessel owner who is the end user of the service. The benefit of these changes will be to insure a minimum level of indemnification in cases involving bodily injury and property damage resulting from, or directly relating to, a contract fee inspector's negligent inspection or recommendation for certification of a boiler or pressure vessel.

Under this regulation, contract fee inspectors would be required to indemnify boiler and pressure vessel owners for any bodily injury and property damage resulting from or directly related to an inspector's negligent inspection or recommendation for certification of a boiler or pressure vessel. Contract fee inspectors would be required to provide documentation of their means of indemnification at the time of their certification or before performing inspections and at renewal of the instrument of insurance, guaranty, surety or self-insurance. No significant impact on the department is anticipated beyond the cost to promulgate the regulation.

There are no disadvantages to the public or to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H 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 impacts.

Summary of the proposed regulation. The Safety and Health Codes Board (board) proposes that contract fee inspectors be required to indemnify boiler and pressure vessel owners against losses resulting from negligent inspection or recommendation for certification.

Estimated economic impact. The General Assembly has mandated that contract fee inspectors:

"...maintain evidence of their financial responsibility, including compensation to third parties, for bodily injury and property damage resulting from, or directly related to, an inspector's negligent inspection of or recommendation for certification of a boiler or pressure vessel."

In order to implement the General Assembly's mandate, the board has been authorized to promulgate appropriate regulation. The regulation that the board proposes enumerates acceptable methods of ensuring fee inspector financial responsibility, sets time frames during which inspectors must provide proof of guaranty and sets minimum

aggregate financial responsibility limits that vary in steps with the market share held by an inspector or inspection company.

Per legislative mandate, the proposed regulation allows contract fee inspectors leeway to choose an acceptable instrument of financial responsibility that best suits their needs. Contract fee inspectors may choose to obtain specific liability or errors and omissions insurance, a surety bond, bank guaranty or may choose to self insure by holding assets in an amount equal to their mandated minimum financial responsibility limit. They may also choose to meet their total responsibility limits by holding several instruments that together meet that limit. For instance, a contract fee inspector may partially self insure and cover the rest of his responsibility limit by purchasing a surety bond. Given that the number of contract fee inspectors is so small and that there is not a well developed market for insurance instruments to cover them in the case of negligent inspection, the proposed regulation will allow contract fee inspectors to minimize the cost of ensuring financial responsibility by choosing among these competing instruments.

Current contract fee inspectors will be required to provide proof that they have indemnified boiler and pressure vessel owners against losses caused by negligent inspection and certification within 90 days of the promulgation of the proposed regulation. New contract fee inspectors will be required to provide proof of indemnification within 30 days of certification and before performing inspections. All contract fee inspectors will be required to provide proof of indemnification when their indemnification instrument is renewed or when they change their method of indemnification.

The proposed regulation defines market share as the percentage of total revenue for inspection of boiler and pressure vessels that is generated by an inspector or agency and mandates minimum guaranty limits that vary in steps with an inspector's or agency's market share. The proposed steps would require that contract fee inspectors or agencies that have a market share of less than 1.0% hold at least \$500,000 in some instrument of financial responsibility. Inspectors or agencies that have a market share of between 1.0% and 10% would be required to hold a minimum of \$1,000,000 and those who have a market share of greater than 10% would be required to hold a minimum of \$2,000,000 in some instrument of financial responsibility. There are seven companies that perform boiler and pressure vessel inspections in the Commonwealth. The vast majority of these inspections are performed by one company, American Boiler Inspection Services, Inc. The Department of Labor and Industry (DOLI) estimates that the cost of meeting the requirements of the proposed regulation with errors and omissions insurance will range between \$2,500 and \$10,000.

Market share percentages for the current year are set using revenue figures from the previous calendar year and so will only be accurate if the boiler inspection market is fairly static from year to year. If the current total market for boiler and pressure vessel inspection grows (or shrinks) and that growth (decline) is unevenly distributed or if individual inspectors or agencies are currently doing considerably more (or considerably less) business in the same sized market then they did during the previous year, then the proposed minimum

financial responsibility limits that inspectors and agencies will be required to maintain will not reflect current market conditions. In this case, individual inspectors may be required to hold instruments of financial responsibility that are smaller (or larger) than the proposed regulation intends. This would be particularly problematic for companies that are currently losing business, and revenue, but would still have to maintain larger and more costly guaranties. This market and its players are fairly static right now but this may not always be the case.

Boiler and pressure vessel owners benefit from the proposed regulation in that they will now be required to be indemnified against losses stemming from the negligent behavior of third party contract fee inspectors.

Businesses and entities affected. The proposed regulation will affect all fee inspectors and fee inspector companies currently operating in the Commonwealth. Individuals who wish to be fee inspectors but are not currently licensed would also be affected. There are currently 14 fee inspectors licensed by the Commonwealth.

Localities particularly affected. The proposed regulation will affect all localities in the Commonwealth.

Projected impact on employment. The proposed regulation may have the effect of suppressing supply-side entry into the fee inspection market since the cost associated with mandatory insurance limits may serve as a barrier to entry. Since all existing fee inspection companies maintain insurance levels at least as high as those required by the proposed regulation, there is likely to be no impact on employment in the insurance industry.

Effects on the use and value of private property. The market for fee inspection errors and omissions insurance is not well developed or large. If the few insurance companies that currently write this type of policy decide to stop, fee inspection companies may have no choice but to shut down operations. None of the fee inspection companies contacted by DPB have assets valuable enough to allow them to self insure for the limits mandated by the proposed regulation. However, since all existing fee inspection companies maintain insurance levels at least as high as those required by the proposed regulation, there is likely to be no immediate impact on the use or value of the property of fee inspectors or fee inspection companies.

Small businesses: reporting, recordkeeping, and administrative costs. The proposed regulation requires contract fee inspectors to provide proof of indemnification at least annually. Contract fee inspectors will have to spend a small amount of their time copying and mailing their certificate of insurance or proof of other indemnification and will have to pay the associated copy and postage fees.

Small businesses: alternative method that minimizes adverse impact. The proposed regulation effectively minimizes the adverse impact on the regulated community given the constraints mandated by the Legislature.

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

Summary:

This proposed regulation requires contract fee inspectors operating in the Commonwealth to demonstrate financial responsibility for bodily injury and property damage resulting from, or directly relating to, an inspector's negligent inspection or recommendation for certification of a boiler or pressure vessel. Financial responsibility in the form of insurance, guaranty, surety, or self-insurance will be required as follows:

Aggregate limits of \$500,000 for any contract fee inspector with less than 1.0% market share; \$1 million for those with 1.0% up to and including 10% market share; and \$2 million for those with more than 10% market share or any contract fee inspector that employs or has an arrangement with other contract fee inspectors.

This regulation includes definitions of "market share" and "contract fee inspection agency." The regulation also clarifies the coverage when a contract fee inspector is working for a contract fee inspection company, as well as to how the aggregate limits apply to contract fee inspection companies.

CHAPTER 55. FINANCIAL REQUIREMENTS FOR BOILER AND PRESSURE VESSEL CONTRACT FEE INSPECTORS.

16 VAC 25-55-10. Definitions.

The following words and terms, "board," "boiler," "Chief Inspector" and "pressure vessel," when used in this chapter, shall have the same meanings as defined in 16 VAC-25-50-10 unless the context clearly indicates otherwise.

"Contract fee inspector" means any certified boiler inspector contracted to inspect boilers or pressure vessels on an independent basis by the owner or operator of the boiler or pressure vessel.

"Contract fee inspection agency" means a company that directly employs contract fee inspectors or has contractual arrangements with other contract fee inspectors for the purpose of providing boiler and pressure vessel inspections to the general public.

"Market share" means a fraction, (i) the numerator of which is the total fees charged by the inspector or agency under 16 VAC 25-50-150 for conducting power boiler and high temperature water boiler, heating boiler, and pressure vessel inspections in the most recent calendar year and (ii) the denominator of which is the total fees charged by all inspectors and agencies under 16 VAC 25-50-150 for conducting power boiler and high temperature water boiler, heating boiler, and pressure vessel inspections in the most recent calendar year.

16 VAC 25-55-20. Financial requirements.

A. Current certified contract fee inspectors shall provide documentation of financial responsibility to the Chief Inspector for approval [within 90 days of the effective date of this regulation] in such form as required by the Chief Inspector.

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Contract fee inspectors initially certified following [the effective date of this regulation] shall provide such documentation to the Chief Inspector within 30 days following the issuance of the certification of the contract fee inspector. The Chief Inspector may revoke a contract fee inspector's inspector identification card as described in 16 VAC 25-50-70 for failure to provide documentation of financial responsibility within the required timeframe.

B. Financial responsibility of a contract fee inspector shall be demonstrated by maintenance of an instrument of insurance, guaranty, surety or by self-insurance, individually or in any combination thereof, for the purpose of compensation to third parties, for bodily injury and property damage resulting from, or directly relating to, an inspector's negligent inspection or recommendation for certification of a boiler or pressure vessel as follows:

1. An aggregate limit of \$500,000 or more for any contract fee inspector or contract fee inspection agency with less than 1.0% market share;
2. An aggregate limit of \$1 million or more for any contract fee inspector or contract fee inspection agency from 1.0% up to and including 10% market share; and
3. An aggregate limit of \$2 million or more for any contract fee inspector or contract fee inspection agency with more than 10% market share.

Contract fee inspectors may be covered under an instrument or instruments of insurance, guaranty, surety or the self-insurance of their employer or a company on behalf of which they have a contractual arrangement to provide boiler and pressure vessel inspections. To be acceptable as proof of financial responsibility for inspections not conducted for the benefit of their employer or company with which the inspector has a contractual arrangement, such instrument, instruments or self-insurance must also cover the contract fee inspector for such inspections. Where contract fee inspectors are not covered for inspections conducted on their own behalf under the instrument of insurance, guaranty, surety or self-insurance of their employer or company with which they have a contractual arrangement, they must provide a separate instrument that covers such inspections.

Contract fee inspectors who elect to self-insure for the full amount of their financial responsibility under this regulation shall maintain assets of an amount sufficient to cover the full minimum liability amount in regulation for his level of market share and shall provide audited financial statements showing total assets and liabilities.

Contract fee inspectors who elect to partially self-insure shall maintain assets in an amount sufficient to cover the stated partial liability amount and shall provide audited financial statements showing their total assets and liabilities. Such assets shall be held in combination with an instrument or instruments of insurance, guaranty, or surety to provide a total amount sufficient to cover the minimum liability amount in regulation for his level of market share. They shall provide copies of such documents to the Chief Inspector.

Aggregate limits approved at such time shall remain in effect until the occurrence of an event described in subsection E of this section.

C. Within 30 days of receipt of documentation of financial responsibility submitted by a contract fee inspector for the purpose of complying with these regulations, the Chief Inspector shall issue a determination to the contract fee inspector as to whether the documentation provided is acceptable. Documentation approval by the Chief Inspector is a requirement to operate as a contract fee inspector within the Commonwealth of Virginia.

D. A contract fee inspector shall notify the Chief Inspector at least 30 days before the effective date of any change in coverage, expiration, or cancellation of an instrument of insurance, guaranty, surety or self-insurance. In the case of self-insurance, the contract fee inspector shall notify the Chief Inspector immediately upon such time as he can no longer maintain self-insurance at the required limit and has not secured insurance, guaranty or a surety to cover his liability to the required limit.

E. Acceptance of proof of financial responsibility shall expire on the effective date of any change in the inspector's instrument of insurance, guaranty or surety, or the expiration date of the inspector's certification whichever is sooner. Application for renewal of acceptance of proof of financial responsibility shall be filed at least 30 days before.

VA.R. Doc. No. R04-68; Filed November 30, 2005, 2:13 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

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

Title of Regulation: 18 VAC 10-20. Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects Rules and Regulations (amending 18 VAC 10-20-420 and 18 VAC 10-20-450).

Statutory Authority: §§ 54.1-201, 54.1-404 and 54.1-411 of the Code of Virginia.

Public Hearing Date: March 16, 2006 - 9 a.m.

Public comments may be submitted until March 16, 2006.
(See Calendar of Events section for additional information)

Agency Contact: Mark N. Courtney, Executive Director, Board of Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 West Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475, or e-mail apelscidla@dpor.virginia.gov.

Basis: Section 54.1-201 of the Code of Virginia empowers the regulatory boards to promulgate regulations that are necessary to ensure continued competency, prevent deceptive or misleading practices by practitioners, and effectively administer the regulatory system administered by the regulatory board.

Section 54.1-404 of the Code of Virginia provides the board the authority to promulgate regulations governing its own organization, the professional qualifications of applicants, the requirements necessary for passing examinations in whole or in part, the proper conduct of its examinations, the implementation of exemptions from license requirements, and the proper discharge of its duties.

Section 54.1-411 of the Code of Virginia requires the board to adopt regulations governing the registration of persons, corporations, partnerships, limited liability companies, sole proprietors and other entities offering or rendering the practice of architecture, engineering, land surveying or offering the title of certified landscape architect or certified interior designer.

Purpose: The proposed change is being made to better protect the health, safety and welfare of the public by including an experience requirement for those landscape architect applicants who possess an LAAB-accredited degree in landscape architecture (they could still be approved to take, and sit for, the examination prior to obtaining the required three years of experience; however, certification would not be awarded until such time as the three years of acceptable experience is obtained, documented, submitted, reviewed and approved). Once a landscape architect is certified, he may hold himself out as, and practice as, a landscape architect/certified landscape architect (see § 54.1-409 of the Code of Virginia); therefore, the current requirement could allow those with an LAAB-accredited degree to become certified and provide services to the public without the benefit of any practical experience.

Of the 20 individuals who obtained certification via examination during the time period of January 1, 2003, through August 11, 2004, 17 possessed an LAAB-accredited degree in landscape architecture. Of the 17 with the LAAB-accredited degree, the amount of time that elapsed between their graduation from the LAAB-accredited degree program and the issue date of their certificate after successfully completing the examination ranged from 3 years, 3 months, to 16 years, 8 months, with an average amount of time being 6 years, 8 months. Therefore, the requirement for those landscape architect applicants who possess an LAAB-accredited degree in landscape architecture to have three years of acceptable experience in order to become certified is currently being met by Virginia candidates.

The need for codifying the requirement is that it would help these candidates in obtaining certification or licensure in other jurisdictions that have an experience requirement. Having Virginia's requirements comparable with other jurisdictions would allow Virginia certificate holders to obtain certification/licensure in other states without having to meet additional experience requirements. Of the 45 jurisdictions (other than Virginia) that currently regulate landscape architecture (of which 37 are practice acts and 8 are title acts),

for those persons holding a bachelors degree: 6 jurisdictions require no experience; 5 require 1 year of experience; 17 require 2 years of experience; 13 require 3 years of experience; and 4 require 4 years of experience. Instituting an experience requirement would bring Virginia's requirements in line with the majority of other jurisdictions that regulate landscape architecture.

Substance: The proposed action amends the entry requirements for those landscape architect applicants who possess an LAAB-accredited degree in landscape architecture to require them to obtain three years of acceptable experience (currently no experience is required for these applicants) before being granted certification (they could still be approved to take, and sit for, the examination prior to obtaining the required three years of experience; however, certification would not be awarded until such time as the three years of acceptable experience is obtained, documented, submitted, reviewed and approved).

Issues: The public will be better protected in that those individuals possessing an LAAB-accredited degree in landscape architecture will be required to have three years of acceptable experience before being granted certification. This will ensure that all landscape architect practitioners have at least some real world experience before being held out to the public as minimally competent by the board. There are no anticipated disadvantages as applicants are currently meeting this standard. Further, this change will make it easier for individuals initially certified in Virginia to become certified/licensed in other jurisdictions that have an experience requirement.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H 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 impacts.

Summary of the proposed regulation. The Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects (board) proposes to require that for future applicants with a degree in landscape architecture to become certified landscape architects, they must obtain at least 12 months of experience/training under the direct control and personal supervision of a licensed or certified landscape architect, and either another 24 months of experience/training under the direct control and personal supervision of a licensed or certified landscape architect, or 48 months of experience/training under the direct control and personal supervision of a licensed architect, professional engineer, or land surveyor.

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Estimated Economic Impact

Description of Landscape Architecture

According to the American Society of Landscape Architects¹, landscape architecture encompasses the analysis, planning, design, management, and stewardship of the natural and built environments. Types of projects include: residential, parks and recreation, monuments, urban design, streetscapes and public spaces, transportation corridors and facilities, gardens and arboreta, security design, hospitality and resorts, institutional, academic campuses, therapeutic gardens, historic preservation and restoration, reclamation, conservation, corporate and commercial, landscape art and earth sculpture, interior landscapes, and more.

Risks Associated with Landscape Architecture

In a report prepared for The American Society of Landscape Architects, Schatz (2003)² points out that "Landscape architects are responsible for decisions that affect the condition of vital infrastructure, rights-of-way, and significant private and public site development. When performed by negligent, incompetent, or unethical practitioners, landscape architecture has the potential to cause serious personal injuries. Poor landscape architecture practices can seriously impair the value and use of property." Schatz provides several examples of physical injury and property damage due to incompetent landscape architecture work, such as: a homeowner who was electrocuted while adjusting a landscape light, playground injuries, pedestrian injuries due to grading defects in streetscapes, and collapsing walls due to inadequate drainage, etc.

Board Proposal

In order to become a certified landscape architect under the current regulations, individuals must pay an application fee, pass an examination prepared by the Council of Landscape Architectural Registration Boards (CLARB) and either have graduated from an accredited landscape architecture program or have had eight years of combined applicable education and experience. For individuals who have graduated from an accredited landscape architecture program, the board proposes to require the following additional requirements: 1) at least 12 months of experience/training under the direct control and personal supervision of a licensed or certified landscape architect, and 2) either another 24 months of experience/training under the direct control and personal supervision of a licensed or certified landscape architect, or 48 months of experience/training under the direct control and personal supervision of a licensed architect, professional engineer, or land surveyor.

Costs and Benefits

The proposed new requirements are burdensome for individuals who have graduated from an accredited program and have passed the qualifying examination, but who would not have otherwise chosen to work for other certified

individuals for three years. Such persons may prefer to start their own business or work in other circumstances that could pay a higher salary or be located closer to their preferred location.

The benefits of the proposed new requirements are uncertain. While poorly done landscape architecture work can produce substantial risks to the public, it is not clear whether the board's proposed additional requirements will significantly reduce those risks. Earning a degree from an accredited institution and passing the qualifying examination both provide evidence of knowledge and skill associated with landscape architecture. A talented individual who has earned a landscape architecture degree and passed the CLARB exam may be better acquainted with the latest developments in the science of landscape architecture than a certified landscape architect who has not been closely following progress in relevant knowledge and procedures. Mandating that the aforementioned talented individual work for someone who may be less knowledgeable concerning important developments may provide little benefit.

Studies of other professions have cast doubt on whether those with greater experience and more time passed since the professional degree was earned are more competent than more recent graduates with less experience. For example, in a recent article in *Annals of Internal Medicine*, Choudry et al (2005)³ found that of 62 published studies that measured either physician knowledge or quality of care, and described time since medical school graduation or age, more than half suggested that physician performance declined over time for all outcomes measured. Only one study showed improved performance for all outcomes measured. What is true for physicians may not necessarily be true for landscape architects, but this evidence does provide some reasonable doubt as to whether greater experience correlates with greater competence in landscape architecture. Hence, we cannot say with confidence that requiring individuals who have earned a landscape architecture degree and passed the CLARB to work for at least three years for other certified individuals will significantly reduce the incidence of incompetent work.

Certification is only required for professionals to list or advertise themselves as a "certified landscape architect" or a "landscape architect." Professionals do not need to become certified to provide and sell landscape architectural services in Virginia. Instead they can, for example, call themselves landscape designers and provide and sell all of the same services. Those individuals who would not have pursued employment in the manner proposed to be required for certification will need to decide if the use of the title is important enough for them to change their work plans. It seems likely that at least some such individuals will choose instead to forego certification. Others will choose to alter their work plans and seek employment in a firm with certified landscape architects. This would represent an increase in supply of individuals seeking to supply their labor services to firms that already have certified landscape architects. An

¹ Source: www.asla.org on February 24, 2005

² Schatz, Alex P., "Regulation of Landscape Architecture and the Protection of Public Health, Safety, and Welfare," produced for The American Society of Landscape Architects, October 2003.

³ Choudry, Niteesh K.; Fletcher, Robert H., and Stephen B. Soumerai, "Systematic Review: The Relationship between Clinical Experience and Quality of Health Care," *Annals of Internal Medicine*: Volume 142, Number 4, February 15, 2005.

increased supply in workers would likely reduce the market salary those workers earn, everything else being equal.

The new proposed requirements will likely increase the cost for consumers to purchase the services of professionals with the title of certified landscape architect in Virginia. The proposal makes it more costly to obtain certification. As discussed above, the extra cost will raise the cost of entering the profession and, hence, fewer individuals will seek certification. Fewer certified individuals means that the supply of certified landscape architects will be smaller. Holding demand constant, a smaller supply will create higher market prices for these services.

Businesses and Entities Affected. The proposed regulations affect landscape architects, architects, professional engineers, and land surveyors, as well as their clients. According to the Department of Professional and Occupational Regulation, approximately 12 individuals seek landscape architect certification each year.

Localities Particularly Affected. The proposed regulations affect localities throughout the Commonwealth.

Projected Impact on Employment. The proposal to require that in order to become a certified landscape architect, applicants with a degree in landscape architecture must obtain at least 12 months of experience/training under the direct control and personal supervision of a licensed or certified landscape architect and either another 24 months of experience/training under the direct control and personal supervision of a licensed or certified landscape architect, or 48 months of experience/training under the direct control and personal supervision of a licensed architect, professional engineer, or land surveyor, may encourage some landscape architects to pursue such employment opportunities who would have otherwise started their own business or work for an employer who does meet those descriptions.

Effects on the Use and Value of Private Property. Firms with licensed or certified landscape architects, architects, professional engineers, or land surveyors may find the supply of landscape architects willing to work for them to be increased due to the proposed new requirement for landscape architecture certification. An increased supply in workers would likely reduce the market salary those workers earn, everything else being equal. Those firms will therefore have their value increased. Also, since the proposed new requirement for landscape architecture certification will likely discourage some individuals from pursuing the certification, the total market supply of services offered by certified landscape architects will likely decrease. When the supply of offered services is reduced, consumers pay higher market prices to obtain those services. Thus, the value of certified landscape architecture firms will increase with the resulting increased market prices.

Individuals who would have started their own business or chosen other work arrangements, but instead work for other certified individuals due to the proposed requirements, may have reduced incomes.

References

Choudry, Niteesh K.; Fletcher, Robert H., and Stephen B. Soumerai, "Systematic Review: The Relationship between Clinical Experience and Quality of Health Care," *Annals of Internal Medicine*: Volume 142, Number 4, February 15, 2005.

Schatz, Alex P., "Regulation of Landscape Architecture and the Protection of Public Health, Safety, and Welfare," produced for The American Society of Landscape Architects, October 2003.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: Generally concur. While we concur with the approval, we do not concur with the statement that the proposed change will be burdensome to the affected individuals (graduates from an LAAB-accredited program) nor do we concur with the suggestion that this change will limit the number of certified practitioners. Of the 20 individuals who obtained certification via examination during the time period of January 1, 2003, through August 11, 2004, 17 possessed an LAAB-accredited degree in landscape architecture. Of the 17 with the LAAB-accredited degree, the amount of time that elapsed between their graduation from the LAAB-accredited degree program and the issue date of their certificate after successfully completing the examination ranged from 3 years, 3 months, to 16 years, 8 months, with an average amount of time being 6 years, 8 months. Therefore, the requirement for those landscape architect applicants who possess an LAAB-accredited degree in landscape architecture to have three years of acceptable experience in order to become certified is currently being met by Virginia candidates.

The need for codifying the requirement is that it would help these candidates in obtaining certification or licensure in other jurisdictions which have an experience requirement. Having Virginia's requirements comparable with other jurisdictions would allow Virginia certificate holders to obtain certification/licensure in other states without having to meet additional experience requirements. Of the 45 jurisdictions (other than Virginia) which currently regulate landscape architecture (of which 37 are practice acts and 8 are title acts), for those persons holding a bachelors degree: 6 jurisdictions require no experience; 5 require 1 year of experience; 17 require 2 years of experience; 13 require 3 years of experience; and 4 require 4 years of experience. Instituting an experience requirement would bring Virginia's requirements in line with the majority of other jurisdictions that regulate landscape architecture.

Finally, while the benefits from the proposed change may not be great, neither is the cost nor the requirements being placed on potential regulants as they are already satisfying the experience requirement prior to obtaining certification.

Summary:

The purpose of the proposal is to amend the entry requirements for those landscape architect applicants who possess an LAAB-accredited degree in landscape architecture to require them to obtain three years of acceptable experience before being granted certification. Applicants could still be approved to take and sit for the examination prior to obtaining the required three years of experience; however, certification would not be awarded until such time as the three years of acceptable experience

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is obtained, documented, submitted, reviewed and approved.

18 VAC 10-20-420. Requirements for certification.

The education or experience, or both, and examination requirements for certification as a landscape architect are as follows:

1. An applicant who has graduated from an accredited landscape architecture curriculum approved by the Landscape Architectural Accreditation Board ~~shall be admitted to a CLARB-prepared examination or equivalent approved by the board. Upon passing such examination, the applicant shall be certified as a landscape architect, if otherwise qualified; or (LAAB) must meet the following requirements for certification as a landscape architect:~~

- a. Passed a CLARB-prepared examination; and
- b. Obtained 36 months of experience/training with a minimum of 12 months under the direct control and

personal supervision of a licensed or certified landscape architect and the other 24 months under the direct control and personal supervision of either a licensed or certified landscape architect, architect, professional engineer, or land surveyor, in accordance with the experience credits portion of the Landscape Architect Equivalency Table. An applicant who has graduated from an accredited landscape architecture curriculum approved by the Landscape Architectural Accreditation Board shall be admitted to a CLARB-prepared examination prior to completing the 36-month experience requirement, if the applicant is otherwise qualified.

2. An applicant who has obtained eight years of combined education and experience, evaluated in accordance with the Landscape Architect Equivalency Table, shall be admitted to a CLARB-prepared examination or equivalent approved by the board. Upon passing such examination, the applicant shall be certified as a landscape architect, if otherwise qualified.

**LANDSCAPE ARCHITECT EQUIVALENCY TABLE.
TABLE OF EQUIVALENTS FOR EDUCATION AND EXPERIENCE.**

DESCRIPTIONS	Education Credits			Experience Credits	
	First 2 Years	Succeeding Years	Max. Credit Allowed	Credit Allowed	Max. Credit Allowed
A-1. Degree from an LAAB-accredited landscape architectural curriculum.	100%	100%	5 years		
A-2. Credits toward a degree in landscape architecture from an accredited school of landscape architecture.	100%	100%	4 years		
A-3. Degree in landscape architecture or credits toward that degree from a nonaccredited school of landscape architecture.	100%	100%	4 years		
A-4. Degree or credits toward that degree in an allied professional discipline, i.e., architecture, civil engineering, environmental science, approved by the board.	75%	100%	3 years		
A-5. Any other bachelor degree or credits toward that degree.	50%	75%	2 years		
A-6. Qualifying experience in landscape architecture under the direct supervision of a landscape architect.				100%	no limit
A-7. Qualifying experience directly related to landscape architecture when under the direct supervision of an architect, professional engineer, or land surveyor.				50%	4 years
EXPLANATION OF REQUIREMENTS					
B-1. Education Credits. Education credits shall be subject to the following conditions:					
B-1.1. Applicants with a degree specified in A-1 through A-5 will be allowed the credit shown in the Maximum Credit Allowed column, regardless of the length of the degree program.					
B-1.2. With a passing grade, 32 semester credit hours or 48 quarter hours is considered to be one year. Fractions greater than one-half year will be counted one-half year and smaller fractions will not be counted.					
B-2. Experience Credits. Experience credits shall be subject to the following conditions:					
B-2.1. Every applicant without an LAAB-accredited degree must earn at least two years of experience credit under category A-6. Every applicant with an LAAB-accredited degree must earn at least one year of experience credit under category A-6.					

18 VAC 10-20-450. Certification by comity.

A person holding a current license to engage in the practice of landscape architecture, issued to the applicant by other states, the District of Columbia, or any territory or possession of the United States based on requirements that do not conflict with and are at least as rigorous as these regulations

and supporting statutes of this board that were in effect at the time of original licensure, may be licensed without further

examination. No person shall be so licensed, however, who has not passed an examination in another jurisdiction that was substantially equivalent to that approved by the board at that time. If the applicant does not meet the requirements for

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licensure in Virginia that were in effect at the time of original licensure, the applicant shall be required to meet the entry requirements current at the time the completed application for

comity is received in the board's office or shall hold a CLARB certificate.

**LANDSCAPE ARCHITECT EQUIVALENCY TABLE.
TABLE OF EQUIVALENTS FOR EDUCATION AND EXPERIENCE.**

DESCRIPTIONS	Education Credits			Experience Credits	
	First 2 Years	Succeeding Years	Max. Credit Allowed	Credit Allowed	Max. Credit Allowed
A-1. Credits toward a degree in landscape architecture from an accredited school of landscape architecture.	100%	100%	4 years		
A-2. Degree in landscape architecture or credits toward that degree from a nonaccredited school of landscape architecture.	100%	100%	4 years		
A-3. Degree or credits toward that degree in an allied professional discipline, i.e., architecture, civil engineering, environmental science, approved by the board.	75%	100%	3 years		
A-4. Any other bachelor degree or credits toward that degree.	50%	75%	2 years		
A-5. Qualifying experience in landscape architecture under the direct supervision of a landscape architect.				100%	no limit
A-6. Qualifying experience directly related to landscape architecture when under the direct supervision of an architect, professional engineer, or land surveyor.				50%	4 years
EXPLANATION OF REQUIREMENTS					
B-1. Education Credits. Education credits shall be subject to the following conditions:					
B-1.1. Applicants with a degree specified in A-1 through A-4 will be allowed the credit shown in the Maximum Credit Allowed column, regardless of the length of the degree program.					
B-1.2. With a passing grade, 32 semester credit hours or 48 quarter hours is considered to be one year. Fractions greater than one-half year will be counted one-half year and smaller fractions will not be counted.					
B-2. Experience Credits. Experience credits shall be subject to the following conditions:					
B-2.1. Every applicant must earn at least two years of experience credit under category A-5.					

NOTICE: The forms used in administering 18 VAC 10-20, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects Regulations, 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 Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Architect Information Sheet, 0401INFO (eff. 10/20/01).

Architect License Application, 0401LIC (rev. 5/1/01).

Verification of Architect Examination and Licensure Form, 0401ELVF (rev. 11/13/00).

Architect Experience Verification Form, 0401 EXP (rev. 10/23/00).

Architect Client Experience Verification Form, 0401CEXP (rev. 5/9/00).

Architect Degree Verification Form, 0401DEG (rev. 5/9/00).

Architect Reference Form, 0401REF (rev. 5/9/00).

Architect License Reinstatement Application, 0401REI (eff. 5/1/01).

Professional Engineer Information Sheet, 0402INFO (eff. 3/29/01).

Professional Engineer License Application, 0402LIC (rev. 3/30/01).

Professional Engineer Reference Form, 0402REF (rev. 3/30/01).

Professional Engineer License Reinstatement Application, 0402REI (eff. 3/30/01).

Professional Engineer and Engineer-in-Training Degree Verification Form, 04EDEG (rev. 3/29/01).

Professional Engineer and Engineer-in-Training Experience Verification Form, 04EEXP (rev. 3/29/01).

Engineer Verification of Examination and Licensure Form, 04EELVF (rev. 3/30/01).

Engineer-in-Training Information Sheet, 0420INFO (eff. 9/17/01).

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Engineer-in-Training Designation Application, 0420DES (rev. 9/17/01).

Engineer-in-Training Reference Form, 0420REF (eff. 3/29/01).

Engineer Examination Scheduling Form, 04EXAM (rev. 9/17/01).

Land Surveyor Information Sheet, 0403INFO (eff. 11/14/01).

Land Surveyor License Application, 0403LIC (rev. 11/14/01).

Land Surveyor License Reinstatement Application, 0403REI (eff. 6/1/01).

Land Surveyor B Information Sheet, 0404INFO (eff. 6/1/01).

Land Surveyor B License Application, 0404LIC (rev. 6/1/01).

Land Surveyor B License Reinstatement Application, 0404REI (eff. 6/1/01).

Land Surveyor and Land Surveyor-in-Training Degree Verification Form, 04LSDEG (eff. 6/1/01).

Land Surveyor Verification of Examination and Licensure Form, 04LSELVF (rev. 6/1/01).

Land Surveyor & Land Surveyor-in-Training Experience Verification Form, 04LSEXP (rev. 11/14/01).

Land Surveyor & Land Surveyor-in-Training Supplemental Experience Verification Form, 04SLSEXP (rev. 11/14/01).

Land Surveyor-in-Training Information Sheet, 0430INFO (eff. 6/1/01).

Land Surveyor-In-Training Designation Application, 0430DES (rev. 6/1/01).

Surveyor Examination Scheduling Form, LSEXAM (eff. 11/14/01).

~~Landscape Architect Information Sheet, 0406INFO (eff. 8/21/01).~~

Landscape Architect Certificate Application, 0406CERT (rev. ~~8/21/01~~ 12/05/05).

Verification of Landscape Architect Examination and Certification Form, 0406ELVF (rev. 8/21/01).

Landscape Architect Experience Verification Form for Examination and Comity Applicants, 0406EXP (rev. 8/21/01).

Landscape Architect Degree Verification Form, 0406DEG (rev. 8/21/01).

Landscape Architect Certificate Reinstatement Application, 0406REI (eff. 8/21/01).

Interior Designer Information Sheet, 0412INFO (eff. 10/25/01).

Interior Design Certificate Application, 0412CERT (rev. 8/21/01).

Verification of Interior Designer Examination and Certification Form, 0412ELVF (rev. 10/25/01).

Interior Designer Degree Verification Form, 0412DEG (rev. 8/21/01).

Interior Designer Experience Verification Form, 0412EXP (rev. 8/21/01).

Interior Designer Certificate Reinstatement Application, 0412REI (eff. 8/21/01).

Professional Corporation Registration Application (rev. 6/6/00).

Business Entity Registration Application (rev. 7/23/01).

Branch Office Application (rev. 10/1/99).

Professional Limited Liability Company Application Form (rev. 10/1/99)

VA.R. Doc. No. R04-240; Filed December 5, 2005, 2:47 p.m.

BOARD OF LONG-TERM CARE ADMINISTRATORS

Title of Regulation: 18 VAC 95-20. Regulations Governing the Practice of Nursing Home Administrators (amending 18 VAC 95-20-220, 18 VAC 95-20-310, 18 VAC 95-20-330, 18 VAC 95-20-340, 18 VAC 95-20-380, 18 VAC 95-20-390; adding 18 VAC 95-20-221).

Statutory Authority: § 54.1-2400 and Chapter 31 (§ 54.1-3100 et seq.) of Title 54.1 of the Code of Virginia.

Public Hearing Date: January 10, 2006 - 9:30 a.m.

Public comments may be submitted until February 24, 2006.
(See Calendar of Events section for additional information)

Agency Contact: Sandra Reen, Executive Director, Board of Long-Term Care Administrators, 6603 West Broad Street, 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-7457, FAX (804) 662-9943, or e-mail sandra.reen@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia establishes the general powers and duties of the Board of Long-Term Care Administrators including the responsibility to promulgate regulations and administer a licensure and renewal program for nursing home administrators.

The statutory authority for licensure and regulation of nursing home administrators is found in Chapter 31 (§ 54.1-3100 et seq.) of Title 54.1 of the Code of Virginia.

Purpose: The Board of Long-Term Care Administrators has addressed the issue of a lack of specificity in the degree requirements for initial licensure, resulting in denial of several applications from individuals who believed their program of study would qualify them for licensure as a nursing home administrator. In 18 VAC 95-20-220, regulations require a degree in "nursing home administration" or "a health care administration field." The board is unaware of any college or university offering a degree in "nursing home administration," so it has eliminated that degree title. A degree in "a health care administration field" is not clearly defined and therefore may be confusing to applicants. While there are schools offering degrees in long-term care administration, there are other related degree programs that may or may not qualify an individual to be licensed as a nursing home administrator. Rather than naming additional degree titles, the board has added 18 VAC 95-20-221 to specify the content areas that

must be included in coursework obtained in a health care-related field in order to qualify a graduate for licensure.

With the current shortage of nursing home administrators, shrinking numbers of applicants and a growing population of aging residents, the board is seeking to proactively address regulatory issues that have been detrimental or discouraging to persons who are seeking licensure. The board holds nursing home administrators responsible for the care of an elderly, frail population but believes it can make certain amendments to regulation that will continue to protect those persons and eliminate barriers and clarify the rules for initial licensure and preceptorships.

Substance: To rectify the lack of specificity and set a clearer standard for applicants and educational programs, a new section is added to set out the coursework required to meet the educational requirements for a degree in a health care-related field to include successful completion of a minimum of 21 semester hours of coursework concentrated on the administration and management of health care services to include a minimum of three semester hours in each of the five content areas of Resident Care and Quality of Life, Human Resources, Finance, and Physical Environment, six semester hours in Leadership and Management, and three semester hours for an internship. With the required coursework content specified, the board has eliminated specific references to degree titles and will require a program in a health care-related field that meets the coursework requirements. Other changes are clarifying and not substantive.

Issues: While the public ultimately benefits from a supply of nursing home administrators who are adequately prepared in all aspects of operating a facility with safety and integrity, the real advantage of the proposed changes would be for persons who are pursuing an education in preparation for licensure and for educational programs that are seeking specificity in the qualifications for licensure in order to guide students to coursework that will qualify them for licensure.

There are no disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H 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 impacts.

Summary of the proposed regulation. The Board of Long-Term Care Administrators (board) proposes to amend the educational requirements for initial licensure that have been problematic or confusing. The board proposes to eliminate the field "nursing home administration," add a new section that

specifies the content areas that must be included within a degree program in a health care-related field, and specify the content of the internship required for licensure.

Estimated economic impact. Under the current regulation, qualifications for initial licensure of nursing home administrators require one of the following (18 VAC 95-20-220):

1. Degree and practical experience. The applicant shall hold a baccalaureate or higher degree in "nursing home administration" or "a health care administration field," together with a minimum of a 320-hour internship and a passing grade on the state examination and the national examination.
2. Certificate program. The applicant shall hold a baccalaureate or higher degree and successfully complete a program with a minimum of 21 semester hours of study in "nursing home administration" or "health care administration," together with a minimum of a 400-hour internship and a passing grade on the state examination and the national examination.
3. Administrator-in-training (A.I.T) program. The applicant shall successfully complete an A.I.T. program that meets the requirements of Part IV (18 VAC 95-20-300 et seq.) of 18 VAC 95-20 and receive a passing grade on the state examination and the national examination.

The terms "nursing home administration" and "health care administration" in the first two sets of requirements cause confusion for some applicants. According to the board, there is no college or university offering a degree in "nursing home administration." Also, a degree in a "health care administration" field is not clearly defined. While there are schools offering degrees in long-term care administration, there are other related degree programs that may qualify an individual to be licensed as a nursing home administrator, for example, Gerontology. The lack of specificity of the current regulation has caused denial of applications from individuals who believed their program of study would qualify them for licensure as a nursing home administrator. According to the Department of Health Professions, among the 66 applications for nursing home administrators in fiscal year 2005, three were denied due to the confusion in the educational requirement.

In order to rectify the lack of specificity and set a clearer standard for applicants and educational programs, the board proposes to eliminate the degree title "nursing home administration," replace "health care administration" field with "health care-related field," and add a section (18 VAC 95-20-221) that specifies the coursework required to meet the educational requirements for a degree in a "health care-related field." A degree in a health care-related field will require successful completion of a minimum of 21 semester hours of coursework concentrated on the administration and management of health care services, which include a minimum of three semester hours in Resident Care and Quality of Life, Human Resources, Finance, or Physical Environment and Atmosphere, six semester hours in Leadership and Management, and three semester hours for

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an internship. The proposed regulation also specifies the content of the internship required for licensure.

This regulatory change clarifies the confusing requirement and replaces the requirement of field title with more specific coursework requirements. It may encourage more individuals to apply for licensure and will potentially reduce the current shortage of nursing home administrators. While at the same time, the specific coursework requirements will make sure that the licensed nursing home administrators will be adequately prepared in all aspects of operating a facility with safety and integrity. As a result, the aging residents will benefit. The proposed regulation will also benefit persons who are pursuing an education in preparation for licensure. The specific coursework requirements will guide them to select the courses that are required for licensure and therefore will save the tuition and time in case of denial and re-application. In addition, the proposed amendment will benefit the educational programs that are seeking specificity in the qualifications for licensure in order to guide students to coursework that will qualify them for licensure.

The proposed regulation will create no direct cost for the public. For the Department of Health Professions (DHP), there will be some one-time costs (less than \$1,000) for notifying Public Participation Guidelines mailing lists, conducting a public hearing, and sending notice of final regulations to regulated entities.

Businesses and entities affected. This regulatory change will affect the 280 nursing homes¹ in Virginia, the persons who are pursuing an education in preparation for licensure, as well as the educational programs that are seeking specificity in the qualifications for licensure in order to guide students to coursework that will qualify them for licensure. The aging residents will also benefit from the increased supply of qualified nursing home administrators.

Localities particularly affected. The proposed regulatory change applies to localities throughout the Commonwealth.

Projected impact on employment. The proposed regulation may encourage more individuals to pursue nursing home administrator licensure and will potentially increase the number of licensed nursing home administrators employed, particularly since there is a current shortage of nursing home administrators.

Effects on the use and value of private property. The proposed regulatory change may modestly increase the supply of licensed nursing home administrators. This increase in supply may modestly reduce the market salary of nursing home administrators. Thus, the proposal may modestly reduce costs for nursing homes, and commensurately increase their value.

Small businesses: costs and other effects. This regulatory change will affect the educational programs that are seeking specificity in the qualifications for licensure in order to guide students to coursework that will qualify them for licensure. This proposal will also modestly reduce costs for nursing homes because of the potential reduced market salary of

nursing home administrators due to increased supply. According to the database provided by Virginia Employment Commission, 277 out of the 280 nursing homes are small businesses.

Small businesses: alternative method that minimizes adverse impact. This regulatory change will positively affect small businesses.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Long Term Care Administrators concurs with the analysis of the Department of Planning and Budget for amendments to 18 VAC 95-20 for clarifications to educational and preceptor requirements.

Summary:

The proposed amendments eliminate the field "nursing home administration," add a new section that specifies the content areas that must be included within a degree program in a health care-related field, and specify the content of the internship required for licensure.

18 VAC 95-20-220. Qualifications for initial licensure.

One of the following sets of qualifications is required for licensure as a nursing home administrator:

1. Degree and practical experience. The applicant shall (i) hold a baccalaureate or higher degree in ~~nursing home administration~~ or a health care ~~administration~~ -related field that meets the requirements of 18 VAC 95-20-221 from an accredited college or university; (ii) have completed not less than a 320-hour internship that addresses the Domains of Practice as specified in 18 VAC 95-20-390 in a licensed nursing home as part of the degree program under the supervision of a preceptor; and (iii) have received a passing grade on the state examination and the national examination;
2. Certificate program. The applicant shall (i) hold a baccalaureate or higher degree from an accredited college or university; (ii) successfully complete a program with a minimum of 21 semester hours study in ~~nursing home administration~~ or a health care ~~administration~~ -related field that meets the requirements of 18 VAC 95-20-221 from an accredited college or university; (iii) successfully complete not less than a 400-hour internship that addresses the Domains of Practice as specified in 18 VAC 95-20-390 in a licensed nursing home as part of the certificate program under the supervision of a preceptor; and (iv) have received a passing grade on the state examination and the national examination; or
3. Administrator-in-training program. The applicant shall have (i) successfully completed an A.I.T. program which meets the requirements of Part IV (18 VAC 95-20-300 et seq.) of this chapter and (ii) received a passing grade on the state examination and the national examination.

18 VAC 95-20-221. Required content for coursework.

To meet the educational requirements for a degree in a health care-related field, an applicant must provide a transcript from an accredited college or university that documents successful

¹ This is the number of nursing care facilities (NAICS 623110) calculated using Virginia Employment Commission database (Quarter 4 of 2004).

completion of a minimum of 21 semester hours of coursework concentrated on the administration and management of health care services to include a minimum of three semester hours in each of the content areas in subdivisions 1 through 4 of this section, six semester hours in the content area set out in subdivision 5 of this section, and three semester hours for an internship.

1. *Resident care and quality of life:* Course content shall address program and service planning, supervision and evaluation to meet the needs of patients, such as (i) nursing, medical and pharmaceutical care; (ii) rehabilitative, social, psycho-social and recreational services; (iii) nutritional services; (iv) safety and rights protections; (v) quality assurance; and (vi) infection control.

2. *Human resources:* Course content shall focus on personnel leadership in a health care management role and must address organizational behavior and personnel management skills such as (i) staff organization, supervision, communication and evaluation; (ii) staff recruitment, retention, and training; (iii) personnel policy development and implementation; and (iv) employee health and safety.

3. *Finance:* Course content shall address financial management of health care programs and facilities such as (i) an overview of financial practices and problems in the delivery of health care services; (ii) financial planning, accounting, analysis and auditing; (iii) budgeting; (iv) health care cost issues; and (v) reimbursement systems and structures.

4. *Physical environment and atmosphere:* Course content shall address facility and equipment management such as (i) maintenance; (ii) housekeeping; (iii) safety; (iv) inspections and compliance with laws and regulations; and (v) emergency preparedness.

5. *Leadership and management:* Course content shall address the leadership roles in health delivery systems such as (i) government oversight and interaction; (ii) organizational policies and procedures; (iii) principles of ethics and law; (iv) community coordination and cooperation; (v) risk management; and (vi) governance and decision making.

18 VAC 95-20-310. Required hours of training.

A. The A.I.T. program shall consist of 2,000 hours of continuous training in a facility as prescribed in 18 VAC 95-20-330 to be completed within 24 months. An extension may be granted by the board on an individual case basis. The board may reduce the required hours for applicants with certain qualifications as prescribed in subsection B and C of this section.

B. An A.I.T. applicant with prior health care work experience may request approval to receive a maximum 1,000 hours of credit toward the total 2,000 hours as follows:

1. *The applicant shall have been employed full time for four of the past five consecutive years immediately prior to application as an assistant administrator or director of nursing in a training facility as prescribed in 18 VAC 95-20-330;*

2. ~~Applicants~~ *The applicant with experience as a hospital administrator shall have been employed full time for three of the past five years immediately prior to application as a hospital administrator-of-record or an assistant hospital administrator in a hospital setting having responsibilities in all of the following areas:*

- a. Regulatory;
- b. Fiscal;
- c. Supervisory;
- d. Personnel; and
- e. Management; or

3. ~~Applicants~~ *The applicant who held holds a license as a registered nurse shall have held an administrative level supervisory position for at least four of the past five consecutive years, in a training facility as prescribed in 18 VAC 95-20-330.*

C. An A.I.T. applicant with the following educational qualifications shall meet these requirements:

1. An applicant with a master's or a baccalaureate degree in a health care ~~administration or a comparable~~ *-related field that meets the requirements of 18 VAC 95-20-221 with no internship shall complete 320 hours in an A.I.T. program;*

2. An applicant with a master's degree in an ~~unrelated~~ *a field other than health care shall complete 1,000 hours in an A.I.T. program;*

3. An applicant with a baccalaureate degree in an ~~unrelated~~ *a field other than health care shall complete 1,500 hours in an A.I.T. program; or*

4. An applicant with 60 semester hours of education in an accredited college or university shall complete 2,000 hours in an A.I.T. program.

D. An A.I.T. shall be required to serve weekday, evening, night and weekend shifts *and* to receive training in all areas of nursing home operation.

18 VAC 95-20-330. Training facilities.

Training *in an A.I.T. program* shall be conducted only in:

1. A nursing home licensed by the Virginia Board of Health or by a similar licensing body in another jurisdiction;

2. An institution operated by the Virginia State Mental Health, Mental Retardation and Substance Abuse Services Board in which long-term care is provided;

3. A certified nursing home owned or operated by an agency of any city, county, or the Commonwealth or of the United States government; or

4. A certified nursing home unit *that is* located in and operated by a licensed hospital as defined in § 32.1-123 of the Code of Virginia, a state-operated hospital, or a hospital licensed in another jurisdiction.

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18 VAC 95-20-340. Supervision of trainees.

A. Training shall be under the supervision of a preceptor who is registered or recognized by a licensing board.

B. A preceptor may supervise no more than two A.I.T.'s at any one time.

C. A preceptor shall:

1. Provide direct instruction, planning and evaluation *in the training facility*;
2. Shall be routinely present with the trainee in the training facility; and
3. Shall continually evaluate the development and experience of the A.I.T. to determine specific areas ~~needed for concentration~~ *in the Domains of Practice that need to be addressed.*

18 VAC 95-20-380. Qualifications of preceptors.

To be registered by the board as a preceptor, a person shall:

1. Hold a current, unrestricted Virginia nursing home administrator license and be employed full time as an administrator *of record* in a training facility for a minimum of two of the past three years immediately prior to registration; and
2. Meet the application requirements in 18 VAC 95-20-230.

18 VAC 95-20-390. Training plan.

Prior to the beginning of the A.I.T. program, the preceptor shall develop and submit for board approval a training plan ~~which~~ *that* shall include and be designed around the specific training needs of the administrator-in-training. The training plan shall ~~include~~ *address* the ~~1996~~ Domains of Practice approved by the National Association of Boards of Examiners for Long Term Care Administrators ~~and incorporated by reference into these regulations~~ *that is in effect at the time the training program is submitted for approval.* An A.I.T. program shall include training in each of the learning areas in the Domains of Practice.

DOCUMENTS INCORPORATED BY REFERENCE

~~The 1996 Domains of Practice structured as an Administrator in Training internship program, 1997, J. E. Allen and National Association of Boards of Examiners for Long Term Care Administrators.~~

VA.R. Doc. No. R05-104; Filed December 6, 2005, 11:36 a.m.

FINAL REGULATIONS

For information concerning Final Regulations, see Information Page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates new text. Language which has been stricken indicates text to be deleted. [Bracketed language] indicates a change from the proposed text of the regulation.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

MARINE RESOURCES COMMISSION

REGISTRAR'S NOTICE: The following regulation filed by the Marine Resources Commission is exempt from the Administrative Process Act in accordance with § 2.2-4006 A 12 of the Code of Virginia; however, the commission is required to publish the full text of final regulations.

Title of Regulation: 4 VAC 20-490. Pertaining to Sharks (amending 4 VAC 20-490-20, 4 VAC 20-490-40 and 4 VAC 20-490-50; adding 4 VAC 20-490-41, 4 VAC 20-490-42, 4 VAC 20-490-43; repealing 4 VAC 20-490-60).

Statutory Authority: § 28.2-201 of the Code of Virginia.

Effective Date: December 1, 2005.

Agency Contact: Deborah R. Cawthon, Agency Regulatory Coordinator, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, FAX (757) 247-2002, or e-mail debbie.cawthon@mrc.virginia.gov.

Summary:

The amendments (i) add, eliminate and modify definitions including replacing the single definition of "shark" with four groupings of shark species and excluding "smooth dogfish" as a defined shark species; (ii) change the general category of catch limit to a recreational catch limit only; (iii) establish commercial catch limitations; and (iv) establish a limited access control rule that potentially limits access to the commercial fishery for sharks.

4 VAC 20-490-20. Definitions.

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

"Carcass length" means that length measured in a straight line from the anterior edge of the first dorsal fin to the posterior end of the shark carcass.

"COLREGS Line" means the COLREGS Demarcation lines, as specified in Coastal Pilot, 35th and 36th editions by Lighthouse Press.

"Control rule" means a time-certain date, past, present or future, used to establish participation in a limited entry fishery and may or may not include specific past harvest amounts.

"Dressed weight" means the result from processing a fish by removal of head, viscera, and fins, but does not include removal of the backbone, halving, quartering, or otherwise further reducing the carcass.

"Finning" means removing the fins and returning the remainder of the shark to the sea.

"Fork length" means ~~that length measured in a straight line from the tip of the nose of the shark to the center of the fork of the tail of the shark~~ the straight-line measurement of a fish from the tip of the snout to the fork of the tail. The measurement is not made along the curve of the body.

"Large coastal shark group" means any of the following species:

Sandbar, *Carcharhinus plumbeus*
Silky, *Carcharhinus falciformis*
Tiger, *Galeocerdo cuvieri*
Blacktip, *Carcharhinus limbatus*
Bull, *Carcharhinus leucas*
Great hammerhead, *Sphyrna mokarran*
Lemon, *Negaprion brevirostris*
Nurse, *Ginglymostoma cirratum*
Scalloped hammerhead, *Sphyrna lewini*
Smooth hammerhead, *Sphyrna zygaena*
Spinner, *Carcharhinus brevipinna*

"Longline" means any fishing gear ~~composed of a line in excess of 1,000 feet in length that has multiple hooks and is either anchored, floating or attached to a vessel that is set horizontally, either anchored, floating or attached to a vessel, and that consists of a mainline or groundline, greater than 1,000 feet in length, with multiple leaders (gangions) and hooks, whether retrieved by hand or mechanical means.~~

"Pelagic shark group" means any of the following species:

Blue, *Prionace glauca*
Oceanic whitetip, *Carcharhinus longimanus*
Porbeagle, *Lamna nasus*
Shortfin mako, *Isurus oxyrinchus*
Thresher, *Alopias vulpinus*.

"Prohibited shark group" means any of the following species:

Atlantic angel, *Squatina dumerili*
Basking, *Cetorhinus maximus*
Bigeye sand tiger, *Odontaspis noronhai*
Bigeye sixgill, *Hexanchus vitulus*
Bigeye thresher, *Alopias superciliosus*
Bignose, *Carcharhinus altimus*
Caribbean reef, *Carcharhinus perezi*
Caribbean sharpnose, *Rhizoprionodon porosus*
Dusky, *Carcharhinus obscurus*
Galapagos, *Carcharhinus galapagensis*
Longfin mako, *Isurus paucus*
Narrowtooth, *Carcharhinus brachyurus*
Night, *Carcharhinus signatus*
Sand tiger, *Odontaspis taurus*
Sevengill, *Hepranchias perlo*
Sixgill, *Hexanchus griseus*
Smalltail, *Carcharhinus porosus*

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Whale, *Rhincodon typus*
White, *Carcharodon carcharias*

"Shark" means any fish of the following species:

Sevengill shark, *Hoptranchias perle*
Sixgill shark, *Hexanchus griseus*
Bigeye sixgill shark, *Hexanchus vitulus*
Atlantic angel shark, *Squatina dumerili*
Nurse shark, *Ginglymostoma cirratum*
Whale shark, *Rhincodon typus*
Ragged-tooth shark, *Odontaspis ferox*
Sand tiger shark, *Odontaspis taurus*
Bigeye thresher, *Alopias superciliosus*
Thresher shark, *Alopias vulpinus*
Basking shark, *Cetorhinus maximus*
White shark, *Carcharodon carcharias*
Shortfin mako, *Isurus oxyrinchus*
Longfin mako, *Isurus paucus*
Porbeagle shark, *Lamna nasus*
Tiger shark, *Galeocerdo cuvieri*
Lemon Shark, *Negaprion brevirostris*
Blue shark, *Prionace glauca*
Blacknose shark, *Carcharhinus acronotus*
Bignose shark, *Carcharhinus altimus*
Narrowtooth shark, *Carcharhinus brachyurus*
Spinner shark, *Carcharhinus brevipinna*
Silky shark, *Carcharhinus falciformis*
Galapagos shark, *Carcharhinus galapagensis*
Finetooth shark, *Carcharhinus isodon*
Bull shark, *Carcharhinus leucas*
Blacktip shark, *Carcharhinus limbatus*
Oceanic whitetip shark, *Carcharhinus longimanus*
Dusky shark, *Carcharhinus obscurus*
Caribbean reef shark, *Carcharhinus perezi*
Sandbar shark, *Carcharhinus plumbeus*
Night shark, *Carcharhinus signatus*
Atlantic sharpnose shark, *Rhizoprionodon terraenovae*
Caribbean sharpnose shark, *Rhizoprionodon porosus*
Scalloped hammerhead, *Sphyrna lewini*
Great hammerhead, *Sphyrna mokarran*
Bonnethead, *Sphyrna tiburo*
Smooth hammerhead, *Sphyrna zygaena*

"Shark carcass" means any shark whose head, gills, tail, and viscera have been removed.

"Smooth dogfish" means any shark of the species *Mustelus canis*.

"Small coastal shark group" means any of the following species:

Atlantic sharpnose, *Rhizoprionodon terraenovae*
Blacknose, *Carcharhinus acronotus*
Bonnethead, *Sphyrna tiburo*
Finetooth, *Carcharhinus isodon*

"Spiny dogfish" means any shark of the species *Squalus acanthias*.

4 VAC 20-490-40. Recreational catch limitations.

A. It shall be unlawful for any person to take or catch by hook and line, rod and reel, or spear and retain possession of more than one shark at any time.

~~1. Any shark taken after the possession limit has been reached shall be returned to the water immediately.~~

~~2. When fishing from any boat or vessel where the entire catch is held in a common hold or container, the possession limit shall be for the boat or vessel and shall be equal to the number of persons on board legally eligible to fish. The captain or operator of the boat or vessel shall be responsible for any boat or vessel possession limit.~~

~~B. It shall be unlawful for any commercial fishing vessel to have on board or to land more than 7,500 pounds of shark carcasses per day, except as provided by subsection F of this section. The vessel captain or operator is responsible for compliance with the provisions of this subsection.~~

~~C. Except as provided in subsection D of this section, it shall be unlawful for any person to land in Virginia or to possess for commercial purposes any shark less than 58 inches in fork length or any shark carcass less than 31 inches in carcass length.~~

~~D. Any person may harvest and land for commercial purposes from Virginia's portion of the Territorial Sea within the three nautical mile line only up to 200 pounds of shark carcasses less than the 31-inch minimum carcass length.~~

~~E. It shall be unlawful for any person to take, possess aboard any vessel or land in Virginia any spiny dogfish harvested from federal waters (Exclusive Economic Zone, 3-200 miles) for commercial purposes after it has been announced that the federal quota for spiny dogfish has been taken.~~

~~F. It shall be unlawful for any person to take, possess aboard any vessel or land in Virginia more than 600 pounds of spiny dogfish per day, from May 1 through October 30, or 300 pounds of spiny dogfish per day, from November 1 through April 30, for commercial purposes.~~

~~G. It shall be unlawful for any person to harvest any spiny dogfish for commercial purposes from state waters after it has been announced that the interstate quota for spiny dogfish has been taken.~~

~~H. All spiny dogfish harvested from state waters or federal waters for commercial purposes must be sold to a federally permitted dealer.~~

~~I. It shall be unlawful for any buyer of seafood to receive any spiny dogfish after any commercial harvest or landing quota described in this section has been attained and announced as such.~~

A. *The taking, catching, or possessing aboard a vessel of more than one shark from either the large coastal, small coastal, or pelagic group per day, or the possession of more than one Atlantic sharpnose shark and one bonnethead shark per person per day, shall constitute a violation of this regulation. When fishing from any boat or vessel where the entire catch is held in a common hold or container, the possession limits for Atlantic sharpnose shark or bonnethead shark shall be for the boat or vessel and shall be equal to the number of persons on board legally eligible to fish. The captain or operator of the boat or vessel shall be responsible for any boat or vessel possession limits.*

B. It shall be unlawful for any person to retain or possess any prohibited shark.

C. It shall be unlawful for any person to possess any large coastal, small coastal or pelagic shark, except Atlantic sharpnose and bonnethead sharks, landed under the recreational catch limitations described in this section, that is less than 54 inches fork length or 30 inches in carcass length.

4 VAC 20-490-41. Commercial catch limitations.

A. It shall be unlawful for any person to take, harvest, land, or possess, for commercial purposes, any shark less than 58 inches in fork length or any shark carcass less than 31 inches in carcass length, from any waters west of the COLREGS Line.

B. It shall be unlawful for any person to possess on board a vessel or to land in Virginia more than 4,000 pounds, dressed weight, of large coastal sharks per day. The person who owns or operates the vessel is responsible for compliance with the provisions of this subsection.

C. It shall be unlawful for any person to fillet a shark at sea. A licensed commercial fisherman may eviscerate and remove the head and fins of sharks, but shall retain the fins with the dressed carcasses. While on board and when offloaded, wet shark fins shall not exceed 5.0% of the dressed weight of the carcasses. Possession of wet shark fins on board a vessel or at offloading that exceeds 5.0% of the dressed weight of the carcasses shall constitute a violation of this regulation.

D. There are no commercial trip limits or possession limits for pelagic or small coastal sharks.

E. It shall be unlawful for any person to retain, possess or purchase any prohibited shark.

4 VAC 20-490-42. Spiny dogfish catch limitations.

A. It shall be unlawful for any person to take, possess aboard any vessel or land in Virginia any spiny dogfish harvested from federal waters (Exclusive Economic Zone (3-200 miles), for commercial purposes after it has been announced that the federal quota for spiny dogfish has been taken.

B. It shall be unlawful for any person to take, possess aboard any vessel or land in Virginia more than 600 pounds of spiny dogfish per day from May 1 through October 30, or 300 pounds of spiny dogfish per day from November 1 through April 30, for commercial purposes.

C. It shall be unlawful for any person to harvest any spiny dogfish for commercial purposes from state waters after it has been announced that the interstate quota for spiny dogfish has been taken.

D. All spiny dogfish harvested from state waters or federal waters, for commercial purposes, must be sold to a federally permitted dealer.

E. It shall be unlawful for any buyer of seafood to receive any spiny dogfish after any commercial harvest or landing quota described in this section has been attained and announced as such.

4 VAC 20-490-43. Limited access control rule.

At such time the status of shark stocks or their fisheries warrant the establishment of a limited access program for participation in the commercial fishery for sharks, a control rule may be enacted that limits participation in the commercial fisheries for sharks to those individuals who participated in that fishery on and before December 31, 2004. The control rule may also include eligibility requirements based on past harvest amounts.

4 VAC 20-490-50. Finning.

A. It shall be unlawful for any person to engage in finning.

~~B. It shall be unlawful for any person to possess fins, except that fins may be removed at sea provided the carcass of the shark is retained and counted as part of any possession or landing limit. The possession of any fins without possession of a comparable number of shark carcasses with fins removed shall be prima facie evidence of a violation of this chapter. The boat or vessel captain or operator is responsible for compliance with the provisions of this section.~~

4 VAC 20-490-60. Exceptions. (Repealed.)

~~Nothing in 4 VAC 20-490-40 or 4 VAC 20-490-50 shall pertain to the taking or possession of the smooth dogfish, and nothing in 4 VAC 20-490-40 A through D shall pertain to the taking or possession of the spiny dogfish.~~

VA.R. Doc. No. R06-120; Filed November 30, 2005, 9:31 a.m.



TITLE 12. HEALTH

STATE BOARD OF HEALTH

REGISTRAR'S NOTICE: The State Board of Health has claimed an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law where no agency discretion is involved. The State Board of Health will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 12 VAC 5-410. Regulations for the Licensure of Hospitals in Virginia (amending 12 VAC 5-410-260 through 12 VAC 5-410-290, 12 VAC 5-410-340 through 12 VAC 5-410-390, 12 VAC 5-410-442, 12 VAC 5-410-444, 12 VAC 5-410-445, 12 VAC 5-410-450, 12 VAC 5-410-480, 12 VAC 5-410-490, 12 VAC 5-410-500, 12 VAC 5-410-650, 12 VAC 5-410-720, 12 VAC 5-410-760, 12 VAC 5-410-1250, 12 VAC 5-410-1260, 12 VAC 5-410-1290, 12 VAC 5-410-1350 and 12 VAC 5-410-1380; adding 12 VAC 5-410-655; repealing 12 VAC 5-410-510 through 12 VAC 5-410-640, 12 VAC 5-410-660 through 12 VAC 5-410-710, 12 VAC 5-410-730, 12 VAC 5-410-740, 12 VAC 5-410-750, 12 VAC 5-410-770 through 12 VAC 5-410-1140, 12 VAC 5-410-1310 through 12 VAC 5-410-1340, 12 VAC 5-410-1360, 12 VAC 5-

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410-1370, 12 VAC 5-410-1390 through 12 VAC 5-410-1420, Appendices A, B, and C).

Statutory Authority: §§ 32.1-12 and 32.1-127 of the Code of Virginia.

Effective Date: January 25, 2006.

Agency Contact: Carrie Eddy, Senior Policy Analyst, Department of Health, Center for Quality Health Care Services and Consumer Protection, 3600 West Broad Street, Suite 216, Richmond, VA 23230, telephone (804) 367-2157, FAX (804) 367-2149, or e-mail carrie.eddy@vdh.virginia.gov.

Summary:

Chapters 177 and 222 of the 2005 Acts of Assembly require that the physical plant standards for hospitals be consistent with the "Guidelines for Design and Construction of Hospital and Health Care Facilities" (Guidelines) of the American Institute of Architects. Therefore, the department is amending the Rules and Regulations for the Licensure of Hospitals in Virginia (12 VAC 5-410) pursuant to § 2.2-4006 A 4 a of the Code of Virginia.

The majority of the amendments relate to physical plant design and construction standards that are: (i) repetitive and duplicative within the regulation and (ii) inaccurate, outdated and otherwise inapplicable as a result of the Virginia Uniform Statewide Building Code (USBC) (§ 36-98 et seq. of the Code of Virginia) or the Guidelines.

The department believes that it still meets its mandated obligation under § 32.1-127 of the Code of Virginia to assure the "environmental protection and life safety of patients and employees and public" by incorporating by reference the USBC and the Guidelines, as well as other appropriate regulatory standards for such public health concerns as sewage and water, incinerators, fire and safety, radiological services and equipment, food service, and pharmacy. The department prefers to establish collegial partnerships with sister agencies for such oversight rather than continuing its current practice of delineating physical plant standards that have resulted in conflicting standards for the licensed entities.

In addition to amendments made to the design and construction standards for hospitals and outpatient surgery centers, amendments have been made regarding formatting and to correct references in:

1. 12 VAC 5-410-260 regarding dietitian qualifications (§ 54.1-2731 of the Code of Virginia) and food services regulation (12 VAC 5-421);
2. 12 VAC 5-410-270 regarding disaster and mass casualty programs;
3. 12 VAC 5-410-280 regarding ambulance services (12 VAC 5-31);
4. 12 VAC 5-410-290, 12 VAC 5-410-340, and 12 VAC 5-410-1250 regarding laboratory, blood bank, and transfusion services (42 CFR 493, 42 CFR 482.27, and 21 CFR 606 respectively);

5. 12 VAC 5-410-350 and 12 VAC 5-410-490 regarding reportable diseases (12 VAC 5-90);

6. 12 VAC 5-410-360 and 12 VAC 5-410-660 regarding radiological and nuclear medicine (12 VAC 5-480);

7. 12 VAC 5-410-370 and 12 VAC 5-410-1260 regarding medical records (§ 32.1-127.1:03 of the Code of Virginia and 42 USC § 1320d (HIPAA));

8. 12 VAC 5-410-380 regarding the multi-state nursing privileges and delegation of nursing services;

9. 12 VAC 5-410-390 regarding pharmacy (Chapter 33 of Title 54.1 of the Code of Virginia and 18 VAC 110-20);

10. 12 VAC 5-410-444 to delete the reference to the Virginia High Priority Infant Tracking program, which has been discontinued;

11. 12 VAC 5-410-450 regarding psychiatric services (12 VAC 5-35-105);

12. 12 VAC 5-410-480 F regarding food service; and

13. 12 VAC 5-410-490 and 12 VAC 5-410-1290 regarding infectious waste.

Incorrectly cited references in Appendix A, namely references 2, 4, 5, 6, 9, and 12 are deleted. Therefore, all references in Appendix A have either been placed with their proper regulatory section or have been deemed inaccurate and deleted.

Because of these amendments, the referenced appendices in 12 VAC 5-410 are deleted as no longer necessary.

12 VAC 5-410-260. Dietary service.

A. Each hospital shall maintain a dietary service directed by a full-time person, qualified by training and experience in organization and administration of food service as allowed in 12 VAC 5-421.

B. Each hospital shall have at least one dietitian, meeting the criteria of § 54.1-2731 of the Code of Virginia, employed on either a full-time, part-time or on a consultative basis, to direct nutritional aspects of patient care and to advise on food preparation and service. ~~The dietitian shall be:~~

- ~~1. A professional dietitian who meets the American Dietetic Association qualification standards; or~~
- ~~2. An individual who is a graduate of an accredited college or university with a baccalaureate degree program with major studies in food and nutrition and at least two years of experience in a health care food or nutrition service.~~

C. Space, equipment and supplies shall be provided for the efficient, safe and sanitary receiving, storage, refrigeration, preparation and serving of food.

D. The hospital food service operation shall comply with applicable standards in ~~Appendix A, Reference 4~~ 12 VAC 5-421.

~~E. Policies and procedures shall be established for dietary services, including but not limited to the following:~~

- ~~1. Responsibilities and functions of personnel;~~

- ~~2. Standards for nutritional care in accordance with Appendix A, Reference 2;~~
- ~~3. Safety and sanitation relative to personnel and equipment;~~
- ~~4. Precise delivery of patient's dietary order;~~
- ~~5. Alterations or modifications to diet orders or schedules;~~
- ~~6. Ancillary dietary services, including food storage and preparation in satellite kitchens, and vending operations;~~
- ~~7. Food purchasing, storage, preparation and service; and~~
- ~~8. Ice making in accordance with Appendix A, Reference 1.~~

~~F. E.~~ A diet manual, approved by the medical staff shall be maintained by the dietary service. Diets served to patients shall comply with the principles set forth in the diet manual.

~~G. F.~~ All patient diets shall be ordered in writing by a member of the medical staff.

~~H. G.~~ Pertinent observations and information relative to the special diets and to dietetic treatment shall be recorded in the patient's medical record.

A hospital contracting for food service shall require, as part of the contract, that the contractor comply with the provisions of this section.

12 VAC 5-410-270. Disaster and mass casualty programs.

A. Each hospital shall develop and maintain a written disaster plan ~~which shall include~~ that includes provisions for complete evacuation of the facility and care of mass casualties ~~in accordance with Appendix A, Reference 9.~~

B. The plan shall provide for widespread disasters as well as for disaster occurring within the local community and hospital facility.

C. The disaster plan shall be rehearsed at least twice a year preferably as part of a coordinated drill in which other community emergency service agencies participate. Written reports and evaluation of all drills shall be maintained for at least two years.

D. A copy of the plan and any revision thereto shall be made available to the licensing agency upon request.

12 VAC 5-410-280. Emergency service.

A. Hospitals with an emergency department/service shall have 24-hour staff coverage and shall have at least one physician on call at all times. Hospitals without emergency service shall have written policies governing the handling of emergencies.

B. No less than one registered nurse shall be assigned to the emergency service on each shift. Such assignment need not be exclusive of other duties, but must have priority over all other assignments.

C. Those hospitals ~~which make provisions for Mobile Intensive Care manned by technical personnel that provide ambulance services~~ shall comply with the requirements of Appendix A, Reference 3 Article 2.1 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia and 12 VAC 5-31.

D. The hospital shall provide equipment, drugs, supplies, and ancillary services commensurate with the scope of anticipated needs, including radiology and laboratory services and facilities for handling and administering of blood and blood products. Emergency drugs and equipment shall remain accessible in the emergency department at all times.

E. Current roster of medical staff members on emergency call, including alternates and medical specialists or consultants shall be posted in the emergency department.

F. Hospitals shall make special training available, as required, for emergency department personnel.

G. Toxicology reference material and poison antidote information shall be available along with telephone numbers of the nearest poison control centers.

12 VAC 5-410-290. Laboratory service; general.

A. The director of laboratory service shall be a physician member of the medical staff. If the physician director of laboratory service is not a pathologist, a pathologist shall be retained on a consultant basis.

When the pathologist provides services only on a consultative basis, these services shall be provided at least on a monthly basis. A written evaluation report with recommendations to the medical staff and administration shall be provided by the consultant pathologist on a monthly basis.

B. Laboratories shall have adequate space, equipment, and supplies, and shall be operated ~~in accordance with Appendix A, Reference 4~~ according to 42 CFR Part 493.

C. Provisions shall be made to assure continuous availability of emergency laboratory services.

12 VAC 5-410-340. Blood banks and transfusion services.

A. If the hospital provides facilities for the procurement, extraction and collection of blood and blood products, written policies and procedures for all phases of operation of blood banks and transfusion services shall be established and periodically revised to comply with ~~standards of Appendix A, Reference 5~~ 42 CFR Part 493, 42 CFR 482.27 and 21 CFR Part 606.

B. Each hospital shall provide appropriate facilities and equipment for the storage and administration of whole blood and blood products.

C. For emergency situations, the hospital shall:

1. Make arrangements by which blood can be quickly obtained from community blood sources, or maintain an up-to-date list of available donors, as well as provide the equipment and personnel and obtain blood from the donor; or
2. Maintain a minimum supply of O negative blood, if the hospital provides obstetrical services.

12 VAC 5-410-350. Isolation of special microorganisms.

When a hospital diagnostic laboratory isolates from clinical, pathological or environmental specimens, any one of the special micro-organisms listed in ~~Appendix A, Reference 11,~~

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~~the original culture or a subculture shall be submitted to the State Laboratory for confirmation and further specific identification, accompanied by data identifying the patient and attending physician 12 VAC 5-90-80, it shall be reported as required pursuant to 12 VAC 5-90.~~

12 VAC 5-410-360. Nuclear medicine.

Every hospital ~~which~~ *that* maintains a nuclear medicine service within the institution or through contractual arrangements shall ensure that it is under the medical supervision of a physician who ~~meets the educational and experience qualifications~~ *is a designated authorized user of isotopes licensed by the Nuclear Regulatory Commission or the Office of Radiologic Health of the Department of Health as required by the medical staff bylaws* 12 VAC 5-480.

1. There shall be quality control procedures governing nuclear medicine services to ensure diagnostic reliability and therapeutic effectiveness.
2. Records of diagnostic or therapeutic services shall be incorporated in the patient's medical record.

12 VAC 5-410-370. Medical records.

A. The medical record department shall be staffed and equipped to facilitate the accurate processing, checking, indexing, filing and retrieval of all medical records.

B. A medical record shall be established and maintained for every person treated on an inpatient, outpatient (ambulatory) or emergency basis, in any unit of the hospital. The record shall be available to all other units.

A separate medical record shall be maintained for each newborn infant. Entered on the chart of the newborn shall be notes of gestational history, including any pathology and information regarding complications of delivery and mother's medication during labor and delivery.

C. Written policies and procedures shall be established regarding content and completion of medical records.

D. Entries in the medical record shall be made by the responsible person in accordance with hospital policies and procedures.

~~E. The content of all medical records (inpatient, outpatient, ambulatory, and emergency) shall conform with applicable standards of Appendix A, Reference 6.~~

F. ~~Medical records shall be kept confidential and:~~

- ~~1. Only authorized personnel shall have access to the records.~~
- ~~2. The hospital shall release copies of a patient's medical record only with the written consent of:~~
 - ~~a. The patient; or~~
 - ~~b. The legal representative; or~~
 - ~~c. If a minor, parent, guardian, or legal representative; or~~
 - ~~d. Duly authorized state or federal health authorities or others as specifically authorized by the Code of Virginia or federal statutes.~~

~~3. The hospital's permanent records may be removed from the hospital's jurisdiction only in accordance with a court order, subpoena or statute.~~

~~G. E. Provisions shall be made for the safe storage of medical records or accurate and legible reproductions thereof in accordance with Appendix A, Reference 6 according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act, or HIPPA (42 USC § 1320d et seq.).~~

~~H. F. All medical records either original or accurate reproductions shall be preserved for a minimum of five years following discharge of the patient.~~

- ~~1. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.~~
- ~~2. Birth and death information shall be retained for 10 years in accordance with § 32.1-274 of the Code of Virginia.~~

12 VAC 5-410-380. Nursing service.

A. Each hospital shall have an organized nursing department. A registered nurse qualified on the basis of education, experience and clinical ability shall be responsible for the direction of nursing care provided the patients.

B. The number and type of nursing personnel on all shifts shall be based upon the needs of the patients and the capabilities of the nursing staff assigned to the patient care unit. All registered nurses and licensed practical nurses shall ~~be currently registered or licensed by the Virginia Board of Nursing~~ *hold a current license issued by the Virginia Board of Nursing or a current multistate licensure privilege to practice nursing in Virginia.*

~~C. All nursing services shall be directly provided by an appropriately qualified registered nurse or licensed practical nurse, except for those nursing tasks that may be delegated by a registered nurse according to 18 VAC 90-20-420 through 18 VAC 90-20-460 of the regulation of the Virginia Board of Nursing with a plan developed and implemented by the hospital.~~

~~G. D. Nursing personnel shall be assigned to patient care units in a manner that minimizes the risk of cross infection and accidental contamination.~~

12 VAC 5-410-390. Pharmaceutical service.

A. Each hospital shall provide pharmaceutical services under the direction of a pharmacist licensed ~~in Virginia in accordance with the regulations of~~ *by the Virginia Board of Pharmacy.*

~~B. There shall be evidence of a current pharmacy license in compliance with the standards of the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) pursuant to Chapter 33 (§ 54.1-3300 et seq.) of Title 54.1 of the Code of Virginia and 18 VAC 110-20.~~

~~B. A program for the control of all drugs throughout the hospital shall be established under the supervision of the director of pharmaceutical services and shall contain policies and procedures pertaining to no less than the following:~~

- ~~1. The authority, responsibilities and duties of the director of pharmaceutical services;~~
- ~~2. Compliance with federal and state laws for the storage, dispensing, administration and disposal of all drugs;~~
- ~~3. The selection, distribution, administration, and storage of drugs;~~
- ~~4. Maintenance of records of all transactions; and~~
- ~~5. Inspection of all drug storage and medication areas and documented evidence of findings.~~

~~C. In addition to the above, the medical staff in cooperation with the pharmacist and other disciplines shall develop policies and procedures relating to:~~

- ~~1. An approved drug list or formulary and exceptions thereto;~~
- ~~2. Emergency access to drugs in the pharmacist's absence;~~
- ~~3. Control of patient medication from any source; and~~
- ~~4. Monitoring program to identify adverse drug reactions.~~

~~D. C. Each hospital shall obtain a criminal history record check pursuant to § 32.1-126.02 of the Code of Virginia on any compensated employee, not licensed by the Board of Pharmacy, whose job duties provide access to controlled substances with the hospital pharmacy.~~

12 VAC 5-410-442. Obstetric service design and equipment criteria.

~~A. In addition to complying with Article 5 of this part, a hospital shall comply with the following requirements of this section for the physical design of obstetric service facilities. Existing hospitals with licensed obstetric and newborn services in operation prior to the effective date of the regulations or revisions thereof, shall comply with all of the regulations of this section with the exception of the minimum dimension and square footage requirements for labor rooms and LDR/LDRP rooms provided for in subdivisions B-5, 6 and 9 of this section. Existing hospitals with an obstetric service may not decrease the dimensions of the labor rooms and the LDR/LDRP rooms from what was granted approval at the time the service was licensed. *Renovation or construction of a hospital's obstetric unit shall be consistent with section 7.8 of the 2001 Guidelines for Design and Construction of Hospital and Health Care Facilities of the American Institute of Architects.*~~

~~B. Labor rooms and LDR/LDRP rooms that are renovated or constructed after the effective date of this chapter shall conform with all of the room dimensions specified in this section.:~~

- ~~1. The space and arrangement of a hospital building or a section of the hospital designated as the obstetric unit (antepartum and postpartum) shall be designed to assure the separation of obstetric patients from other patients with the exception of clean gynecological patients. Clean gynecological patients shall be defined in approved written hospital policy.~~

~~2. The hospital shall identify specific rooms and beds as obstetric rooms and beds. Adjacent rooms and beds may be used for clean gynecological cases.~~

~~3. Labor, delivery, recovery and labor, delivery, recovery and postpartum rooms shall be physically separate from emergency and operating rooms.~~

~~4. The obstetric nursing unit shall meet the requirements of 12 VAC 5-410-750 A except for the following:~~

- ~~a. A handwashing lavatory must be provided in each patient room;~~
- ~~b. The soiled workroom and janitors' closet in the obstetric nursing unit shall only be shared with the newborn services unit; and~~
- ~~c. All bathing facilities shall be showers or tub units with showers.~~

~~5. Labor rooms shall be single bed or two bed rooms with a minimum clear area of 180 square feet for each bed.~~

~~6. In hospitals having only one delivery room, two labor rooms shall be provided. One labor room shall be large enough to function as an emergency delivery room with a minimum of 300 square feet (27.87 sq. m). Each room shall have at least two oxygen and two wall mount suction outlets. Hospitals must equip a labor room with the same equipment as a delivery room if it is to be used as a delivery room. Each labor room shall contain a handwashing lavatory. Each labor room shall have access to a toilet room. One toilet room may serve two labor rooms. At least one shower shall be provided for labor room patients. A water closet shall be accessible to the shower without patients having to enter a corridor or general area.~~

~~7. The delivery room shall have a minimum clear area of 300 square feet (27.87 sq. m) exclusive of fixed and movable cabinets and shelves. The minimum dimensions shall be 16'0" (4.88 m) in any direction between two walls. Separate resuscitation facilities (electrical outlets, oxygen, suction, and compressed air) shall be provided for newborn infants.~~

~~8. The recovery room shall contain a minimum of two beds, charting facilities located to permit staff to have visual control of all beds, facilities for medicine dispensing, handwashing facilities, a clinical sink with a bedpan flushing device, and storage for supplies and equipment.~~

~~9. Hospitals that include birthing LDR/LDRP rooms in their obstetrical program shall designate room(s) within the labor suite for this purpose. Birthing LDR/LDRP rooms shall be designed to prohibit unrelated traffic through the labor and delivery suite and to be readily accessible to delivery rooms and operating rooms. Birthing LDR/LDRP rooms shall meet the requirements of labor rooms which may be used as emergency delivery rooms as specified in 12 VAC 5-410-830 D. The minimum dimensions shall be 16'0" (4.88 m) clear between walls or fixed cabinets or shelving and shall have a clear area of 300 square feet (27.87 sq. m). Each LDR/LDRP room shall have a private water closet, shower, and handwashing lavatory.~~

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~~10. When specified in this subsection, service areas shall be located in individual rooms. Alcoves or other open spaces that do not interfere with traffic may be used unless individual rooms are specified. Service areas, except the soiled workroom and the janitors' closet, may be shared within the obstetrical unit. If shared, service areas shall be arranged to avoid direct traffic between the delivery and operating rooms. The following service areas shall be provided:~~

~~a. A control station that is located to permit visual surveillance of all traffic that enters the labor and delivery suite;~~

~~b. A supervisor's office or station;~~

~~c. Sterilizing facilities with high speed autoclaves conveniently located to serve all delivery rooms. If provisions have been made for the replacement of sterile instruments during a delivery, sterilizing facilities will not be required;~~

~~d. A drug distribution station equipped for storage, preparation, and dispensing of medication;~~

~~e. At least two scrub stations located near the entrance to each delivery room. Two scrub stations may serve two delivery rooms if the stations are located adjacent to the entrance to each delivery room. Scrub facilities shall be arranged to minimize any incidental splatter on nearby personnel or supply carts;~~

~~f. A soiled workroom for the exclusive use of the labor and delivery room personnel. The workroom shall contain a clinical sink or equivalent flushing type fixture, a work counter, a handwashing lavatory, a waste receptacle and a linen receptacle;~~

~~g. Fluid waste disposal facilities conveniently located to the delivery rooms. A clinical sink or equivalent equipment in a soiled workroom or soiled holding room may meet this requirement;~~

~~h. A clean workroom that contains a work counter, handwashing lavatory, and space for clean and sterile supplies;~~

~~i. Anesthesia storage facilities. Unless official hospital board action, in writing, prohibits use of flammable anesthetics, a separate room shall be provided for storage of flammable gases in accordance with the requirements detailed in NFPA 99 and NFPA 70;~~

~~j. An anesthesia workroom for cleaning, testing, and storing anesthesia equipment. The workroom shall contain a work counter and sink;~~

~~k. A space for reserve storage of nitrous oxide and oxygen cylinders;~~

~~l. Storage rooms for equipment and supplies used in the labor and delivery suite;~~

~~m. Staff's clothing change areas for personnel working within the labor and delivery suite. The areas shall contain lockers, showers, toilets, handwashing lavatories, and space for donning scrub suits and boots;~~

~~n. Lounge and toilet facilities for obstetrical staff shall be provided near the labor rooms and recovery room(s);~~

~~o. A janitors' closet containing a floor receptor or service sink and storage for housekeeping supplies and equipment. The closet may be shared only with the newborn services unit; and~~

~~p. A stretcher storage area that is out of direct line of traffic.~~

~~C. Equipment requirements shall include:~~

~~4. B. Delivery rooms, LDR/LDRP rooms, and nurseries shall be equipped to provide emergency resuscitation for mothers and infants.~~

~~2. C. Equipment and supplies shall be assigned for exclusive use in the obstetric and newborn units.~~

~~3. D. The same equipment and supplies required for the labor room and delivery room shall be available for use in the LDR/LDRP rooms during periods of labor, delivery, and recovery.~~

~~4. E. Sterilizing equipment shall be available in the obstetric unit or in a central sterilizing department. Flash sterilizing equipment or sterile supplies and instruments shall be provided in the obstetric unit.~~

~~5. F. Daily monitoring is required of the stock of necessary equipment in the labor, delivery, and recovery rooms (LDR) and labor, delivery, recovery and postpartum (LDRP) rooms and nursery.~~

~~6. G. The hospital shall provide the following equipment in the labor, delivery and recovery rooms and, except where noted, in the LDR/LDRP rooms:~~

~~a. 1. Labor rooms.~~

~~(1) a. A labor or birthing bed with adjustable side rails.~~

~~(2) b. Adjustable lighting adequate for the examination of patients.~~

~~(3) c. An emergency signal and intercommunication system.~~

~~(4) d. A sphygmomanometer, stethoscope and fetoscope or doppler.~~

~~(5) e. Fetal monitoring equipment with internal and external attachments.~~

~~(6) f. Mechanical infusion equipment.~~

~~(7) g. Wall-mounted oxygen and suction outlets.~~

~~(8) h. Storage equipment.~~

~~(9) i. Sterile equipment for emergency delivery to include at least one clamp and suction bulb.~~

~~(10) j. Neonatal resuscitation cart.~~

~~b. 2. Delivery rooms.~~

~~(1) a. A delivery room table that allows variation in positions for delivery. This equipment is not required for the LDR/LDRP rooms.~~

- ~~(2)~~ *b.* Adequate lighting for vaginal deliveries or cesarean deliveries.
 - ~~(3)~~ *c.* Sterile instruments, equipment, and supplies to include sterile uterine packs for vaginal deliveries or cesarean deliveries, episiotomies or laceration repairs, postpartum sterilizations and cesarean hysterectomies.
 - ~~(4)~~ *d.* Continuous in-wall oxygen source and suction outlets for both mother and infant.
 - ~~(5)~~ *e.* Equipment for inhalation and regional anesthesia. This equipment is not required for LDR/LDRP rooms.
 - ~~(6)~~ *f.* A heated, temperature-controlled infant examination and resuscitation unit.
 - ~~(7)~~ *g.* An emergency call system.
 - ~~(8)~~ *h.* Plastic pharyngeal airways, adult and newborn sizes.
 - ~~(9)~~ *i.* Laryngoscope and endotracheal tubes, adult and newborn sizes.
 - ~~(10)~~ *j.* A self-inflating bag with manometer and adult and newborn masks that can deliver 100% oxygen.
 - ~~(11)~~ *k.* Separate cardiopulmonary crash carts for mothers and infants.
 - ~~(12)~~ *l.* Sphygmomanometer.
 - ~~(13)~~ *m.* Cardiac monitor. This equipment is not required for the LDR/LDRP rooms.
 - ~~(14)~~ *n.* Gavage tubes.
 - ~~(15)~~ *o.* Umbilical vessel catheterization trays. This equipment is not required for LDR/LDRP rooms.
 - ~~(16)~~ *p.* Equipment that provides a source of continuous suction for aspiration of the pharynx and stomach.
 - ~~(17)~~ *q.* Stethoscope.
 - ~~(18)~~ *r.* Fetoscope.
 - ~~(19)~~ *s.* Intravenous solutions and equipment.
 - ~~(20)~~ *t.* Wall clock with a second hand.
 - ~~(21)~~ *u.* Heated bassinets equipped with oxygen and transport incubator.
 - ~~(22)~~ *v.* Neonatal resuscitation cart.
- e- 3. Recovery rooms.
- ~~(1)~~ *a.* Beds with side rails.
 - ~~(2)~~ *b.* Adequate lighting.
 - ~~(3)~~ *c.* Bedside stands, overbed tables, or fixed shelving.
 - ~~(4)~~ *d.* An emergency call signal.
 - ~~(5)~~ *e.* Equipment necessary for a complete physical examination.
 - ~~(6)~~ *f.* Accessible oxygen and suction equipment.

12 VAC 5-410-444. Newborn service medical direction; physician consultation and coverage; nursing direction, nurse staffing and coverage; policies and procedures.

A. The governing body shall appoint a physician as medical director of the organized newborn service who meets the qualifications specified in the medical staff bylaws. In addition, the medical director must meet the qualifications specified for the medical direction of the highest level of newborn service provided by the hospital.

1. If a hospital offers only general level newborn services, the medical director shall be a physician qualified to provide normal newborn care, including the ability to immediately resuscitate and stabilize a sick newborn for transfer to a higher level of service.
2. If a hospital offers intermediate level newborn services, the medical director shall be a board-certified or board-eligible pediatrician with training and experience in the care of preterm neonates, including stabilization and ventilation management.
3. If a hospital offers specialty level newborn services, the medical director shall be a board-certified or board-eligible neonatologist.
4. If a hospital offers subspecialty level newborn services, the medical director shall be a board-certified or board-eligible neonatologist.

B. The duties and responsibilities of the medical directors of all levels of newborn service shall include, but not be limited to the:

1. General supervision of the quality of care provided patients admitted to the service;
2. Establishment of criteria for admission to the service;
3. Adherence of the service to standards of professional practices, policies and procedures, the medical protocol, and the hospital's collaboration agreements adopted by the medical staff and governing body applicable to the service;
4. Development of recommendations to the medical staff on standards of professional practice and staff privileges applicable to the service;
5. Identification of clinical conditions and medical and surgical procedures that require physician consultation;
6. Conducting conferences, at least quarterly, to review routine and emergency surgical procedures, complications and infant and maternal mortality and morbidity. Infant mortality and morbidity shall be discussed with the obstetric service staff; and
7. Active participation in the service's quality assurance program.

C. The hospital shall provide the following physician consultation and coverage in the general level newborn nursery service and all higher level nursery services unless unique requirements are specifically imposed for the higher level nursery services:

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- D. 1. A physician with pediatric privileges capable of arriving on-site within 30 minutes of notification shall be on the 24-hour on-call duty roster;
- E. 2. A physician or nurse skilled in neonatal cardiopulmonary resuscitation (CPR) shall be available in the hospital at all times .
- F. 3. A current roster of physicians, with a delineation of their newborn, pediatric, medical and surgical privileges shall be posted at each nurses' station in the newborn service unit.
- G. 4. A copy of the 24-hour on-call duty schedule, including a list of on-call consulting physicians, shall be posted at each nurses' station in the newborn service unit.
- H. 5. If the medical director is not a board-certified or board-eligible pediatrician, the hospital shall have a written agreement with one or more board-certified or board-eligible pediatricians to be available to provide consultation on a 24-hour basis. Consultation may be by telephone.
- I. 6. If a hospital does not have a neonatologist on staff available on a 24-hour basis, it shall have a written agreement with another hospital to provide consultation, at least by telephone, on a 24-hour basis, by a board-certified or board-eligible neonatologist. The consultant shall be available to advise on the development of a protocol for the care and transport of sick newborns.
- J. The physician consultation and coverage for the intermediate level newborn nursery service shall be the same as the general level newborn service with the following exceptions:
1. ~~Subdivision~~ *Subsection C 4* of this section shall not apply.
 2. Physician coverage shall be provided on a 24-hour on-call basis by a board-certified or board-eligible pediatrician or pediatricians capable of arriving on-site within 30 minutes of notification.
- K. The physician consultation and coverage for the specialty level and the subspecialty level newborn services shall be the same as for the lower level newborn services with the following exceptions:
1. ~~Subdivision~~ *Subsection C 4* of this section shall not apply.
 2. In-house physician consultation and coverage shall be provided 24 hours a day by a:
 - a. Board-certified or board-eligible neonatologist;
 - b. Board-certified or board-eligible pediatrician;
 - c. Second year or higher level pediatric resident; or
 - d. Neonatal nurse practitioner.
 3. Whenever in-house coverage is provided as stated in subdivision 2 b, c, or d of this subsection, a board-certified or board-eligible neonatologist shall be on-call and available to be on-site within 20 minutes of request.
- L. The nursing direction, staff and coverage required for the general level newborn service shall be as follows:
1. The neonatal nursing program shall be under the direction of a registered nurse.
 2. The nursing director's responsibilities shall include, but not be limited to:
 - a. Directing neonatal nursing services;
 - b. Guiding the development and implementation of neonatal nursing policies and procedures;
 - c. Collaborating with the medical staff; and
 - d. Consulting with referral hospitals with which a hospital has transfer agreements applicable to the service or services.
 3. Each occupied unit of the newborn service shall be under the direct supervision of a registered nurse 24 hours a day. The registered nurse shall have documented competence in neonatal nursing appropriate to the level of service provided.
 4. If a general level newborn nursery is organized as a separate nursing unit, staffing shall be based on a formula of a minimum of one nursing personnel to every eight newborns. Staffing shall include at least one registered nurse for the unit for each duty shift to provide direct supervision for nursing care.
 5. If the postpartum and general level newborn units are organized as combined rooming-in or modified rooming-in units, staffing shall be based on a formula of one nursing personnel for every four mother-baby units. The rooming-in units shall always be staffed with no less than two nursing personnel assigned to each shift. One of the two nursing personnel shall be a registered nurse to provide direct supervision of nursing care.
 6. When infants are present in the nursery, at least one nursing personnel trained in the care of newborn infants, with duties restricted to the care of the infants, shall be assigned to the nursery at all times. This nursing personnel is in addition to the registered nurse who is required to provide supervision.
 7. To ensure adequate nursing staff for the nursery for normal newborns, duty schedules shall be developed and actual shift staffing shall occur according to the following minimum nurse to patient ratios:
 - a. 1:4 Recently born infants and those needing close observation.
 - b. 1:8 Newborns needing only routine care.
 - c. 1:4 Mother-newborn routine care.
 8. Student nurses, licensed practical nurses and nursing aides who assist in the nursing care of newborn infants shall be under the direct supervision of a registered nurse.
 9. At least one nurse on each shift who is skilled in neonatal cardiopulmonary resuscitation must be immediately available to the nursery.

10. All nursing personnel assigned to the newborn service shall have orientation to the nursery, including orientation to patient care appropriate for the service level provided.

M. The nursing direction, staff and coverage required of the intermediate level newborn service shall be the same as required of the general level newborn service with the following exceptions:

1. To ensure adequate nursing staff for the nursery, duty schedules shall be developed and actual shift staffing shall occur according to a ratio of at least one nurse to four neonates.

2. All registered nurses assigned to the newborn service shall be trained in neonatal cardiopulmonary resuscitation (CPR).

N. The nursing direction, staff and coverage for the specialty level newborn service shall be the same as the lower level newborn service levels with the following exceptions:

1. The newborn nursery service shall have a nurse manager. The nurse manager shall be a registered nurse with advanced training and experience in the nursing management of high-risk neonates and their families. The responsibilities of the nurse manager shall include, but not be limited to:

- a. Daily management of the nursery;
- b. Supervision and evaluation of nursing personnel assigned to the nursery;
- c. Assuring nursing coverage 24 hours a day; and
- d. Implementing nursing policies and procedures at the service level.

2. All registered nurses shall have advanced training and experience in the management of neonatal patients, including specialized care technology and ventilator care for neonates. Only registered nurses with this advanced training and experience shall be assigned to care for neonates on ventilators.

3. To ensure adequate nursing staff for the nursery, duty schedules shall be developed and actual shift staffing shall occur according to a ratio of at least one nurse to three patients for neonates requiring specialty level care. For those neonates who have been assessed as no longer needing specialty level care, nurse to patient ratios shall be according to the neonate's appropriate level of service.

O. The nursing direction, staff and coverage for the subspecialty level newborn service shall be the same as all lower levels of newborn services with the following exceptions:

1. A neonatal clinical nurse specialist shall be assigned to the nursery, duties and responsibilities shall include staff consultation, collaboration, and teaching.

2. All registered nurses shall have advanced training and experience, beyond what is required of nurses in the lower level nurseries, in the management of high-risk neonates, including the care of unstable neonates with multisystem problems.

3. To ensure adequate nursing staff for the nursery, duty schedules shall be developed and actual shift staffing shall occur according to the following minimum nurse to patient ratios for neonates requiring subspecialty level care:

- a. 1:2 Neonates requiring subspecialty level care; and
- b. 1:1 Neonates requiring multisystem support.

For those neonates who have been assessed as no longer needing subspecialty level care, nurse to patient ratios shall be according to the neonate's appropriate level of service.

4. All nursing patient care shall be provided by registered nurses assigned to the subspecialty level nursery.

P. The governing body shall adopt written policies and procedures approved by the medical and nursing staff of the service, for the medical care of newborns.

Q. The policies and procedures for the general level nursery and all higher levels of newborn services shall include, but not be limited to:

1. Medical criteria for the identification of high-risk neonatal patients.

2. Protocols for the management of all neonatal medical conditions that are routinely managed by the service as well as protocols for the stabilization and transfer of neonates that require a higher level of newborn service. These protocols shall be maintained in the nursery in addition to the telephone numbers of each nursery and the names of each referral newborn service medical director.

3. Written collaboration agreements with hospitals with higher levels of newborn services. A hospital may enter into more than one collaboration agreement. The collaboration agreements shall specifically identify those medical conditions that require consultation and may necessitate a neonatal transfer as well as the interim treatment required prior to transfer. Nothing in the regulation shall require a birth hospital to enter into a collaboration agreement with a referral hospital that disagrees with the medical, consultation and transfer protocols adopted by the birth hospital. All neonatal transfers shall conform with Section 1867 of the Social Security Act, its amendments in force to date and implementing regulations. At the time of any transfer, the medical treatment at the referral hospital shall outweigh the risks to the neonate from affecting the transfer. The collaboration agreements shall include, but not be limited to:

- a. Criteria for neonatal transfer to the referral nursery;
- b. Procedures for neonatal transport;
- c. Back transfer criteria which provides for the return of the neonate to the referring hospital when medically appropriate;
- d. Annual review by both parties of all cases of neonatal transfer;
- e. Annual review by both parties of the collaboration agreements; and

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- f. Annual evaluation by both parties of the collaboration agreement and modification of the agreement, as necessary, as indicated by the evaluation results.
4. Establishment and maintenance of an ongoing, documented quality assurance program by the service that utilizes a multidisciplinary team of health practitioners and administrators for review and is integrated with the hospital's overall quality assurance program.
- a. The quality assurance program shall include:
- (1) Problem identification;
 - (2) Action plans;
 - (3) Evaluation; and
 - (4) Follow-up.
- b. The quality assurance program shall include an annual review of the following:
- (1) Neonatal transfer cases;
 - (2) Management of in-house neonatal cases; and
 - (3) Staff in-house inservice programs.
- c. Outcome statistics, including morbidity, mortality, and the appropriateness of neonatal transfers, shall be compiled in a standardized manner and reviewed quarterly by a multidisciplinary committee.
5. Immediate resuscitation and stabilization of the sick neonate in accordance with current cardiopulmonary resuscitation (CPR) standards of the American Heart Association and the American Academy of Pediatrics.
6. Care of newborns after delivery to include the following:
- a. Care of eyes, skin and umbilical cord and the provision of a single parenteral dose of Vitamin K-1, water soluble, as a prophylaxis against hemorrhagic disorder;
- b. Maintenance of the newborn's airway, respiration, and body temperature; and
- c. Assessment of the newborn and recording of the one-minute and five-minute Apgar scores.
7. Performance of prophylaxis against ophthalmia neonatorum by the administration of a 1.0% solution of silver nitrate aqueous solution, erythromycin, or tetracycline ointment or solution. This process is to be performed within one hour of delivery with documentation entered in the newborn's medical record. The process may be performed in the nursery.
8. Clamping or tying of the umbilical cord and, when indicated, collecting a sample of cord blood.
9. Performance of Rh type and Coombs' test for every newborn born to a Rh negative mother and performing major blood grouping and Coombs' tests when indicated for every newborn born to an O blood group mother or a mother with a family history of blood incompatibility. If such qualitative tests are performed, the results shall be documented in the newborn's medical record.
10. Identification and treatment of hyperbilirubinemia and hypoglycemia.
11. Identification of each newborn, prior to leaving the delivery room, with two identification bands fastened on the newborn and one identification band fastened on the mother. The newborn's medical record shall accompany the infant from the delivery room.
12. Newborn transport, within the hospital, of all newborns who are either premature or compromised by using a heated bassinet equipped with oxygen, a transport incubator or other similar equipment.
13. Registered nurse or physician assessment of a newborn within one hour after delivery and documentation of the assessment in the newborn's medical record. Assessment in the delivery area is permitted if the hospital permits a newborn and its mother to remain together during the immediate post-delivery period.
14. Delineation of how infants are to be monitored during stays with their mothers and under what circumstances infants must be taken to the nursery immediately after delivery and not allowed to remain with their mothers.
15. Physician examination of the newborn consistent with guidelines of the American Academy of Pediatrics. A high-risk newborn shall be examined upon admission to the nursery.
16. Ensuring that every bassinet and incubator in the nursery bears the identification of the newborn's last name, sex, date and time of birth, the mother's last name, and the attending physician's name.
17. The management of mothers who utilize breast milk with their newborns. Breast milk shall be collected in aseptic containers, dated, stored under refrigeration and consumed or disposed of within ~~24-48~~ 24-48 hours of collection if the breast milk has not been frozen. This policy pertains to breast milk collected while in the hospital or at home for hospital use.
18. Preparation and use of formula including, but not limited to:
- a. The distribution of feeding units immediately after assembly;
 - b. The use of prepared formula only within the time period designated on the package; and
 - c. The use of presterilized formula only, except in the case of facility-defined emergencies.
19. Screening newborns for risk factors associated with hearing impairment as required in §§ 32.1-64.1 and 32.1-64.2 of the Code of Virginia and in accordance with the regulations of the Board of Health governing the Virginia Hearing Impairment Identification and Monitoring System (12 VAC 5-80).
20. Screening and treatment of genetic, metabolic, and other diseases identifiable in the newborn period as specified in § 32.1-65 of the Code of Virginia and in

accordance with the Regulations Governing the Newborn Screening and Treatment Program (12 VAC 5-70).

21. Reporting to the Department of Health all required reportable congenital defects.

22. Visitor contact with the newborn, including newborns delivered by cesarean section, and premature, sick, congenitally malformed, and dying newborns.

23. Completion of birth certificates.

24. Discharge planning appropriate for the needs of the patient for at-risk infants. ~~The Virginia High Priority Infant Tracking Program Enrollment Form should be used as part of the discharge planning.~~

R. The additional policies and procedures required for the intermediate level newborn service shall include, but not be limited to:

1. Insertion and maintenance of peripheral intravenous lines and use of pediatric infusion pumps that are accurate to plus or minus one milliliter an hour;

2. Insertion and maintenance of umbilical arterial lines and the use of pediatric infusion pumps accurate to plus or minus one milliliter an hour;

3. Use of heated, humidified, and blended supplemental oxygen by hood with a recording of oxygen levels every hour using a calibrated constant oxygen analyzer. The policy shall address consultation with a higher level nursery identified in the collaboration agreement when oxygen levels exceed 40% and remain at 40% or greater for a period of four hours or more;

4. Administration of nasogastric or orogastric feedings;

5. Use of saturation monitor (pulse oximeter or equivalent) for any newborn requiring supplemental oxygen;

6. Use of assisted ventilation in preparation for transport;

7. Initiation of PgE1 prior to transport; and

8. Administration of blood components and a policy for provision of partial and total exchange transfusions.

S. The additional policies and procedures required for the specialty level newborn service shall include, but not be limited to:

1. Provision of ongoing assisted ventilation;

2. Administration of surfactant;

3. Preparation and administration of total parenteral nutrition (TPN);

4. Initiation and maintenance of pressor medications;

5. Provision for developmental follow up;

6. Insertion and maintenance of central umbilical arterial catheters or peripheral arterial lines with constant pressure monitoring;

7. Placement of chest tubes with water seal on an emergency basis;

8. Use of heated, humidified, and blended supplemental oxygen by hood with a recording of oxygen levels every hour using a calibrated constant oxygen analyzer;

9. Administration and maintenance of CPAP including the requirement for in-house physician coverage;

10. Daily availability of appropriate drug peak and trough assays on one milliliter or less of blood;

11. Cardioversion capability specific for newborns; and

12. Provision for ophthalmology consult and requirements regarding the examination of high-risk newborns.

T. The additional policies and procedures required for the subspecialty level newborn service shall include, but not be limited to:

1. Provision for returning patients to the operating room within 30 minutes, if indicated;

2. Provision for echocardiography evaluation;

3. Provision for patient treatment on an extracorporeal membrane oxygenator (ECMO) or a written collaboration agreement with a hospital with this capability;

4. Provision for maintenance of central venous pressure monitoring; and

5. Provision for the maintenance of neonates on prostaglandin E1 (PgE1).

12 VAC 5-410-445. Newborn service design and equipment criteria.

~~A. In addition to complying with 12 VAC 5-410-430 and 12 VAC 5-410-790, a hospital shall comply with the following physical design criteria for its newborn services: Construction and renovation of a hospital's nursery shall be consistent with section 7.4 of the 2001 Guidelines for Design and Construction of Hospital and Health Care Facilities of the American Institute of Architects.~~

~~1. The general level nursery design criteria are:~~

~~a. The newborn nursery shall be located adjacent to the obstetric nursing unit. The nursery must have adequate lighting and ventilation and be equipped to prevent direct drafts on infants. The temperature and humidity in the nursery shall be maintained at a level best suited for the protection of newborns as determined by the medical and nursing staff of the newborn service and as recommended by the American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) in the most current edition of Guidelines for Perinatal Care.~~

~~b. The nursery shall be designed to preclude unrelated traffic. Connecting nurseries shall have the capability to close the doors for infection control purposes.~~

~~c. Each nursery shall contain the following:~~

~~(1) One handwashing lavatory for every eight bassinets. Lavatories shall be equipped with wrist, knee or foot controls, soap dispenser and paper towel dispenser;~~

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- ~~(2) A nurses' emergency calling system that meets the requirements of 12 VAC 5-410-1130; and~~
- ~~(3) Glazed observation windows to permit infants to be viewed from public areas, from workrooms, and between adjacent nurseries.~~
- ~~d. There shall be a minimum of 24 square feet of floor area for each bassinets, exclusive of nonpatient areas, and a minimum of three feet (91 cm) between bassinets in the newborn nursery.~~
- ~~e. Each nursery shall contain no more than 16 infant stations in open bassinets, self-contained incubators, open radiant heat infant care systems, or combination thereof. When a rooming-in program is used, the total number of bassinets provided in the general level nursery may be appropriately reduced but the nursery may not be omitted. A hospital designed for 16 infant stations or less shall provide two rooms with eight infant stations so that a room is available to permit cohorting in the case of infection.~~
- ~~f. A special care area for infants requiring close observation or stabilization, such as those with low birth weight, is required in hospitals having 25 or more postpartum beds that do not have higher level nurseries. The minimum floor area for each infant station shall be 40 square feet (3.72 sq. m).~~
- ~~g. Each nursery shall be served by a connecting workroom. The workroom shall contain gowning facilities at the entrance for staff and personnel, work space with counter, refrigerator, storage space and handwashing lavatory which meets the requirements of 12 VAC 5-410-1090. One workroom may serve more than one nursery.~~
- ~~h. The examination and treatment room shall contain a work counter, storage, handwashing lavatory and charting facilities. This may be part of the workroom.~~
- ~~i. A closet for the use of the housekeeping staff in maintaining the nurseries shall be provided. It shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.~~
- ~~j. Lighting and wall finishes shall be sufficient to permit easy detection of jaundice and cyanosis. Shadow-free illumination with at least 100 foot candle intensity at the infant's level using fluorescent lamps with proper diffusers to prevent glare is required.~~
- ~~k. All incubators and electrical appliances used in nurseries shall be free from electrical hazards and approved by Underwriters Laboratories.~~
- ~~l. One grounded duplex electrical outlet shall be provided for every bassinets.~~
- ~~m. Task illumination and selected electrical outlets shall be on the hospital's emergency electrical system. In new construction, one outlet for each bassinets shall be on the hospital's emergency electrical system. Emergency electrical outlets shall be clearly marked. Outlets shall be checked at least monthly for safety and grounding.~~

- ~~n. An incubator shall be available and maintained for every 10, or fraction thereof, bassinets.~~
 - ~~o. Bassinets shall be equipped to allow for medical examinations of newborn infants and for storing necessary supplies and equipment. Bassinets shall be provided in a number to exceed obstetric beds by 25% at the minimum, to accommodate multiple births, extended stays, and fluctuating patient loads. Bassinets are to be separated by a minimum of three feet measuring from the edge of one bassinets to the edge of the adjacent bassinets.~~
 - ~~p. The hospital shall provide isolation facilities that follow universal precautions in accordance with its approved policies and procedures and the most recent editions of the Guidelines for Perinatal Care (AAP/ACOG) and the Control of Communicable Diseases in Man (American Public Health Association).~~
- ~~2. The intermediate level nursery design criteria are:~~
- ~~a. There shall be efficient and controlled access to the nursery from the labor and delivery area, the emergency room or other referral entry areas. The nursery shall be designed to preclude unrelated traffic.~~
 - ~~b. Lighting and wall finishes shall be sufficient to permit easy detection of jaundice and cyanosis. Shadow-free illumination with at least 100 foot candle intensity at the infant's level using fluorescent lamps with proper diffusers to prevent glare is required. The level of general lighting shall be adjustable to simulate day-night patterns and to satisfy diagnostic and procedural requirements.~~
 - ~~c. The temperature, humidity, and ventilation in the nursery shall be maintained at levels best suited for the protection of newborns as determined by the medical and nursing staff of the newborn service and as recommended by the American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) in the most current edition of Guidelines for Perinatal Care. The nursery must be equipped to prevent direct drafts on neonates.~~
 - ~~d. Each nursery shall contain the following:~~
 - ~~(1) One handwashing lavatory for at least every four patient stations. Lavatories shall be equipped with wrist, knee or foot controls, soap dispenser and paper towel dispenser; and~~
 - ~~(2) A nurses' emergency calling system that meets the requirements of 12 VAC 5-410-1130.~~
 - ~~e. Each nursery shall be served by a connecting workroom. The workroom shall contain gowning facilities at the entrance for staff and personnel, work space with counter, refrigerator, storage space and handwashing lavatory which meets the requirements of 12 VAC 5-410-1090 B. One workroom may serve more than one nursery.~~
 - ~~f. A closet for the use of the housekeeping staff in maintaining the nursery shall be provided. It shall contain~~

~~a floor receptor or service sink and storage space for housekeeping equipment and supplies.~~

~~g. All incubators and electrical appliances used in nurseries shall be free from electrical hazards and approved by Underwriters Laboratories.~~

~~h. Outlets shall be checked at least monthly for safety and grounding.~~

~~i. The hospital shall provide isolation facilities that follow universal precautions in accordance with its approved policies and procedures and the most recent editions of the Guidelines for Perinatal Care (AAP/ACOG) and the Control of Communicable Diseases in Man (American Public Health Association). Connecting nurseries shall have the capability to close the doors for infection control purposes.~~

~~j. All electrical outlets shall be connected to both regular and auxiliary power.~~

~~k. An additional outlet wired to accommodate a portable x-ray machine shall be available in each nursery.~~

~~l. The minimum floor area for each infant station in a nursery constructed or renovated after August 10, 1995, shall be 50 square feet (4.66 sq m) with a minimum of four feet between infant stations and aisles at least five feet wide.~~

~~m. At least eight electrical outlets, two oxygen outlets, two compressed air outlets and two suction outlets shall be provided for each infant station.~~

~~3. The specialty level and subspecialty level nurseries design criteria are:~~

~~a. The requirement of 12 VAC 5-410-445 A-2 a through k shall apply;~~

~~b. Nurseries constructed or renovated after August 10, 1995, shall have a minimum floor area for each infant station of 80 square feet with at least six feet between incubators or overhead warmers, and aisles at least eight feet wide.~~

~~e. Each infant station shall have a least 12 electrical outlets, two oxygen outlets, two compressed air outlets and two suction outlets.~~

B. The hospital shall provide the following equipment in the general level nursery and all higher level nurseries, unless additional equipment requirements are imposed for the higher level nurseries:

1. Resuscitation equipment as specified for the delivery room in 12 VAC 5-410-442 ~~C-6-b~~ G 2 shall be available in the nursery at all times;

2. Equipment for the delivery of 100% oxygen concentration, properly heated, blended, and humidified, with the ability to measure oxygen delivery in fractional inspired concentration (FI02). The oxygen analyzer shall be calibrated every eight hours and serviced according to the manufacturer's recommendations by a member of the hospital's respiratory therapy department or other responsible personnel trained to perform the task;

3. Saturation monitor (pulse oximeter or equivalent);

4. Equipment for monitoring blood glucose;

5. Infant scales;

6. Intravenous therapy equipment;

7. Equipment and supplies for the insertion of umbilical arterial and venous catheters;

8. Open bassinets, self-contained incubators, open radiant heat infant care system or any combination thereof appropriate to the service level;

9. Equipment for stabilization of a sick infant prior to transfer that includes a radiant heat source capable of maintaining an infant's body temperature at 99F;

10. Equipment for insertion of a thoracotomy tube; and

11. Equipment for proper administration and maintenance of phototherapy.

C. The additional equipment required for the intermediate level newborn service and for any higher service level is:

1. Pediatric infusion pumps accurate to plus or minus 1 milliliter (ml) per hour;

2. On-site supply of PgE1;

3. Equipment for 24-hour cardiorespiratory monitoring for neonatal use available for every incubator or radiant warmer;

4. Saturation monitor (pulse oximeter or equivalent) available for every infant given supplemental oxygen;

5. Portable x-ray machine; and

6. If a mechanical ventilator is selected to provide assisted ventilation prior to transport, it shall be approved for the use of neonates.

D. The additional equipment required for the specialty level newborn service and a higher newborn service is as follows:

1. Equipment for 24-hour cardiorespiratory monitoring with central blood pressure capability for each neonate with an arterial line;

2. Equipment necessary for ongoing assisted ventilation approved for neonatal use with on-line capabilities for monitoring airway pressure and ventilation performance;

3. Equipment and supplies necessary for insertion and maintenance of chest tube for drainage;

4. On-site supply of surfactant;

5. Computed axial tomography equipment (CAT) or magnetic resonance imaging equipment (MRI);

6. Equipment necessary for initiation and maintenance of continuous positive airway pressure (CPAP) with ability to constantly measure delineated pressures and including alarm for abnormal pressure (i.e., vent with PAP mode); and

7. Cardioversion unit with appropriate neonatal paddles and ability to deliver appropriate small watt discharges.

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E. The hospital shall document that it has the appropriate equipment necessary for any of the neonatal surgical and special procedures it provides that are specified in its medical protocol and that are required for the specialty level newborn service.

F. The additional equipment requirements for the subspecialty level newborn service are:

1. Equipment for emergency gastrointestinal, genitourinary, central nervous system, and sonographic studies available 24 hours a day;
2. Pediatric cardiac catheterization equipment;
3. Portable echocardiography equipment; and
4. Computed axial tomography equipment (CAT) and magnetic resonance imaging equipment (MRI).

G. The hospital shall document that it has the appropriate equipment necessary for any of the neonatal surgical and special procedures it provides that are specified in the medical protocol and are required for the subspecialty level newborn service.

12 VAC 5-410-450. Psychiatric service.

A. The psychiatric service shall be under the supervision of a physician, *licensed by the Board of Medicine*, who meets the qualifications of the medical staff bylaws.

B. Psychiatric units shall conform to the applicable licensure requirements ~~of the Department of Mental Health, Mental Retardation and Substance Abuse Services in accordance with Appendix A, Reference 15 pursuant to 12 VAC 35-105.~~

12 VAC 5-410-480. Housekeeping service.

A. Written housekeeping procedures shall be established for the cleaning of all areas in the hospital and copies posted in appropriate areas.

B. All parts of the hospital and its premises shall be kept clean, neat, and free of litter and rubbish.

C. Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe and sanitary condition.

D. Cleaning solutions and substances shall be labeled, stored in a safe place, and kept separate from food storage and patient care supplies.

E. Cleaning shall be performed in a manner which will minimize the spread of pathogenic organisms in the hospital atmosphere.

~~F. Exhaust ducts from kitchens and other cooking areas shall be equipped with proper filters and cleaned at regular intervals. The ducts shall be cleaned and inspected no less than twice a year.~~

12 VAC 5-410-490. Infection control.

A. Each hospital shall have an infection control committee to perform at least the following functions:

1. Establish a hospital-wide infection surveillance program and designate an infection control officer to conduct all

infection surveillance activities and to maintain appropriate records to include infection rates by body site and clinical service and all hospital acquired blood stream pathogens.

2. Establish written policies governing the admission and isolation, including protective isolation, of patients with known or suspected infectious diseases.

3. Develop, periodically evaluate, and revise as needed, infection control policies, procedures and techniques for all appropriate phases of hospital operation and service in order to protect patients, employees, and visitors. These policies shall include, but are not limited to, appropriate employee health screening and immunization and acceptable techniques and practices for high risk procedures such as parenteral hyperalimentation, urinary tract catheterization, dialysis, and intravenous therapy. ~~(Written advice and guidance is available in the "Guidance for Appropriate Communicable Disease and Employee Health Policies in General and Special Hospitals" provided by the Division of Epidemiology, Virginia Department of Health.)~~

B. An educational program on infection control for all appropriate personnel shall be conducted.

~~C. Reporting of diseases shall be as follows: 1. The hospital shall report promptly to the Virginia Department of Health through the local health department cases of disease designated as "reportable diseases" by the Board when such cases are admitted to or are diagnosed in the hospital in accordance with Appendix A, Reference 10. This obligation for reporting shall include all hospital outpatient care and emergency facilities. 2. The hospital shall report promptly to the Virginia Department of Health through the local health department in accordance with Appendix A, Reference 10, any outbreak of infectious disease, including nosocomial infections. The hospital shall report promptly to its local health department diseases designated as "reportable" according to 12 VAC 5-90-80 when such cases are admitted to or are diagnosed in the hospital and shall report any outbreak of infectious disease, including nosocomial infections, as required by 12 VAC 5-90. An outbreak shall be defined as an increase in incidence of any infectious disease above the usual incidence at the hospital.~~

~~3. In addition, two or more epidemiologically related infections, including, but not limited to, staphylococcus aureus, group A beta hemolytic streptococcus, and salmonella species occurring in the obstetrical or nursery units shall be reported to the Virginia Department of Health through the local health department.~~

~~D. Accumulated waste, including all contaminated sharps, dressings, or similar infectious waste, shall be disposed of in a manner compliant with the OSHA Bloodborne Pathogens standard (29 CFR 1910.1030).~~

12 VAC 5-410-500. Laundry service.

~~Each hospital shall make provisions for the safe and effective cleaning of all linens as follows:~~

~~4. A. Hospitals providing laundry service shall have adequate facilities and equipment for the safe and effective operation of such service. 2. There shall be distinct areas for the separate~~

~~storage and handling of clean and soiled linens. Those areas used for storage and handling of soiled linens shall be negatively pressurized. Those areas used for storage and handling of soiled linens shall be negatively pressurized or vented to the outside.~~

~~3. B. Special procedures shall be established for the handling and processing of contaminated linens.~~

~~4. C. All soiled linen shall be placed in closed containers prior to transportation.~~

~~5. D. To safeguard clean linens from cross-contamination, they shall be:~~

~~a. 1. Transported in containers used exclusively for clean linens unless such containers are routinely and regularly sanitized before use as a clean linen transport container and shall be kept covered at all times while in transit; and~~

~~b. 2. Stored in areas designated exclusively for this purpose.~~

~~Article 5.~~

~~Physical Plant Requirements for Existing Buildings.~~

~~12 VAC 5-410-510. General. (Repealed.)~~

~~Existing inpatient hospitals shall comply with the physical plant requirements in this section.~~

~~1. For purposes of this section an existing hospital is one which was licensed, or had approved final working drawings and specifications, or was under construction, prior to the effective date of this chapter.~~

~~2. Each hospital or part thereof shall be maintained and equipped in accordance with the codes and standards under which it was constructed to provide a functional, sanitary, safe and comfortable environment.~~

~~12 VAC 5-410-520. Fire and safety. (Repealed.)~~

~~Each hospital shall establish a monitoring program for the internal enforcement of all applicable fire and safety laws and regulations and such a program shall include written procedures for the implementation of said rules and regulations, and logs shall be maintained for at least two years.~~

~~12 VAC 5-410-530. Incinerators. (Repealed.)~~

~~A. Incinerators shall be designed, constructed and separated from other parts of the building in accordance with Appendix A, Reference 12.~~

~~B. Incinerators shall be approved by the Virginia Air Pollution Control Board.~~

~~12 VAC 5-410-540. Lighting and electrical services. (Repealed.)~~

~~A. Policies and procedures shall be established to minimize the hazards in the use and operation of all electrical equipment.~~

~~B. The standards of Appendix A, Reference 13 of this chapter shall serve as a guide to determine the lighting levels within each area of the hospital.~~

~~C. All electrical appliances used by hospitals shall have the Underwriters Laboratories' label or its equivalent.~~

~~D. An alternate source of electricity to serve critical areas in the event of power failure shall be provided. The emergency system shall be installed so that it is automatically activated in the event of failure of the major power source and shall be capable of providing at least 24 hours of uninterrupted light and power.~~

~~12 VAC 5-410-550. Plumbing. (Repealed.)~~

~~A. All plumbing material and plumbing systems or parts thereof shall meet the minimum requirements of Appendix A, Reference 13.~~

~~B. All plumbing shall be installed in such a manner as to prevent back siphonage or cross connections between potable and nonpotable water supplies.~~

~~12 VAC 5-410-560. Sewage disposal systems. (Repealed.)~~

~~All required sanitary waste piping systems shall be connected to an approved sewage system.~~

~~12 VAC 5-410-570. Waste disposal. (Repealed.)~~

~~Pathological and bacteriological wastes, dressings and other contaminated wastes shall be incinerated at the hospital or disposed of by other methods as approved by the licensing agency.~~

~~12 VAC 5-410-580. Water supply. (Repealed.)~~

~~A. Water shall be obtained from an approved water supply system.~~

~~B. The water shall be distributed to conveniently located taps and fixtures throughout the buildings and shall be adequate in volume and pressure for all hospital purposes, including fire fighting.~~

~~C. Plumbing fixtures which require hot water and which are intended for patients' use shall be supplied with water which is controlled to provide a maximum tap water temperature of 120°F at the fixture.~~

~~D. Hot water heaters and tanks shall be of sufficient capacity to supply the hot water needs for the entire facility at all times.~~

~~12 VAC 5-410-590. Heating system. (Repealed.)~~

~~The heating system shall be capable of maintaining a temperature of 75°F, uniformly throughout the patient areas. Space heaters or heaters of an open coil type shall not be used.~~

~~12 VAC 5-410-600. Ventilation system. (Repealed.)~~

~~The ventilation system shall be maintained functional at all times to change the air on a basis commensurate with the type of occupancy.~~

~~12 VAC 5-410-610. Patient rooms. (Repealed.)~~

~~A. All patient bedrooms shall be above ground level and shall have an operable window.~~

~~B. No room opening off the kitchen shall be used for patient care.~~

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~~C. Patients' rooms shall have at least 70 sq. ft. of floor area per bed in multi-bed rooms and 100 sq. ft. per bed in single-bed rooms. The usable space should provide for at least three feet between beds, three feet from the end of the bed to the wall and at least two feet six inches between the bed and the wall.~~

~~D. A nurses signaling device shall be provided at each patient's bedside and at all toilet bathing facilities used by patients.~~

12 VAC 5-410-620. Nursing units. (Repealed.)

The following services shall be provided for each unit:

- ~~1. A nurses station shall be provided with space for nurses desk and charting, a medicine preparation area with work counter and sink and a locked medication cabinet. The medication preparation shall be well ventilated.~~
- ~~2. At least one utility room divided into clean and soiled sections (unless separate clean and soiled utility rooms are provided).~~
- ~~3. A janitor's closet with at least a service sink or floor receptor. The janitor's closet shall be separate from any toilet or utility room.~~
- ~~4. Toilet, handwashing and bathing facilities shall be provided on each floor in a reasonable ratio according to the number and sex of patients and personnel.~~
- ~~5. General storage space to accommodate all required supplies and equipment shall be provided.~~
- ~~6. Corridors used by patients shall be maintained free and unobstructed to permit safe patient and personnel traffic.~~

12 VAC 5-410-630. Safety procedures. (Repealed.)

~~A. Safety precautions shall be maintained against electrical, mechanical and radiation hazards, as well as against fire and explosion in accordance with the standards of Appendix A, References 7 and 13.~~

~~B. All radiographic machines shall be registered with the Bureau of Radiological Health of the Virginia Department of Health. Installation, calibration and testing of machines and storage facilities shall conform to the requirements of Appendix A, Reference 7.~~

~~C. Monitoring of personnel and of areas shall be carried out through the use of appropriate measuring devices, and records shall be maintained of results of such monitoring in accordance with the standards of Appendix A, Reference 7.~~

12 VAC 5-410-640. Alteration of existing hospitals. (Repealed.)

~~A. Architectural drawings shall be submitted for such alterations in accordance with 12 VAC 5-410-720 of this chapter, and the project approved in writing by the department before the changes are made.~~

~~B. Alterations in existing hospitals shall not be undertaken unless the changes meet the applicable standards for new buildings in accordance with Part III of this chapter.~~

Article 1. Standards and Design Criteria.

12 VAC 5-410-650. General building and physical plant information.

~~A. The requirements set forth herein have been established under authority of §§ 32.1-127 and 32.1-132 of the Code of Virginia and constitute minimum requirements for designing, constructing, and equipping of hospitals built in Virginia after the effective date of this chapter. All construction of new buildings and additions, renovations, alterations or repairs of existing buildings for occupancy as a hospital shall conform to state and local codes, zoning and building ordinances, and the Uniform Statewide Building Code.~~

~~In addition, hospitals shall be designed and constructed according to sections 1 through 7 of the 2001 Guidelines for Design and Construction of Hospital and Health Care Facilities of the American Institute of Architects. However, the requirements of the Uniform Statewide Building Code and local zoning and building ordinances shall take precedence.~~

~~B. Additions, alterations or renovations to existing licensed hospitals or existing buildings to be occupied as a hospital shall conform to these minimum requirements, except where variances are granted by the Commissioner in accordance with 12 VAC 5-410-30 A of this chapter. All buildings shall be inspected and approved as required by the appropriate building regulatory entity. Approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose.~~

~~C. Conversions of existing buildings to hospital occupancy shall be considered only in those buildings which were originally constructed for institutional occupancy. Variances may be considered by the Commissioner in accordance with 12 VAC 5-410-30 A of this chapter provided patient care and safety to life from fire are not adversely affected by such variance.~~

~~D. Additions, alterations and renovations to existing buildings shall be programmed and phased so that on-site construction will minimize disruptions of existing patient care services. Access, exitways, and fire protection shall be maintained so that the safety of the occupants will not be jeopardized during construction.~~

12 VAC 5-410-655. Additional building regulations and standards.

~~A. The use of an incinerator shall require permitting from the nearest regional permitting office for the Department of Environmental Quality.~~

~~B. Water shall be obtained from an approved water supply system. Hospitals shall be connected to sewage systems approved by the Department of Health or the Department of Environmental Quality.~~

~~C. Each hospital shall establish a monitoring program for the internal enforcement of all applicable fire and safety laws and regulations.~~

~~D. All radiological machines shall be registered with the Office of Radiological Health of the Virginia Department of Health.~~

~~Installation, calibration and testing of machines and storage facilities shall comply with 12 VAC 5-480.~~

~~E. A hospital's food services operation shall comply with 12 VAC 5-421.~~

~~F. Hospital pharmacy services shall comply with Chapter 33 (§ 54.1-3300 et seq.) of Title 54.1 of the Code of Virginia and 18 VAC 110-20.~~

12 VAC 5-410-660. Codes and fire safety. (Repealed.)

~~All construction of new buildings and additions, renovations or alterations of existing buildings for occupancy as a hospital shall comply with the applicable sections of the following state and local codes:~~

- ~~1. Statewide Uniform Building Code, including the requirements of the Life Safety Code, National Fire Protection Association, #101, 1973 Edition; In matters regulated by both the Statewide Uniform Building Code and the Life Safety Code, the requirements of the Life Safety Code shall supersede the Statewide Uniform Building Code.~~
- ~~2. Rules and Regulations approved by the State Board of Health and the State Water Control Board governing sewage systems (12 VAC 5-580-10 et seq.).~~
- ~~3. Waterworks Regulations (12 VAC 5-590-10 et seq.) approved by the State Board of Health;~~
- ~~4. Solid Waste Management Regulations (9 VAC 20-80-10 et seq.) and Hazardous Waste Management Regulations (9 VAC 20-60-10 et seq.) approved by the Virginia Waste Management Board;~~
- ~~5. Local zoning housing and building ordinances.~~

12 VAC 5-410-670. Certification of medical care facilities. (Repealed.)

~~Under authority of § 32.1-137 of the Code of Virginia the board is the sole state agency of the Commonwealth authorized to enter into a contract with the United States government for the certification of medical facilities under Title XVIII of the Social Security Act or any amendments thereto.~~

12 VAC 5-410-680. Special design considerations for the handicapped. (Repealed.)

~~Special design features for the handicapped (patients, staff, and visitors) shall be provided for all hospitals. The following items are listed to emphasize some of these special design elements.~~

- ~~1. Walkways and curbs shall be planned to facilitate travel by people in wheelchairs, on crutches or walkers.~~
- ~~2. Signals, such as elevator calls, shall be both audible and visible. Elevator control buttons shall be accessible to wheelchair occupants.~~
- ~~3. Not less than 2.0% of all parking spaces (with a minimum of two spaces) shall be set aside for the handicapped.~~
- ~~4. Special design attention shall be given to the shielding of sharp projections, moving parts, and heated surfaces.~~

~~5. Drinking fountains, toilets, handwashing facilities and telephones shall be available for physically handicapped patients, staff, and visitors. At least one bathing facility, one handwashing lavatory, and one toilet on each nursing floor shall be provided for physically handicapped patients.~~

~~6. At least one primary grade level entrance to the building shall be arranged to be fully accessible to handicapped persons.~~

~~7. Provisions shall be made to identify each room and each floor for the visually handicapped, such as using raised letters or numerals at corridor doors and elevator entrances and controls.~~

~~8. All carpeting in areas subject to use by handicapped individuals shall be specified as high density, with a low, uncut pile. Underlayments are permissible provided they are specified as firm or hard and do not exceed 3/8 inches in depth. Carpets, and underlayments if used, shall be installed stretched taut and securely anchored at all edges to the floor to provide a minimum of resistance to wheelchair travel and to avoid tripping hazards.~~

12 VAC 5-410-690. Site requirements. (Repealed.)

~~A. The following shall be considered in selecting the site of any new hospital:~~

- ~~1. Easy access to the community and to service vehicles such as fire protection apparatus and other emergency vehicles.~~
- ~~2. The accessibility by public transportation.~~
- ~~3. Accessibility to professional personnel (physicians, nurses) and other employees.~~
- ~~4. Availability of water supply and sewage disposal services and facilities. The water supply system shall provide adequate capacity for domestic and fire protection systems.~~
- ~~5. To minimize flood damage, due consideration shall be given to possible flood effects when selecting and developing the site.~~

~~B. Paved roads shall be provided within the lot to provide access to the main entrance, emergency entrance, and to service entrances, including loading docks for delivery trucks. Hospitals which have an organized outpatient service shall have the outpatient entrance well marked to facilitate entry from the public roads or streets serving the site. Access to the emergency entrance shall not conflict with other vehicular traffic or pedestrian traffic. Paved walkways shall be provided for necessary pedestrian traffic.~~

~~C. Each hospital shall have parking space to satisfy the minimum needs of patients, employees, staff, and visitors. A minimum of two parking spaces per licensed bed may be used as a guideline. This ratio may be reduced in an area convenient to a public transportation system or to public parking facilities or where other arrangements to reduce traffic have been developed if justification is included in the narrative program and provided that approval of any reduction is obtained from the appropriate state or local agency. Additional parking may be required to accommodate outpatient and other~~

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services and space shall be provided for emergency and delivery vehicles.

~~D. The site and building shall be designed to minimize any adverse environmental effects on the neighborhood and community. All applicable Federal and State regulations pertaining to environmental pollution such as noise, air, and traffic must be met.~~

12 VAC 5-410-700. Equipment. (Repealed.)

~~A. All equipment necessary for the operation of the hospital as designed, shall be shown on the drawings or equipment list. The design shall provide for the installation and replacement of large and special items of equipment, and also make provision for the accessibility to service and maintenance of all fixed equipment.~~

~~B. Equipment which is not included in the construction contract but which requires mechanical or electrical service connections or construction modifications shall be so identified on the drawings to ensure coordination with the architectural, mechanical, and electrical phases of construction.~~

12 VAC 5-410-710. Record drawings and manuals. (Repealed.)

~~A. Upon completion of the contract, the hospital shall maintain a complete set of legible drawings showing all construction, fixed equipment, and mechanical and electrical systems, as installed or built.~~

~~B. The hospital shall maintain a complete set of installation, operation, and maintenance manuals for the installed equipment.~~

~~C. The hospital shall maintain complete design data of the building(s) including structural design loadings, summary of heat loss assumptions and calculations, estimated water consumption, and electric power requirements of installed equipment.~~

12 VAC 5-410-720. Drawings and specifications.

~~A. Architectural drawings and specifications for all new construction or for additions, alterations or renovations to any existing building shall be submitted to the licensing agency for review dated, stamped with licensure seal and signed by the architect. Construction shall not be commenced prior to approval by the office. The architect shall certify that the drawings and specifications were prepared to conform to building code requirements. The certification shall be forwarded to the center.~~

~~B. Architecture drawings and specifications and any revisions thereto shall be dated, stamped with licensure seal and signed by the architect. The architect shall certify that the drawings and specifications were prepared to conform to building code requirements. Additional approval may include a Certificate of Public Need.~~

~~C. Drawings for all proposed alterations shall be submitted to the licensing agency for approval. Minor alterations which do not affect the structural integrity of the building, fire safety, functional operation, or which do not increase capacity over that for which the hospital is licensed, may be freehand sketches or drawings. Maintenance and repairs routinely done~~

~~by the hospital do not require approval of the licensing agency, but shall be done in compliance with the applicable provisions of this chapter. Upon completion of the construction, the hospital shall maintain a complete set of legible "as built" drawings showing all construction, fixed equipment, and mechanical and electrical systems, as installed or built.~~

12 VAC 5-410-730. Construction inspections and certifications. (Repealed.)

~~A. The owner of a hospital shall notify the licensing agency in writing, not later than 10 days after the date construction is commenced; and also when stages of construction are 50%, 75% and 95% and on completion.~~

~~B. At the completion of construction the contractor shall certify, in writing, that the project was constructed to the requirements shown in the approved drawings and specifications. A copy of this certification must be forwarded to the licensing agency.~~

~~C. The architect shall issue a Certificate of Substantial Completion and prepare a final punch list prior to the final construction inspection by the licensing agency.~~

~~D. The hospital shall provide the licensing agency with a copy of certification of testing in accordance with applicable codes and standards for the emergency electrical system, medical gas system, isolated power systems, radiation protection, and elevators, when applicable.~~

12 VAC 5-410-740. General physical plant requirements. (Repealed.)

~~A. Hospitals shall conform to applicable sections of these physical plant requirements according to the proposed services to be provided.~~

~~B. The sizes of the space for various departments will depend upon program requirements and organization of service within the hospital. Some functions requiring separate spaces or rooms may be combined provided the resulting design will not compromise the best standards of safety and of medical and nursing practices.~~

~~C. Space for dietary, laundry, power plant, mechanical equipment, ambulance entrance, autopsy or morgue, loading dock, incinerator, garbage can cleaning and storage areas for garbage and trash shall be located or constructed in a manner that will minimize noise, steam, odors, hazard and unsightliness to patient bedrooms, dining rooms, and lounge areas.~~

12 VAC 5-410-750. Acute care nursing unit. (Repealed.)

~~A. Acute nursing units shall conform to the following:~~

~~1. Patient rooms, service rooms or service areas shall not be used as required corridors or passageways to other patient rooms, service areas or required exits.~~

~~2. Patient rooms shall be located no more than 120 feet (36.6m) from the nurses' station, the clean workroom or the soiled workroom.~~

~~3. All patient corridors in the nursing unit shall be visible from the nurses' station.~~

~~4. Where one or more walls of a court contain a door or window of one or more patient rooms, the least dimension of the court shall be 30 feet (9.14m) between facing structures. A court is defined as an open exterior space bounded on three or more sides by walls of a structure.~~

~~5. Corridors used by patients shall have a minimum width of 8 feet (2.44m). Handrails shall be mounted 33 inches (84cm) above the finished floor and shall have ends that return to the wall.~~

~~6. Night lights shall be provided in patient rooms.~~

~~B. Each patient room shall meet the following requirements:~~

~~1. Minimum room areas exclusive of toilet rooms, closets, columns or other projections shall be 100 square feet (9.29 sq. m) in single bed rooms and 80 square feet (7.43 sq. m) per bed in multi bed rooms. In multi bed rooms, a clearance of 3'8" (1.12m) shall be available at the foot of each bed to permit the passage of beds.~~

~~2. Each room shall have direct access to the patient corridor except that such access may be through an anteroom or vestibule.~~

~~3. Each room shall be provided with natural light as a primary source of light. Windows shall be openable from the inside, without the use of special tools. Window openings shall be designed to prevent accidental falls by patients.~~

~~4. Nurses' calling system shall meet the requirements of 12 VAC 5-410-1130. Medical gas system shall meet the requirements of 12 VAC 5-410-1090.~~

~~5. One handwashing lavatory shall be provided in each patient room except that it may be omitted from a single bed or a two bed room, if a lavatory is located in adjoining toilet room which serves that room only.~~

~~6. Each patient shall have access to a toilet room with a water closet without entering the general corridor area. One toilet room shall serve no more than four beds and no more than two patient rooms.~~

~~7. Each patient shall have a wardrobe, locker, or closet that is suitable for hanging full length garments and for storing personal effects.~~

~~8. Cubicle curtains for visual privacy shall be provided for each bed in multi bed rooms.~~

~~C. The service areas noted below shall be located in each nursing unit. The size and design requirements for each service area will depend upon the number of beds to be served. Although identifiable spaces are required for each of the indicated functions, consideration will be given to design solutions to accommodate functions without specifying areas or rooms, or the sharing of some functions with other nursing units. Details of such proposals shall be included on the architecture drawings when submitted to the licensing agency. The following shall be provided in each nursing unit.~~

~~1. Nursing station with space for nurses' charting, doctors charting, storage for administrative supplies, and a handwashing lavatory. This handwashing lavatory could~~

~~also serve the drug distribution station, if conveniently located.~~

~~2. Nurses office.~~

~~3. Toilet room(s) for staff.~~

~~4. Individual closets or compartments for the safekeeping of coats and personal effects of nursing personnel shall be located convenient to the nurses station or in a central location.~~

~~5. The clean workroom shall contain a work counter, handwashing lavatory and storage area.~~

~~6. The soiled workroom shall contain a clinical sink or equivalent flushing rim fixture, handwashing lavatory, work counter, waste receptacle and linen receptacle.~~

~~7. Provision shall be made for convenient and prompt 24-hour distribution of medicine to patients. This may be from a medicine preparation room or unit, a self-contained medicine dispensing unit, or by another approved system. A medicine preparation room shall be under the nursing staff's visual control and contain a work counter, refrigerator, and locked storage for biologicals and drugs. A medicine dispensing unit may be located at the nurses' station, in the clean workroom, or in an alcove or other space under direct control of the nursing or pharmacy staff.~~

~~8. A janitor's closet shall be provided with floor receptor or service sink.~~

~~9. Clean linen storage shall be a separate closet or a designated area within the clean workroom. If a closed cart system is used, storage may be in an alcove.~~

~~10. A nourishment station shall contain a handwashing lavatory, work counter, equipment for serving nourishment between scheduled meals, refrigerator, ice maker and storage cabinets.~~

~~11. An equipment storage room shall be used for storage of equipment such as I.V. stands, stretchers, wheelchairs, inhalators, air mattresses, and walkers.~~

~~12. Bathtubs or showers shall be provided at the rate of one for each 10 beds which are not otherwise served by bathing facilities within patient rooms. Each tub or shower shall be in an individual room or enclosure which provides space for the private use of the bathing fixture and for drying and dressing. At least one bathing facility on each nursing floor shall be designated to permit use by a wheelchair patient with an assisting attendant.~~

~~D. Rooms for patients requiring isolation shall be provided at the rate of one for each 40 beds or major fraction thereof. These may be located within each nursing unit or placed together in a separate unit. Each isolation room shall be a single bed room and designated as a patient room, except as follows:~~

~~1. Entrance from the patient corridor shall be through a vestibule (a closed anteroom or a passageway open to the room) which shall contain a handwashing lavatory, storage spaces for clean and soiled materials and gowning facilities;~~

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~~2. If a closed anteroom is used, a viewing panel shall be provided for observation of the patient from the anteroom.~~

~~3. A private toilet room containing a water closet and a bathtub or shower shall be provided for the exclusive use of the patient with direct entry from the patient bed area without passing through the vestibule; and~~

~~4. A handwashing lavatory shall be provided for the exclusive use of the patient. It shall be located in the patient room or in the private toilet area.~~

~~E. Rooms for disturbed medical patients. When psychiatric facilities are not available elsewhere in the community, each hospital shall provide at least one single bed room for patients needing close supervision for medical and/or psychiatric care. This may be part of the psychiatric unit described in 12 VAC 5-410-810. If the room is part of the acute care nursing unit it shall be located so that the doorway is visible for direct supervision. Such room shall be designed to minimize potential for escape, hiding, injury, or suicide.~~

12 VAC 5-410-760. Long-term Long-term care nursing units.

~~Long-term Construction and renovation of long-term care nursing units, including intermediate and skilled nursing care nursing units shall conform to the requirements of Part III, § 44, of the "Rules and Regulations for the Licensure of Nursing Homes in Virginia (12 VAC 5-370-10 et seq.)," which includes but is not limited to: 1. A total of 25 square feet (2.32 sq. m) per bed with a minimum size of not less than 225 square feet (20.9 sq. m) shall be provided for patient dining and recreational areas; 2. A separate room and appropriate equipment shall be provided for hair care and grooming needs of patients; and 3. Adequate facilities shall be provided for physical therapy, occupational therapy or activities, and consultation section 8, as applicable, of the 2001 Guidelines for Design and Construction of Hospital and Health Care Facilities of the American Institute of Architects.~~

12 VAC 5-410-770. Intensive care unit. (Repealed.)

~~A. Facilities for the intensive care of medical, surgical, or cardiac patients have specific space requirements. These patients, especially those requiring cardiac care, are often acutely aware of the surroundings environment and may be affected by it. Controlling unnecessary noise is important. Each patient may require individual privacy, although each is required to be under constant observation. Natural lighting by windows minimizes the possibility of disorientation. Cardiac intensive care patients shall be housed in single bed rooms. Intensive care units may be designed with single bed rooms or multi-bed rooms, provided each unit contains at least one single bed room. All beds shall be arranged to permit direct visual observation by nursing staff.~~

~~B. Patient rooms shall meet the following requirements:~~

~~1. Clearance between beds in multi-bed rooms shall be not less than 7'0" (2.13 m). Single bed rooms or cubicles shall have a minimum clear space of 120 square feet (11.15 sq. m) and a minimum dimension of 10'0" (3.05 m);~~

~~2. Viewing panels shall be provided indoors and walls for nursing observation. Curtains or other means shall be~~

~~provided to cover the viewing panels when the patient requires privacy. Glazing in viewing panels shall be a safety glass, wire glass, or clear plastic, except that wire glass is required in glazed openings to corridors or passageways used as means of egress for fire safety purposes;~~

~~3. An I.V. solution support shall be provided for each bed and designed so that the solution is not suspended directly over the patient;~~

~~4. A handwashing lavatory and water closet shall be provided in each single bed room. In multibed rooms one handwashing lavatory and water closet for each six beds shall be provided which is directly accessible from the bed area;~~

~~5. Each water closet shall have sufficient clearance around it to facilitate its use by patients needing assistance;~~

~~6. A nurses calling system which meets the requirements of 12 VAC 5-410-1130 shall be provided;~~

~~7. Each patient room shall have an operable window which meets the requirements of 12 VAC 5-410-1040;~~

~~8. Individual lockers of a size to permit hanging of full-length garments shall be provided for storage of patient clothing and personal effects. These lockers may be located outside the intensive care units; and~~

~~9. A separate visitors waiting room shall be provided in close proximity to the intensive care unit. Toilet, handwashing and public telephone facilities shall be available to the waiting area.~~

~~C. The following service areas shall be located in or readily available to each intensive care or cardiac care unit. One area may serve two or more adjacent units. The size and location of each service will depend on the number of beds to be served.~~

~~1. A nurses station shall be located to permit direct visual observation of each patient.~~

~~2. Handwashing facilities shall be convenient to nurses' station and drug distribution station.~~

~~3. Charting facilities shall be separated from monitoring service.~~

~~4. Staff's toilet room shall contain a water closet and a handwashing lavatory.~~

~~5. Individual closets or compartments for the safekeeping of coats and personal effects of nursing personnel. These shall be located at or near the nurses' station.~~

~~6. Clean workroom shall contain a work counter, handwashing lavatory and storage facilities.~~

~~7. Soiled workroom shall contain a clinical sink or equivalent flushing rim fixture, handwashing lavatory, work counter, waste receptacle and linen receptacle.~~

~~8. Drug distribution station shall meet the requirements of 12 VAC 5-410-750 C 7.~~

~~9. Janitor's closet shall meet the requirements of 12 VAC 5-410-750 C 8.~~

~~10. Clean linen storage area shall meet the requirements of 12 VAC 5-410-750 C-9.~~

~~11. Nourishment station area shall meet the requirements of 12 VAC 5-410-750 C-10.~~

~~12. Emergency equipment storage space shall be provided for a "crash cart and similar emergency equipment."~~

~~13. Equipment storage room area shall meet the requirements of 12 VAC 5-410-750 C-11.~~

12 VAC 5-410-780. Obstetric nursing unit. (Repealed.)

~~A. The obstetric nursing unit shall be designed to assure the separation of the postpartum patients from any other type of patient. "Clean" gynecological patients, as defined in hospital policy, may be housed on the unit.~~

~~B. The obstetric nursing unit shall meet the requirements of 12 VAC 5-410-750 C of this chapter, except the following:~~

- ~~1. A handwashing lavatory shall be provided directly in the patient room;~~
- ~~2. A soiled workroom and janitors' closet shall be for the use of the obstetric nursing unit and newborn services unit;~~
- ~~3. All required bathing facilities shall be showers or tub units with showers.~~

12 VAC 5-410-790. Newborn nurseries. (Repealed.)

~~A. Newborn infants shall be housed in nurseries which are located adjacent to the obstetric nursing unit. The nurseries shall be designed to preclude unrelated traffic. No nursery shall open directly into another nursery.~~

~~B. Each nursery shall contain the following:~~

- ~~1. One handwashing lavatory for each eight bassinets. Lavatories shall be equipped with knee, wrist or foot controls, soap dispenser and paper towel dispenser;~~
- ~~2. The nurse emergency calling system shall meet the requirements of 12 VAC 5-410-1130;~~
- ~~3. Glazed observation windows to permit viewing infants from public areas, from workrooms, and between adjacent nurseries.~~

~~C. The general care nursery shall contain no more than 16 infant stations. A minimum of 3 feet (91 cm) shall be provided between bassinets. The minimum floor area shall be 24 square feet (2.23 sq. m) for each infant station. When a rooming-in program is used, the total number of bassinets provided in the general care nursery may be appropriately reduced, but the nursery may not be omitted.~~

~~D. A special care area for infants requiring close observation, such as those with low birth weight, is required in hospitals having 25 or more postpartum beds. The minimum floor area per infant station shall be 40 square feet (3.72 sq. m).~~

~~E. Each nursery shall be served by a connecting workroom.~~

~~F. The workroom shall contain gowning facilities at the entrance for staff and personnel, work space with counter, refrigerator, storage space and handwashing lavatory which~~

~~meets the requirements of 12 VAC 5-410-1090 B. One workroom may serve more than one nursery.~~

~~G. The examination and treatment room shall contain a work counter, storage, handwashing lavatory and charting facilities. This may be part of the workroom.~~

~~H. Janitors' closet. A closet for the use of the housekeeping staff in maintaining the nurseries shall be provided. It shall contain a floor receptor or service sink and storage space for housekeeping equipment and storage.~~

12 VAC 5-410-800. Pediatric and adolescent unit. (Repealed.)

~~A. A hospital with a designated pediatric unit shall house young children and adolescents in a nursing unit separate from adults.~~

~~B. The requirements of 12 VAC 5-410-750 shall be applied to a pediatric unit containing pediatric beds, except that patient rooms used for cribs shall contain at least 60 square feet (5.58 sq. m) of clear area for each crib with no more than six cribs in a room.~~

~~C. Each nursery serving pediatric patients shall contain no more than 8 bassinets and shall meet the requirements of 12 VAC 5-410-790 B.~~

~~D. The service areas in the pediatric and adolescent nursing unit shall meet the requirements of 12 VAC 5-410-750 and shall meet the following additional conditions:~~

- ~~1. Multipurpose or individual room(s) shall be provided for dining, educational, and play purposes. Special provisions shall be made to minimize the impact noise transmission through the floor of the multipurpose room(s) to occupied spaces below;~~
- ~~2. Patient's toilet room(s) be provided convenient to multipurpose room(s) and central bathing facilities;~~
- ~~3. Storage closets or cabinets for toys and for educational and recreational equipment shall be provided; and~~
- ~~4. Storage space shall be provided for replacement of cribs and beds to provide flexibility for interchange of patient accommodations.~~

12 VAC 5-410-810. Psychiatric nursing unit. (Repealed.)

~~A. Units intended for psychiatric nursing care shall be designed to facilitate care of ambulatory and non-ambulatory inpatients. Insofar as practical, provisions shall be made for flexibility in arranging various types of psychiatric therapy, and to present as noninstitutional an atmosphere as possible. The unit shall provide a safe environment for patients and staff.~~

~~B. Psychiatric units shall conform to the licensure requirements of the Department of Mental Health, Mental Retardation and Substance Abuse Services, Appendix A, Reference 15, insofar as they do not conflict with life safety requirements for the total hospital or affect patients care in other section of the hospital.~~

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12 VAC 5-410-820. Surgical facilities. (Repealed.)

~~A. The number of operating room and recovery beds and the sizes of the service areas are based on the expected surgical workload and shall be located and arranged to preclude unrelated traffic through the suite.~~

~~B. Each general operating room shall have a minimum clear area of 360 square feet (33.45 sq. m), exclusive of fixed and movable cabinets and shelves, with a minimum dimension of 18'0" (5.49m) between two walls. Each room shall contain an emergency communications system connecting with the surgical suite control station and at least two X-ray film illuminators. Storage space for splints and traction equipment shall be provided for rooms equipped for orthopedic surgery.~~

~~C. Room(s) for surgical cystoscopic and other endoscopic procedures shall be designed to accommodate the types of procedures to be used but shall have not less than a minimum clear area of 250 square feet (23.23 sq. m), exclusive of fixed and movable cabinets and shelves. Each room shall contain an emergency communications system connecting with the surgical suite control station. Facilities for the disposal of liquid wastes shall be provided.~~

~~D. Recovery room(s) for post-anesthesia recovery of surgical patients shall be provided and shall contain a drug distribution station, handwashing facilities, charting facilities, clinical sink and storage space for supplies and equipment. Design space shall provide for at least 3'0" each side of each recovery bed. Separate and additional recovery space may be necessary to accommodate surgical outpatients.~~

~~E. Individual service rooms shall be provided when so noted, otherwise alcoves for other open spaces which will not interfere with traffic may be used. Services, except the soiled workroom and the janitors' closet may be shared with and organized as part of the obstetrical facilities. Service areas shall be arranged to avoid direct traffic between the operating and the delivery rooms. The following service areas shall be provided:~~

- ~~1. Control station located to permit visual surveillance of all traffic entering the operating suite;~~
- ~~2. Supervisor's office or station;~~
- ~~3. Sterilizing facilities with high speed autoclave(s) conveniently located to serve all operating rooms. When the program plan indicates that adequate provisions have been made for replacement of sterile instruments during surgery sterilizing facilities in the surgical suite will not be required;~~
- ~~4. Provision for a drug distribution station shall be made for the storage and preparation of medication;~~
- ~~5. At least two scrub stations shall be provided near the entrance to each operating room. Two scrub stations may serve two operating rooms if they are located adjacent to the entrance of each operating room. Scrub facilities shall be arranged to minimize any incidental splatter on nearby personnel or supply carts;~~
- ~~6. The soiled workroom shall be for the exclusive use of the surgical suite personnel and shall contain a clinical sink or~~

~~equivalent flushing type fixture, work counter, handwashing lavatory, waste receptacle and linen receptacles;~~

~~7. Fluid waste disposal facilities shall be conveniently located to the general operating rooms. A clinical sink or equivalent equipment in a soiled workroom would meet this requirement;~~

~~8. A clean workroom is required when clean materials are assemble within the surgical suite prior to use. The clean workroom shall contain a work counter, handwashing lavatory and space for clean and sterile supplies;~~

~~9. Anesthesia storage facilities unless official hospital board action prohibits, in writing, the use of flammable anesthetics a separate room shall be provided for storage of flammable gases in accordance with the requirements of NFPA 56A and NFPA 70;~~

~~10. Anesthesia workroom for cleaning, testing and storing anesthesia equipment shall contain a work counter and sink;~~

~~11. Medical gas supply with storage space for reserve nitrous oxide and oxygen cylinders shall be provided;~~

~~12. Equipment storage room(s) for equipment and supplies used in surgical suite;~~

~~13. Appropriate areas for staff clothing change shall be provided for personnel working within the surgical suite. The areas shall contain lockers, showers, toilets, handwashing lavatories and space for donning scrub suits and boots.~~

~~14. In facilities with two or more operating rooms, a room or alcove as a patient holding area shall be provided to accommodate stretcher patients waiting for surgery. This waiting area shall be under the visual control of the staff;~~

~~15. Stretcher storage area shall be out of direct line of traffic;~~

~~16. Lounge and toilet facilities for surgical staff shall be provided in hospitals having three or more operating rooms and shall be located to permit use without leaving the surgical suite. A staff toilet room shall be provided near the recovery room(s);~~

~~17. A janitor's closet containing a floor receptor or service sink and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite;~~

~~18. An outpatient surgery change area shall be provided where outpatients change from street clothing into hospital gowns and are prepared for surgery. This would include a waiting room, lockers, toilets and clothing change or gowning area; and~~

~~19. Provisions shall be made for separating inpatient and outpatient recovery where outpatients are not subjected to general anesthesia. This requirement may be satisfied by separated rooms or by scheduling of procedures.~~

12 VAC 5-410-830. Labor and delivery facilities. (Repealed.)

~~A. Existing hospitals with licensed obstetric and newborn services in operation prior to the effective date of this chapter or revisions thereof, shall comply with all of the regulations of this section with the exception of the minimum dimensions and square footage requirements for labor rooms and LDR/LDRP rooms provided in subsections D and E of this section. Existing hospitals may not decrease the dimensions of the labor rooms and LDR/LDRP rooms from what was specified in the chapters at the time the service, or parts thereof, was granted licensure approval. Labor rooms and LDR/LDRP rooms that are renovated at the time the service, or parts thereof, was granted licensure approval. Labor rooms and LDR/LDRP rooms that are renovated in existing hospitals or are newly constructed after the effective date of this chapter shall conform with all of the room dimensions specified in this solution.~~

~~B. The number of labor rooms, delivery rooms, recovery beds, and the sizes of the service areas shall depend upon the estimated obstetrical workload.~~

~~1. The labor and delivery suite shall be designed and arranged to assure separation of obstetrical patients from other types of patients and to preclude unrelated traffic through the suite.~~

~~2. Labor and delivery rooms shall be entirely separate from emergency and operating rooms.~~

~~C. Each delivery room shall have a minimum clear area of 300 square feet (27.87 sq. m) exclusive of fixed and movable cabinets and shelves. The minimum dimension shall be 16'0" (4.88 m) in any direction between two walls. Separate resuscitation facilities (electrical outlets, oxygen, suction, and compressed air) shall be provided for newborn infants.~~

~~D. Labor rooms shall be single bed or two bed rooms with a minimum clear area of 180 square feet per bed. In facilities having only one delivery room, two labor rooms shall be provided one of which shall be large enough to function as an emergency delivery room with a minimum of 300 square feet. Labor rooms shall have at least two oxygen and two wall-mount suction outlets. Each labor room shall contain a handwashing lavatory. Each labor room shall have access to a toilet room. One toilet room may serve two labor rooms. At least one shower shall be provided for labor room patients without patients having to enter a corridor or general area. A water closet shall be accessible to the shower facility.~~

~~E. Hospitals, which include LDR/LDRP rooms in their obstetrical program, shall designate room(s) within the labor suite for this purpose. Such rooms(s) shall be designated and arranged to prohibit unrelated traffic through the labor and delivery suite. These rooms shall meet the requirements of a labor room which may be used as an emergency delivery room as specified in subsection D of this section. The minimal dimensions shall be 16'0" clear between walls or fixed cabinets or shelving. The rooms shall have a clear area of 300 square feet. Each LDR/LDRP room shall have access to a private water closet and shower. The water closet and shower may be shared by two rooms.~~

~~F. The recovery room shall contain a minimum of two beds, charting facilities located to permit staff to have visual control of all beds, facilities for medicine dispensing, handwashing facilities, clinical sink with bedpan flushing device, and storage for supplies and equipment.~~

~~G. Individual rooms shall be provided when so noted, otherwise, alcoves or other open spaces which will not interfere with traffic may be used. Service areas, except the soiled workroom and the janitors' closet, may be shared with in the obstetrical unit. If shared, service areas shall be arranged to avoid direct traffic between the delivery and operating rooms. The following services shall be provided:~~

~~1. Control station located to permit visual surveillance of all traffic which enters the labor and delivery suite;~~

~~2. Supervisor's office or station;~~

~~3. Sterilizing facilities with high speed autoclave(s) conveniently located to serve all delivery rooms. When provisions have been made for replacement of sterile instruments during a delivery, sterilizing facilities will not be required;~~

~~4. Provisions for a drug distribution station shall be made for storage, preparation, and dispensing of medication;~~

~~5. At least two scrub stations shall be provided near the entrance to each delivery room. Two scrub stations may serve two delivery rooms if they are located adjacent to the entrance of each delivery room. Scrub facilities shall be arranged to minimize any incidental splatter on nearby personnel or supply carts;~~

~~6. The soiled workroom shall be for the exclusive use of the labor and delivery room personnel and shall contain a clinical sink or equivalent flushing type fixture work counter, handwashing lavatory, waste receptacle and linen receptacle;~~

~~7. Fluid waste disposal facilities conveniently located to the delivery rooms. A clinical sink or equivalent in a soiled workroom or soiled holding room would meet this requirement;~~

~~8. A clean workroom shall contain a work counter, handwashing lavatory, and space for clean and sterile supplies;~~

~~9. Unless official hospital board action, in writing, prohibits use of flammable anesthetics a separate room shall be provided for storage of flammable gases in accordance with the requirements detailed in NFPA 99 and NFPA 70;~~

~~10. An anesthesia workroom for cleaning, testing and storing anesthesia equipment shall contain a work counter and sink;~~

~~11. A medical gas storage space for reserve storage of nitrous oxide and oxygen cylinders shall be provided;~~

~~12. Equipment storage room(s) for equipment and supplies used in the labor and delivery suite;~~

~~13. Appropriate staff's clothing change areas shall be provided personnel working within the labor and delivery suite. The areas shall contain lockers, showers, toilets,~~

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handwashing lavatories, and space for donning scrub suits and boots;

14. Lounge and toilet facilities for obstetrical staff and nurses shall be provided near the labor rooms and recovery room(s);

15. A janitor's closet containing a floor receptor or service sink and storage for housekeeping supplies and equipment shall be provided for the labor and delivery suite to be shared only with the newborn services unit;

16. The stretcher storage area shall be out of direct line of traffic;

12 VAC 5-410-840. Outpatient and emergency suite. (Repealed.)

A. Facilities for minimum emergency care shall be provided in each hospital as specified in subsection B of this section. Facilities for outpatient care shall be provided as required by the hospital program.

B. The extent of emergency patient care services planned for the hospital will depend upon community needs and availability of other organized programs for emergency care within the community. Hospitals that plan for a minimum level of emergency services shall provide at least an entrance, treatment room, and patient's toilet room convenient to the treatment room. Hospitals which have an organized program for emergency care must meet the following minimum requirements:

1. An entrance at grade level, sheltered from the weather, and with provision for ambulance and pedestrian access;

2. A reception and control area which is conveniently located near the entrance, waiting area and treatment rooms;

3. Public waiting space with toilet facilities, public telephone and drinking fountain;

4. Treatment rooms. Handwashing facilities shall be provided in each room or shall be conveniently adjacent to each room. The rooms shall contain cabinets, medication storage, work counter, suction outlets, x-ray film illuminators, and space for storage of emergency equipment such as emergency treatment trays, defibrillator, cardiac monitor and resuscitator;

5. Storage area out of line of traffic for stretchers and wheelchairs;

6. Staff work and charting area(s). This may be combined with reception and control area or located within the treatment room;

7. Clean supply storage. This may be a separate room or located within the treatment room;

8. Soiled workroom or area containing clinical work, work counter, handwashing lavatory, waste receptacle and linen receptacle; and

9. Patient toilet room convenient to treatment room(s).

C. The outpatient administrative, clinical, and diagnostic space will be determined by the types of services to be offered and the estimated patient load. The design of outpatient facilities should provide for the privacy and dignity of the patient during interview, examination, and treatment. The facilities shall be located so that outpatients do not pass through inpatient units. The following shall be provided or made available to the outpatient service:

1. The entrance shall be located at grade level, sheltered from weather, and able to accommodate wheelchairs.

2. The lobby shall include:

a. Wheelchair storage space(s);

b. Reception and information counter or desk;

c. Waiting space(s);

d. Public toilet facilities;

e. Public telephones; and

f. Drinking fountain(s).

3. An area for private interviews relating to social service, credit, and admissions.

4. General or individual office(s) shall be provided for business transactions, records, and administrative and professional staffs.

5. Storage space for employees' personal effects; and

6. Storage facilities for office supplies, sterile supplies, pharmaceutical supplies, splints and other orthopedic supplies and housekeeping supplies and equipment.

7. General and special purpose examination room(s). Each room shall have a minimum floor area of 80 square feet (7.43 sq. m), excluding such spaces as vestibule, toilet, closet and water counter (whether fixed or movable). Arrangement shall permit at least 2'8" (81 cm) clearance at each side and at the foot of the examination table. A handwashing lavatory and a counter or shelf space for writing shall be provided.

8. Treatment rooms. Each room used for minor surgical procedures and cast procedures shall have a minimum floor area of 120 square feet (11.15 sq. m), excluding such spaces as vestibule, toilet, closet and work counter (whether fixed or movable). The minimum room dimension shall be 10'0" (3.05 m) between two walls. A work counter, storage cabinets and a handwashing lavatory shall be provided.

9. Observation room(s). A room handling isolation, suspect, or disturbed patients shall be conveniently located to nurses' station or other control station. Patients shall have access to a toilet room without entering the general corridor area. A separate room is not required if an examination room is modified to accommodate this function.

10. Facilities for charting and for clinical records. A nurses station with work counter, communication system, and space for supplies shall be provided. A separate space may

be omitted if these functions are accommodated in each examination room and each treatment room.

~~11. Drug distribution station. This area shall meet the requirements of 12 VAC 5-410-750 C 7.~~

~~12. Clean workroom. The clean workroom shall meet the requirements of 12 VAC 5-410-770 C 6.~~

~~13. Soiled workroom or soiled holding room. The soiled workroom shall contain clinical sink or equivalent flushing rim fixture, handwashing lavatory, work counter, waste receptacle, and linen receptacle. A soiled holding room that is part of a system for collection and disposal of soiled materials and shall be similar to the soiled workroom except that the clinical sink and the work counter may be omitted.~~

~~14. Stretcher storage space out of direct line of traffic.~~

~~D. Radiological facilities for diagnostic services shall be made available to the outpatient and emergency service. If a separate radiological unit is installed within the outpatient and emergency areas it shall comply with the requirements of 12 VAC 5-410-850.~~

12 VAC 5-410-850. Radiology suite. (Repealed.)

~~Equipment for the radiology suite shall be provided for diagnostic purposes required by the hospital program. The suite shall contain the following elements:~~

- ~~1. Radiographic room(s). Radiation protection meet the requirements of 12 VAC 5-410-1040 V;~~
- ~~2. Film processing facilities;~~
- ~~3. Viewing and administration area(s) with film storage facilities;~~
- ~~4. A toilet room with handwashing facilities which are directly accessible from each fluoroscopy room without entering the general corridor area;~~
- ~~5. A dressing area(s) with convenient access to toilets;~~
- ~~6. A waiting room or alcove for ambulatory patients;~~
- ~~7. A holding area for stretcher patients which is out of the direct line of normal traffic; and~~
- ~~8. Handwash facilities shall be provided in each radiographic room unless the room is used only for routine diagnostic screening such as for chest X-rays.~~

12 VAC 5-410-860. Diagnostic laboratory suite. (Repealed.)

~~A. Diagnostic laboratory facilities shall be provided for hematology, clinical chemistry, urinalysis, cytology, pathology, microbiology and bacteriology to meet the workload proposed in the hospital program. These services may be provided within the hospital or through a contract arrangement with a reference laboratory.~~

~~B. If laboratory services are provided by contractual arrangement at least the following minimum services shall be available within the hospital:~~

- ~~1. A laboratory work counter(s) with sink, medical gases, and electrical services;~~

~~2. A lavatory(ies) or counter sink(s) equipped for handwashing;~~

~~3. Storage cabinet(s) or closet(s);~~

~~4. Blood storage facilities; and~~

~~5. Specimen collection facilities. Urine collection rooms shall be equipped with a water closet and handwashing lavatory. Blood collection facilities shall have a work counter, handwashing lavatory, and space for patient seating.~~

12 VAC 5-410-870. Renal dialysis suite. (Repealed.)

~~A. The following requirements include facilities for outpatient renal dialysis treatment. The number and type of treatment stations and the sizes of the service areas shall be based upon the projected patient load, the condition of the patients to be treated and the type of service to be provided. Inpatients will be housed in nursing units conforming to the requirements of 12 VAC 5-410-750.~~

~~B. The treatment area shall contain the number of stations required by the program and shall include the following:~~

- ~~1. Patient treatment station areas shall have a minimum of 80 square feet (7.43 sq. m);~~
- ~~2. Cubicle curtains shall be provided around each treatment station for privacy;~~
- ~~3. Handwashing lavatories with knee or foot controls shall be provided at the rate of one for each six treatment stations;~~
- ~~4. Windows shall be provided conforming to requirements specified in 12 VAC 5-410-1040;~~
- ~~5. Patient toilet facilities shall be conveniently located to the treatment area and be equipped to accommodate the physically handicapped;~~
- ~~6. Patient locker facilities shall be provided for outpatients and be conveniently located to the treatment area; and~~
- ~~7. Provisions shall be made for the isolation or treatment of hepatitis B positive antigen patients.~~

~~C. The following service areas shall be located in or conveniently adjacent to the Renal Dialysis Suite. The size and location of each service area will depend upon the number of patient stations served:~~

- ~~1. Nurses station shall be located to permit direct visual observation of each patient being treated. The station shall be provided with an emergency communication system connected to a central control station.~~
- ~~2. Charting facilities for nurses and doctors.~~
- ~~3. Lounge and toilet room(s) for staff.~~
- ~~4. Individual closets or compartments for the safekeeping of personal effects of nursing personnel. These shall be located convenient to the nurses station or in a central location.~~
- ~~5. Clean workroom. The clean workroom shall meet the requirements of 12 VAC 5-410-750 C 5.~~

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~~6. Soiled workroom. The soiled workroom shall meet the requirements of 12 VAC 5-410-750 C-6.~~

~~7. Drug distribution station. This area shall meet the requirements of 12 VAC 5-410-750.~~

~~8. Supply storage. A separate room for dialysis supplies shall be provided.~~

~~9. Equipment workroom and storage. A separate room shall be provided for the water treatment equipment and the repairs, adjustments, cleaning and sanitizing of dialysis equipment.~~

~~10. Nourishment station. This station shall meet the requirements of 12 VAC 5-410-750 C-10. The station may be combined with or a part of the Clean Workroom on the Medication Station.~~

~~11. Janitor's closet. The janitor's closet shall meet the requirements of 12 VAC 5-410-750 C-8.~~

~~D. A separate waiting area shall be provided for patients and family members and others bringing patients to and from the treatment facility or visiting with patients during treatment. A toilet room, public telephone, drinking fountain and seating accommodations shall be provided.~~

12 VAC 5-410-880. Physical therapy suite. (Repealed.)

~~Appropriate areas may be designed and arranged for shared use by occupational therapy patients and staff. If a physical therapy area is required by the hospital program, the following elements shall be provided:~~

~~1. Treatment area(s) shall be provided with the required space and equipment designed for the planned program and may include thermotherapy, diathermy, ultrasonics, and hydrotherapy;~~

~~2. Provisions shall be made for individual patient privacy, handwashing facilities and facilities for the collection of soiled linen and other material;~~

~~3. Exercise area;~~

~~4. Storage for clean linen, supplies, and equipment;~~

~~5. Toilet room equipped for the physically handicapped with water closet and handwashing lavatory;~~

~~6. Service sink; and~~

~~7. Wheelchair and stretcher storage.~~

12 VAC 5-410-890. Occupational therapy suite. (Repealed.)

~~The following appropriate areas may be designed and arranged for shared use by physical therapy patients and staff. If an occupational therapy suite is required by the hospital program, the following elements shall be provided:~~

~~1. The activities area shall include sink or lavatory and facilities for collection of waste products prior to disposal;~~

~~2. Storage for supplies and equipment; and~~

~~3. Toilet room equipped for the physically handicapped with water closet and handwashing lavatory.~~

12 VAC 5-410-900. Inhalation therapy unit. (Repealed.)

~~If an inhalation therapy unit is required by the hospital program, it shall be located convenient to the Intensive Care/Cardiac Care Unit and shall contain the following elements:~~

~~1. Office space including records file;~~

~~2. Storage for supplies and equipment;~~

~~3. Equipment servicing area; and~~

~~4. Separate soiled and clean workrooms which meet the requirements of 12 VAC 5-410-750 C-5 and C-6.~~

12 VAC 5-410-910. Morgue and autopsy. (Repealed.)

~~These facilities shall be designed for direct access to an outside entrance and shall be located to avoid movement of bodies through public use areas.~~

~~1. The following elements shall be provided when autopsies are performed within the hospital:~~

~~a. Work counter with handwashing lavatory;~~

~~b. Storage space for supplies, equipment, and specimens;~~

~~c. Autopsy table;~~

~~d. Clothing change area with shower, toilet, and lockers;~~

~~e. Janitor's service sink or receptacle; and~~

~~f. Refrigerated facilities for body holding.~~

~~2. If autopsies are performed outside the hospital, only a well-ventilated body holding room needs to be provided.~~

12 VAC 5-410-920. Pharmacy suite. (Repealed.)

~~The size and type of space to be provided in the pharmacy will depend upon the type of drug distribution system used in the hospital and whether the hospital proposes to provide, purchase, or share pharmacy services with other medical facilities. Provision shall be made for the following functional areas:~~

~~1. Dispensing area with handwashing lavatory;~~

~~2. Editing or order review area;~~

~~3. Sterile Products area. For the compounding of I.V. admixtures and other sterile products. May also be used for extemporaneous compounding;~~

~~4. Administrative areas. Office area for the pharmacist and any other personnel required for the proper maintenance of records and reports and for purchasing and accounting;~~

~~5. Storage areas. Areas for bulk, refrigeration, vault, volatile liquids storage shall be provided;~~

~~6. Drug information area;~~

~~7. Packaging area. Provide an area only if required by the hospital program;~~

~~8. Bulk compounding area. Provide an area only if required by the hospital program; and~~

9. Quality control area. An area is required only if either packaging or bulk compounding areas are provided.

12 VAC 5-410-930. Dietary facilities. (Repealed.)

A. Food service facilities shall be designed and equipped to meet the requirements of the hospital program. These may consist of areas for an on-site conventional food preparing system, a convenience food service system, or an appropriate combination of the two.

B. The following facilities shall be provided in the size required to implement the type of food service selected:

1. Control station for receiving food supplies;
2. Storage space for food supply including food requiring cold storage. At least 2 cubic feet of refrigerated storage per bed (0.05 cubic meter per bed) and 2 square feet of dry food storage per bed (0.7 sq. m per bed) shall be provided;
3. Food preparation facilities. Conventional food preparation systems require space and equipment for preparing, cooking, and baking. Convenience food service systems such as frozen prepared meals, bulk packaged entrees, and individual packaged portions, or systems using contractual commissary services require space and equipment for thawing, portioning, cooking, or baking;
4. Handwashing facility(ies) located in the food preparation area;
5. Patients meal service facilities such as, tray assembly and distribution;
6. Warehousing space located in a room or an alcove separate from food preparation and serving areas with commercial-type dishwashing equipment shall be provided. Space shall also be provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using area. A handwashing lavatory shall be conveniently available to the area;
 - a. Energy saving dishwashing equipment may be used if the equipment is approved by the licensing agency prior to installation.
 - b. Potwashing facilities;
 - c. Sanitizing facilities and storage areas for cans, carts, and mobile tray conveyors. The sanitizing facilities may be combined with those required for linen services;
 - d. Waste storage facilities shall be provided in a separate room which is easily accessible to the outside for direct pickup or disposal;
 - e. Office or suitable work space for the dietitian or the food service supervisor;
 - f. Toilets with handwashing lavatory which is for dietary staff conveniently accessible but does not open directly into food service areas;
 - g. Janitors' closet located within the dietary department. The closet shall meet the requirements of 12 VAC 5-410-750; and

h. Ice-making facilities may be provided in areas separate from food preparation area but shall be easily cleanable and convenient to dietary facilities.

12 VAC 5-410-940. Administration and public areas. (Repealed.)

The following areas shall be provided:

1. The entrance shall be at grade level, sheltered from the weather, and able to accommodate wheelchairs.
2. The lobby shall include space for:
 - a. Storage for wheelchairs;
 - b. Reception and information counter or desk;
 - c. Waiting space(s);
 - d. Public toilet facilities;
 - e. Public telephones; and
 - f. Drinking fountain(s).
3. Space for private interviews relating to social service, credit, and admissions.
4. Space for business transactions, medical and financial records, and administrative and professional staffs.
5. Storage space for office equipment and supplies.

12 VAC 5-410-950. Medical records service. (Repealed.)

The following rooms or areas shall be provided:

1. Medical records administrator/technician office or space;
2. Review and dictating room(s) or spaces;
3. Work area for sorting, recording, or microfilming records; and
4. Storage area for records.

12 VAC 5-410-960. Central services department. (Repealed.)

The various elements shall be designed and arranged to provide one-way traffic pattern for supplies from soiled to clean to sterile. The following shall be provided:

1. Receiving and decontamination room. The room shall contain work space and equipment for cleaning medical and surgical equipment and for disposal of or processing unclean material. Handwashing facilities, lockers, showers, and toilets for staff shall be provided in this area if they are not available in adjacent employee facilities serving other soiled areas;
2. Clean workroom. The room shall contain work space and equipment for sterilizing and disinfecting medical and surgical equipment and supplies and handwashing facilities;
3. Storage areas for clean supplies and for sterile supplies. This area may be in clean workroom; and
4. Cart storage. This area shall meet the requirements of 12 VAC 5-410-980.

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12 VAC 5-410-970. Linen service. (Repealed.)

~~A. If linen is to be processed on the site, the following elements shall be designed and arranged to provide a one-way traffic pattern of linens from soiled processing to clean storage and include the following:~~

- ~~1. Soiled linen receiving, holding, and sorting room with handwashing facilities;~~
- ~~2. Laundry processing room with commercial type equipment and handwashing facilities. Energy saving laundry equipment may be considered if it is approved by the licensing agency prior to installation;~~
- ~~3. Storage for laundry supplies;~~
- ~~4. A janitors' closet which meets the requirements of 12 VAC 5-410-750 C 8;~~
- ~~5. Clean linen inspection and mending room or area;~~
- ~~6. Clean linen storage, issuing, and holding room or area; and~~
- ~~7. Cart storage and sanitizing facilities which meet the requirements of 12 VAC 5-410-980.~~

~~B. If linen is to be processed off-site the site, the following shall be provided:~~

- ~~1. Soiled linen holding room with a handwashing lavatory;~~
- ~~2. Clean linen receiving, holding, inspection, and storage room(s); and~~
- ~~3. Cart storage and sanitizing facilities which meet the requirements of 12 VAC 5-410-980.~~

12 VAC 5-410-980. Facilities for cleaning and sanitizing carts. (Repealed.)

~~A. Facilities shall be provided to clean and sanitize carts serving the central services, dietary, and linen services. These may be centralized or departmentalized.~~

~~B. At a minimum, a separate area will be provided with a floor drain, a reel type spray hose with hot and cold water and a steam gun.~~

12 VAC 5-410-990. General stores. (Repealed.)

~~General stores shall include the following:~~

- ~~1. Offstreet unloading facilities;~~
- ~~2. Receiving area;~~
- ~~3. General storage rooms. A total area of not less than 20 square feet (1.86 sq. m) per inpatient bed shall be provided. General stores shall be concentrated in one area, but, in a multiple building complex, they may be in separate concentrated areas in one or more individual buildings; and~~
- ~~4. Additional storage area for outpatient facilities. At least 5.0% of the total area of the outpatient facilities shall be provided. This area may be combined with the general stores or located within the outpatient department.~~

12 VAC 5-410-1000. Employees facilities. (Repealed.)

~~In addition to the employees' facilities as locker rooms, lounges, toilets, or shower facilities called for in certain departments, a sufficient number of such facilities that may be required to accommodate the needs of all personnel and volunteers shall be provided.~~

12 VAC 5-410-1010. Janitors' closets. (Repealed.)

~~In addition to the janitors' closets called for in certain departments, sufficient janitors' closets shall be provided throughout the hospital to maintain a clean and sanitary environment. Each closet shall meet the requirements of 12 VAC 5-410-750 C 8.~~

12 VAC 5-410-1020. Engineering service and equipment areas. (Repealed.)

~~The following shall be provided:~~

- ~~1. Room(s) or separate building(s) for boilers mechanical equipment and electrical equipment;~~
- ~~2. Engineer's office;~~
- ~~3. Maintenance shop(s);~~
- ~~4. Storage room for building maintenance supplies; and~~
- ~~5. A separate room or building for yard maintenance equipment and supplies.~~

12 VAC 5-410-1030. Waste processing service. (Repealed.)

~~A. Space and facilities shall be provided for the sanitary storage and disposal of waste by incineration, mechanical destruction, sterilization, compaction, containerization, removal, or by a combination of these techniques.~~

~~B. A gas, electric, or oil fired incinerator shall be provided for the complete destruction of pathological and infectious waste. Infectious waste shall include, but shall not be limited to, dressings and material from open wounds, laboratory specimens, and all waste material from isolation rooms.~~

~~C. The incinerator shall be in a separate room or placed outdoors. Incinerators with a capacity of less than 50 pounds per hour may be locked in a separate area within the facility boiler room. In all cases, rooms and areas containing incinerators shall have space and facilities for cleaning.~~

~~D. Design and construction of incinerators and trash chutes shall be in accordance with NFPA Standard 82.~~

~~E. Incinerators shall be designed and equipped to conform to requirements prescribed by air pollution chapters for the community.~~

12 VAC 5-410-1040. Details and finishes. (Repealed.)

~~A. Details and finishes in the design of new construction projects, including additions and alterations, shall comply with the following requirements. The nonconforming portions of existing facilities, which because of financial hardship are not being totally modernized, shall comply with the safety requirements dealing with details and finishes as listed in NFPA Standard 101.~~

~~B. Compartmentation, exits, fire alarms, automatic extinguishing systems, and other details relating to fire prevention and fire protection shall comply with requirements listed in the NFPA Standard 101. Public corridors in outpatient suites need not be more than 5'0" (1.52 m) in width except in those areas which may be commonly used by hospital inpatients being transported in beds.~~

~~G. Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width below the required minimum.~~

~~D. Rooms containing bathtubs, sitz baths, showers, and water closets, subject to occupancy by patients, shall be equipped with doors and hardware which will permit access from the outside in any emergency. When such rooms have only one opening or are small, the doors shall be capable of opening outwards or be otherwise designed to be opened without need to push against a patient who may have collapsed within the room.~~

~~E. The minimum width of all doors to rooms needing access for beds shall be 3'8" (1.12m) wide. Doors to rooms needing access for stretchers and to patient toilet rooms and other rooms needing access for wheelchairs shall have a minimum width of 2'10" (86.4 cm).~~

~~F. Doors on all openings between corridors and rooms or spaces subject to occupancy, except elevator doors, shall be swing. Openings to showers, baths, patient toilets, and other small wet type areas not subject to fire rating are exempt from this requirement.~~

~~G. Doors, except those to spaces such as small closets which are not subject to occupancy, shall not swing into corridors in a manner that might obstruct traffic flow or reduce the required corridor width. Large walk in type closets are considered as occupiable spaces.~~

~~H. Windows and outer doors which may be frequently left in an open position shall be provided with insect screens.~~

~~I. Patient rooms intended for occupancy 24 hours a day shall have windows operable without the use of tools, except that windows in ICU and ICCU may be 60" (1.52m) above the floor. Windows in buildings designed with an engineered smoke control system in accordance with NFPA 90A are not required to be operable. Attention is called to the fact that natural ventilation possible with operable windows may in some areas permit a reduction in energy requirements.~~

~~J. Doors sidelights, borrowed lights, and windows in which the glazing extends down to within 18 inches (46 cm) of the floor thereby creating possibility of accidental breakage by pedestrian traffic, shall be glazed with safety glass, wire glass, or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken. Similar materials shall be used in wall openings of recreation rooms and exercise rooms unless otherwise required for fire safety. Safety glass or plastic glazing materials shall be used for shower doors and bath enclosures.~~

~~K. Where labeled fire doors are required, these shall be certified by an independent testing laboratory as meeting the construction requirements equal to those for fire doors in~~

~~NFPA Standard 80. Reference to a labeled door shall be construed to include labeled frame and hardware.~~

~~L. Elevator shaft openings shall have class B 1 1/2 hour labeled fire doors.~~

~~M. Linen and refuse chutes shall meet or exceed the following requirements (see 12 VAC 5-410-1030):~~

~~1. Service openings to chutes shall not be located in corridors or passageways but shall be located in a room of construction having a fire resistance of not less than 1 hour. Doors to such rooms shall be not less than class C 3/4-hour labeled doors;~~

~~2. Service openings to chutes shall have approved self-closing class B 1 1/2-hour labeled fire doors;~~

~~3. Minimum cross-sectional dimension of gravity chutes shall be not less than 2'0" (61 cm);~~

~~4. Chutes shall discharge directly into collection rooms separate from incinerator, laundry, or other services. Separate collection rooms shall be provided for trash and for linen. The enclosure construction for such rooms shall have a fire resistance of not less than 2 hours, and the doors thereto shall be not less than class B 1 1/2-hour labeled fire doors; and~~

~~5. Gravity chutes shall extend full diameter through the roof with provisions for continuous ventilation as well as for fire and smoke ventilation. Openings for fire and smoke ventilation shall have an effective area of not less than that of the chute cross-section and shall be not less than 4'0" (1.22m) above the roof and not less than 6'0" (1.83 m) clear of other vertical surfaces. Fire and smoke ventilating openings may be covered with single strength sheet glass.~~

~~N. Dumbwaiters, conveyors, and material handling systems shall not open directly into a corridor or exitway but shall open into a room enclosed by construction having a fire resistance of not less than one hour and provided with class C 3/4-hour labeled fire doors. Service entrance doors to vertical shafts containing dumbwaiters, conveyors, and material handling systems shall be not less than class B 1 1/2-hour labeled fire doors. Where horizontal conveyors and material handling systems penetrate fire-rated walls or smoke partitions, such openings must be provided with class B 1 1/2-hour labeled fire doors with 2-hour walls and class C 3/4-hour labeled fire doors for 1-hour walls or partitions.~~

~~O. Thresholds and expansion joint covers shall be made flush with the floor surface to facilitate use of wheelchairs and carts. Expansion joints shall be constructed to restrict passage of smoke.~~

~~P. Grab bars shall be provided all patients' toilets, showers, tubs, and sitz baths. The bars shall have 1 1/2 inch (3.8 cm) clearance to walls and shall have sufficient strength and anchorage to sustain a concentrated load of 250 pounds (113.4 kilograms).~~

~~Q. Soap dishes, towel bars and robe hooks shall be provided at showers and bathtubs.~~

~~R. Location and arrangement of handwashing facilities shall permit their proper use and operation. Particular care should~~

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be given to the clearances required for blade-type operating handles. (See 12 VAC 5-410-1090 B 2).

S. Mirrors shall not be installed at handwashing fixtures in food preparation areas or in sensitive areas such as nurseries, clean and sterile supplies, and scrub sinks.

T. Provisions for hand drying shall be included at all handwashing facilities except scrub sinks.

U. Lavatories and handwashing facilities shall be securely anchored to withstand an applied vertical load of not less than 250 pounds (113.4 kilograms) on the front of the fixture.

V. Radiation protection requirements of X-ray and gamma ray installations shall conform with NCRP Reports Nos. 33, 49 and 51 and "Virginia Radiation Protection Regulations (12 VAC 5-480-10 et seq.)" of the Virginia Department of Health. Provision shall be made for testing the completed installation before use and all defects must be corrected before acceptance.

W. The minimum ceiling height shall be 8'0" (2.44m) with the following exceptions:

1. Boiler rooms shall have ceiling clearances not less than 2'6" (76 cm) above the main boiler header and connecting piping;
2. Radiographic, operating and delivery rooms, and other rooms containing ceiling-mounted equipment or ceiling mounted surgical light fixtures shall have height required to accommodate the equipment or fixtures;
3. Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms shall be not less than 7'8" (2.34m); and
4. Suspended tracks, rails, and pipes located in the path of normal traffic shall be not less than 6'8" (2.03m) above the floor.

X. Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated shall not be located directly over patient bed area, delivery or operating suites, unless special provisions are made to minimize such noise.

Y. Rooms containing heat producing equipment, such as boiler or heater rooms and laundries; shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of 10°F (6°C) above the ambient room temperature.

Z. Noise reduction criteria shown in Table 1 of Appendix C, of this chapter shall apply to partition, floor, and ceiling construction in patient areas.

AA. Cubicle curtains and draperies shall be noncombustible or rendered flame retardant and shall pass both the large and small scale tests of NFPA Standard 701.

BB. Flame spread and smoke developed ratings of finishes are included in 12 VAC 5-410-1050 B 2. Whenever possible, the use of materials known to produce large amounts of noxious gases shall be avoided.

CC. Floors in areas and rooms in which flammable anesthetic agents are stored or administered to patients shall comply with NFPA Standard 56A. Conductive flooring may be omitted

from emergency treatment, operating, and delivery rooms when a written resolution is signed by the hospital board stating that no flammable anesthetic agents will be used in these areas and provided that appropriate notices are permanently and conspicuously affixed to the wall in each such area and room.

DD. Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved. Floors in areas used for food preparation or food assembly shall be water and grease resistant. Joints in tile and similar material in such areas shall be resistant to food acids. In all areas frequently subject to wet cleaning methods floor materials shall not be physically affected by germicidal and cleaning solutions. Floors that are subject to traffic while wet (such as shower and bath areas, kitchens and similar work areas) shall have a nonslip, nonabrasive surface.

EE. Wall bases in kitchens, operating and delivery rooms, soiled workrooms, and other areas which are frequently subject to wet cleaning methods shall be made integral and coved with the floor, tightly sealed within the wall, and constructed without voids that can harbor insects.

FF. Wall finishes in kitchens, operating rooms, delivery rooms and in other sensitive treatment areas shall be washable and not affected by germicidal and cleaning solutions. Wall finishes in the immediate area of plumbing fixtures shall be moisture resistant. Finish, trim, and floor and wall construction in dietary and food preparation areas shall be free from spaces that can harbor rodents and insects.

GG. Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

HH. Ceilings shall be cleanable and those in sensitive areas such as surgical, delivery, and nursery rooms shall be readily washable and without crevices that can retain dirt particles. These sensitive areas along with the dietary and food preparation areas shall have a finished ceiling covering all overhead ductwork and piping. Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces, unless required for fire-resistive purposes.

II. Acoustical ceilings shall be provided for corridors in patient areas, nurses stations, labor rooms, dayrooms, recreation rooms, dining areas, and waiting areas.

12 VAC 5-410-1050. Construction, including fire-resistive requirements. (Repealed.)

A. Every building and every portion thereof shall be designed and constructed to sustain all dead and live loads in accordance with the Uniform Statewide Building Code and accepted engineering practices and standards, including seismic forces where they apply.

B. Foundations shall rest on natural solid bearing if a satisfactory bearing is available at reasonable depths. Proper soil-bearing values shall be established in accordance with recognized standards. If solid bearing is not encountered at partial depths, the structure shall be supported on driven piles or drilled piers designed to support the intended load without detrimental settlement, except that one story buildings may

rest on a fill designed by a soils engineer. When engineered fill is used, site preparation and placement of fill shall be done under the direct full-time supervision of the soils engineer. The soils engineer shall issue a final report on the compacted fill operation and certification of compliance with the job specifications. All footings shall extend to a depth not less than 1'0" (30.5 cm) below the estimated maximum frost line.

~~C. Construction shall be in accordance with the requirements of the Statewide Uniform Building Code and NFPA Standard 101 and the minimum requirements contained herein.~~

~~D. Separate freestanding buildings housing nonpatient areas such as the boiler plant, laundry, shops, or general storage may be of unprotected noncombustible construction, protected noncombustible construction, or fire-resistive construction.~~

~~E. Enclosures for stairways, elevator shafts, chutes and other vertical shafts, boiler rooms, and storage rooms of 100 square feet (9.29 square meters) or greater area shall be of construction having a fire-resistance rating of not less than two hours. Note that hazardous areas shall have rated enclosures and sprinklers as described in NFPA 101.~~

~~F. Interior finish materials shall comply with the flame spread limitations and the smoke production limitations shown in Table 2, Appendix C of this chapter. If a separate underlayment is used with any floor finish materials, the underlayment and the finish material shall be tested as a unit or equivalent provisions made to determine the effect of the underlayment on the flammability characteristics of the floor finish material. Tests shall be performed by an independent testing laboratory. The above does not apply to minor quantities of wood or other trim (see NFPA 101) nor does it apply to wall covering less than 4 mil in thickness applied over a noncombustible base.~~

~~G. Building insulation materials, unless sealed on all sides and edges, shall have a flame spread rating of 25 or less and a smoke developed rating of 150 or less when tested in accordance with NFPA 255.~~

~~H. Special provisions shall be made in the design of buildings in regions where local experience shows loss of life or extensive damage to buildings resulting from hurricanes, tornadoes, floods, or earthquakes.~~

12 VAC 5-410-1060. Elevators. (Repealed.)

~~A. All hospitals having patient facilities (such as bedrooms, dining rooms, or recreation areas) or critical services (such as operating, delivery, diagnostic, or therapy) located on other than the main entrance floor shall have electric or electrohydraulic elevators. Installation and testing of elevators shall comply with the National Elevator Code. The minimum number of elevators which must be provided, shall be as follows:~~

- ~~1. At least one hospital-type elevator shall be installed where 1 to 59 patient beds are located on any floor other than the main entrance floor.~~
- ~~2. At least two hospital-type elevators shall be installed where 60 to 200 patient beds are located on floors other than the main entrance floor, or where the major inpatient services are located on a floor other than those containing~~

~~patient beds. (Elevator service may be reduced for those floors which provide only partial inpatient services.)~~

~~3. At least three hospital-type elevators shall be installed where 201 to 350 patient beds are located on floors other than the main entrance floor, or where the major inpatient services are located on a floor other than those containing patient beds. (Elevator service may be reduced for those floors which provide only partial inpatient services.)~~

~~4. For hospitals with more than 350 beds, the number of elevators shall be determined from a study of the hospital design and the estimated vertical transportation requirements.~~

~~B. Cars of hospital-type elevators shall have inside dimensions that will accommodate a patient bed and attendants and shall be at least (1.52m) wide by 7'6" (2.29m) deep. The car door shall have a clear opening of not less than 4'0" (1.22m).~~

~~C. Elevators shall be equipped with an automatic leveling device of the two-way automatic maintaining type with an accuracy of $\pm 1/2$ inch (± 1.3 cm).~~

~~D. Elevators, except freight elevators, shall be equipped with a two-way special service switch to permit cars to bypass all landing button calls and be dispatched directly to any floor.~~

~~E. Elevator controls, alarm buttons, and telephones shall be accessible to wheelchair occupants.~~

~~F. Elevator call buttons, controls, and door safety stops shall be of a type that will not be activated by heat or smoke.~~

~~G. Inspections and tests shall be made and the owner shall be furnished written certification that the installation meets the requirements set forth in this section and all applicable safety regulations and codes.~~

12 VAC 5-410-1070. General mechanical requirements. (Repealed.)

~~A. Prior to completion and acceptance of the facility, all mechanical systems shall be tested, balanced, and operated to demonstrate to the owner or his representative that the installation and performance of these systems conform to the requirements of the approved plans and specifications.~~

~~B. Upon completion of the contract, the owner shall be furnished with a complete set of manufacturers' operating, maintenance; and preventive maintenance instructions, and parts lists and procurement information with numbers and description for each piece of equipment and be provided with instructions in the operational use of systems and equipment as required.~~

~~C. Insulation shall be provided within the building for the following:~~

- ~~1. Boilers, smoke breeching, and stacks;~~
- ~~2. Steam supply and condensate return piping;~~
- ~~3. Hot water piping above 120°F (49°C) and all hot water heaters, generators, and converters;~~

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4. Chilled water, refrigerant, other process piping and equipment operating with fluid temperatures below ambient dew point;

5. Water supply and drainage piping on which condensation may occur;

6. Air ducts and casings with outside surface temperature below ambient dew point or temperature above 80°F (27°C); and

7. Other piping, ducts, and equipment as necessary to maintain the efficiency of the system. Insulation required above may be omitted from hot water and steam condensate piping not subject to contact by patients when the heat loss from such piping without insulation does not increase the energy requirements of the system. Insulation on cold surfaces shall include an exterior vapor barrier. Insulation, including finishes and adhesives on the exterior surfaces of ducts, pipes, and equipment, shall have a flame spread rating of 25 or less and a smoke developed rating of 50 or less as determined by an independent testing laboratory in accordance with NFPA 255. Linings in air ducts and equipment shall meet the Erosion Test Method described in Underwriters' Laboratories, Inc., Publication No. 181. These linings, including coatings and adhesives, and insulation in building spaces used as air supply plenums, shall have a flame spread rating of 25 or less and a smoke developed rating of 50 or less as determined by an independent testing laboratory in accordance with NFPA 255. Duct linings shall not be used in systems supplying operating rooms, delivery rooms, recovery rooms, nurseries, isolation rooms, and intensive care units unless terminal filters of at least 90% efficiency are installed downstream of linings.

D. Boilers shall have the capacity, based upon the net ratings published by the Hydronics Institute, to supply the normal requirements of all systems and equipment. The number and arrangement of boilers shall be such that, when one boiler breaks down or routine maintenance requires that one boiler be temporarily taken out of service, the capacity of the remaining boiler(s) shall be sufficient to provide hot water service for clinical, dietary, and patient use; steam for sterilization and dietary purposes; and heating for operating, delivery, labor, recovery, intensive care, nursery, and general patient rooms, except that capacity for space heating is not required in areas with a design temperature of 20°F (-7°C) or more, based on the Median of Extremes in the ASHRAE Handbook of Fundamentals.

E. Boiler feed pumps, heating circulating pumps, condensate return pumps, and fuel oil pumps shall be connected and installed to provide normal and standby service.

F. Supply and return mains and risers of cooling, heating, and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return ends except that vacuum condensate returns need not be valved at each piece of equipment.

G. The designed capacity of the mechanical systems shall provide the temperatures and humidities in special areas as found in Table 3 of Appendix C of this chapter. For other

areas occupied by inpatients the indoor winter design temperature shall be 75°F (24°C). (A minimum relative humidity of 30% is recommended but not required.) For all other occupied areas, the indoor winter design temperature shall be 72°F (22°C).

12 VAC 5-410-1080. Ventilation system details. (*Repealed.*)

A. All air supply and air exhaust systems shall be mechanically operated. All fans serving exhaust systems shall be located at the discharge end of the system. The ventilation rates shown in Table 4, Appendix C of these Regulations shall be considered as minimum acceptable rates and shall not be construed as precluding the use of higher ventilation rates.

B. In the interest of energy conservation, the applicant is encouraged to utilize recognized procedures such as variable air volume and load shedding systems in areas not listed in Table 4, Appendix C and where direct patient care is not affected such as administrative and public areas, general storage, etc. Consideration may be given to special design innovations in areas of Table 4, Appendix C provided that pressure relationship as an indication of direction of air flow and total number of air changes as listed are maintained.

C. Outdoor intakes shall be located as far as practical but not less than 25'0" (7.62 m) from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vents stacks, or from areas which may collect vehicular exhaust and other noxious fumes (plumbing and vacuum vents that terminate above the level of the top of the air intake may be located as close as 10'0" (3.05m). The bottom of outdoor air intakes serving central systems shall be located as high as practical but not less than 6'0" (1.83 m) above ground level, or if installed above the roof, 3'0" (91cm) above the roof level.

D. The ventilation systems shall be designed and balanced to provide the pressure relationship as shown in Table 4, Appendix C.

E. All air supplied to operating rooms, delivery rooms, and nurseries shall be delivered at or near the ceiling of the area served, and all return air from the area shall be removed near floor level. At least two return air outlets shall be used in each operating and delivery room.

F. Each space routinely used for the administering of inhalation anesthetizing agents shall be provided with a separate scavaging system for venting of waste anesthetizing gases. Pressure balance must be such that the gas collecting system does not interfere with required room pressure relationship or with breathing circuit that may affect patient safety. The intake shall be appropriately located in relation to the patient and the equipment designed so that gases are exhausted directly to the outside.

Potentially harmful effects upon personnel subject to constant exposure to anesthetizing gases are generally recognized but acceptable levels of concentration are unknown at this time. In the absence of specific figures, any scavaging system should be designed to remove as much of the anesthetizing gas as possible. Maximum effectiveness of the scavaging system may also require careful attention to selection and maintenance of anesthetizing equipment used.

G. The bottoms of ventilation (supply/return) openings shall be not less than three inches (7.6 cm) above the floor of any room.

H. Corridors shall not be used to supply air to or exhaust air from any room, except that air from corridors may be used to ventilate bathrooms, toilet rooms, janitors' closets, and small electrical or telephone closets opening directly on corridors provided that ventilation can be accomplished by undercutting of doors.

I. Isolation rooms and intensive care rooms may be ventilated by induction units if the induction units contain only a reheat coil and if only the primary air supplied from a central system passes through the reheat coil.

J. All central ventilation or air conditioning systems shall be equipped with filters having efficiencies no less than those specified in Table 5, Appendix C of this chapter. Where two filter beds are required, filter bed No. 1 shall be located upstream of the air conditioning equipment and filter bed No. 2 shall be downstream of the supply fan, any recirculating spray water systems, and water reservoir type humidifiers. Where only one filter bed is required, it shall be located upstream of the air conditioning equipment unless an additional prefilter is employed. In this case, the prefilter shall be upstream of the equipment and the main filter may be located further downstream.

K. All filter efficiencies shall be average atmospheric dust spot efficiencies tested in accordance with ASHRAE Standard 52-76 except as noted in subsections U and V of this section.

L. Filter frames shall be durable and carefully dimensioned and shall provide an airtight fit with the enclosing ductwork. All joints between filter segments and the enclosing ductwork shall be gasketed or sealed to provide a positive seal against air leakage.

M. A manometer shall be installed across each filter bed serving sensitive areas or central air systems.

N. Air handling duct systems shall meet the requirements of NFPA Standard 90A, and those serving sensitive areas shall also comply with requirements for duct linings specified in 12 VAC 5-410-1070 C.

O. Ducts which penetrate construction for intended X-ray or other ray protection shall not impair the effectiveness of the protection.

P. Fire and smoke dampers shall be constructed, located, and installed in accordance with the requirements of NFPA Standard 90A, except that all systems, regardless of size, which serve more than one smoke or fire zone, shall be equipped with smoke detectors to shut down fans automatically as delineated in paragraph 4.3.2 of that standard. Access for maintenance shall be provided at all dampers.

Q. Switching for restart of fans may be conveniently located for fire department use to assist in evacuation of smoke after the fire is controlled, provided that provisions are made to avoid possible damage to the system because of closed dampers.

R. Supply and exhaust ducts which pass through a smoke separation of required compartmentation and through which smoke can be transferred to another area shall be provided with dampers at the separation controlled to close automatically to prevent flow of air or smoke when the fan, which moves the air through the duct, stops. Dampers shall be equipped with remote control reset devices except that manual reopening will be permitted if dampers are conveniently located.

S. Return air ducts which pass through a smoke separation of required compartmentation shall be provided with a damper at the separation actuated by smoke or products of combustion (other than heat) detectors. These dampers shall be operated by the detectors located to sense smoke in the return air duct from the smoke zone. On high velocity systems, a time delay is required so that fan will be stopped prior to damper closing. Engineered smoke exhaust systems may be considered for approval as described by NFPA on a case by case basis.

T. If the air changes required in Table 4, Appendix C of this chapter do not provide sufficient air for use by hoods and safety cabinets, the required makeup air shall be provided as necessary to maintain required room pressure relationship.

U. Laboratory hoods shall meet the following general requirements:

1. Have an average face velocity of not less than 75 feet per minute (0.38 meters per second);
2. Be connected to an exhaust system which is separate from the building exhaust system;
3. Have an exhaust fan located at the discharge end of the system; and
4. Have an exhaust duct system of noncombustible corrosion-resistant material as needed to meet the planned usage of the hood.

V. Laboratory hoods shall meet the following special requirements:

1. Each hood which processes infectious or radioactive materials shall have a minimum face velocity of 100 feet per minute (0.51 meters per second), shall be connected to an independent exhaust system, shall have filters with a 99.97% efficiency (based on the DOP, dioctyl-phthalate, test method) in the exhaust stream, and shall be designed and equipped to permit the safe removal, disposal, and replacement of contaminated filters; and
2. Duct systems serving hoods in which radioactive and strong oxidizing agents (e.g. perchloric acid) are used shall be constructed of chemical resistant materials and shall be equipped with washdown facilities.

W. Exhaust hoods in food preparation centers shall have an exhaust rate of not less than 50 cfm per square foot (0.25 cubic meters per second per square meter) of face area. Face area is defined for this purpose as the open area from the exposed perimeter of the hood to the average perimeter of the cooking surfaces. All hoods over cooking ranges shall be equipped with grease filters, fire extinguishing systems, and heat-actuated fan controls. Cleanout openings shall be

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provided every 20'0" (6.10m) in horizontal exhaust duct system serving these hoods.

X. The ventilation system for anesthesia storage rooms shall conform to the requirements of NFPA Standard 56A, including the gravity option. The mechanically operated air systems required in this Section of chapters is optional in this room only.

Y. Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and to limit temperatures in working stations to 97°F (36°C) Effective Temperatures (ET⁺) as defined by ASHRAE Handbook of Fundamentals.

Z. See 12 VAC 5-410-1040 for additional boiler room, food preparation center, and laundry ventilation requirements.

12 VAC 5-410-1090. Plumbing and other piping systems. (Repealed.)

A. All plumbing systems shall be designed and installed in accordance with the requirements of the Statewide Uniform Building Code, article for "Health Care Facility Plumbing."

B. Plumbing fixtures shall comply with the following:

1. The material used for plumbing fixtures shall be of nonabsorptive acid-resistant material;

2. The water supply spout for lavatories and sinks required in patient care areas shall be mounted so that its discharge point is a minimum distance of five inches (12.7 cm) above the rim of the fixture. All fixtures used by medical and nursing staff and all lavatories used by patients and food handlers shall be trimmed with valves which can be operated without the use of hands (single lever devices may be used subject to above). Where blade handles are used for this purpose, they shall not exceed 4 1/2 inches (11.4 cm) in length, except that handles on scrub sinks and clinical sinks shall be not less than 6 inches (15.2 cm) long;

3. Clinical sinks shall have an integral trap in which the upper portion of a visible trap seal provides a water surface and shall be provided with a hose spray attachment with hot and cold water and a vacuum breaker;

4. Shower bases and tubs shall provide nonslip surfaces;

5. Bedpan flushing devices shall be provided in each patient toilet room, except those in ambulatory care areas;

6. Flush valves installed on plumbing fixtures shall be of a quiet operating type, equipped with silencers; and

7. Backflow preventers (vacuum breakers) shall be installed on hose bibbs, laboratory sinks, janitors' sinks, bedpan flushing attachments, autopsy tables, and on all other fixtures to which hoses or tubing can be attached.

C. Water supply systems shall conform to Virginia Health Department Waterworks Regulations (12 VAC 5-590-10 et seq.) in addition to the Statewide Plumbing Code and the following:

1. Systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand periods;

2. Each water service main, branch main, riser, and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture; and

3. Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at bathing and handwashing facilities shall not exceed 120°F (49°C).

D. The hot water heating equipment shall have sufficient capacity to supply water at the temperatures and amounts indicated in Table 6, Appendix C of this chapter. Water temperatures to be taken at hot water point of use or inlet to processing equipment. Storage tank(s) shall be fabricated of corrosion-resistant metal or lined with noncorrosive material.

E. Drainage systems shall conform to the following:

1. Drain lines from sinks in which acid wastes may be poured shall be fabricated from an acid-resistant material;

2. Drain lines serving automatic blood cell counters shall be of carefully selected material because of a possible undesirable chemical reaction between blood count waste which includes sodium azide, and plumbing system materials such as copper, lead, brass, and solder;

3. Insofar as possible, drainage piping shall not be installed within the ceiling nor installed in an exposed location in operating and delivery rooms, nurseries, food preparation centers, food serving, food storage areas, and other critical areas. Special precautions shall be taken to protect these areas from possible leakage or condensation from overhead piping systems;

4. Floor drains shall not be installed in operating and delivery rooms. Flushing rim type floor drains may be installed in cystoscopic operating rooms; and

5. Building sewers shall discharge into a community sewage system, or other approved system.

F. Nonflammable medical gas system installations shall be in accordance with the requirements of NFPA 56A and 56F. (See Table 7, Appendix C of this chapter for rooms which require station outlets.) As part of the project contract, where any piping or supply of medical gases is affected by change, alteration, or additions, the entire system shall be tested and certified as to type, quality, and quantity of medical gas at each outlet and exact areas affected by each control valve station.

G. Clinical vacuum (suction) system installations shall be in accordance with the requirements of Compressed Gas Association Pamphlet No. P-2.1. (See Table 7, Appendix C of this chapter for rooms which require station outlets.)

H. Service outlets for central housekeeping vacuum systems, if used, shall not be located within operating or delivery rooms.

I. All piping, including heating, ventilating, air conditioning (HVAC) shall be color coded or otherwise marked for easy identification.

12 VAC 5-410-1100. General electrical requirements. (Repealed.)

A. All materials including conductors, controls and signaling devices shall be installed to provide a complete electrical system with the necessary characteristics and capacity to supply the electrical facilities shown in the specifications or indicated on the architectural drawings. All materials shall be listed as complying with available standards of Underwriters' Laboratories, Inc., or other similarly established standards.

B. All electrical installations and systems shall conform to the Statewide Uniform Building Code (National Electrical Code) and be tested to show that the equipment is installed and operates as planned or specified. A written record of performance tests on special electrical systems and equipment shall be supplied to the owner. Such tests shall show compliance with the governing codes including conductive floors, isolated power systems, grounding continuity, and alarm systems.

C. Circuit breakers or fusible switches that provide disconnecting means and overcurrent protection for conductors connected to switchboards and panelboards shall be enclosed or guarded to provide a dead-front type of assembly. The main switchboard shall be located in a separate enclosure accessible only to authorized persons. The switchboards shall be convenient for use, readily accessible for maintenance, clear of traffic lanes, and in a dry ventilated space free of corrosive fumes or gases. Overload protective devices shall be suitable for operating properly in the ambient temperature conditions.

D. Panelboards serving lighting and appliance circuits shall be located on the same floor as the circuits they serve.

12 VAC 5-410-1110. Lighting and receptacles. (Repealed.)

A. All spaces occupied by people, machinery, and equipment within buildings, approaches to buildings, and parking lots shall have lighting.

B. Patients' rooms shall have general lighting and night lighting. A reading light shall be provided for each patient. Flexible light arms shall be mechanically controlled to prevent the bulb from coming in contact with bed linen. At least one light fixture for night lighting shall be switched at the entrance to each patient room. All switches shall be of the quiet operating type.

C. Operating and delivery rooms shall have general lighting in addition to local lighting provided by special lighting units at the operating and delivery tables. Each fixed special lighting unit at the tables, except for portable units, shall be connected to an independent circuit.

D. Nursing unit corridors shall have general illumination with provisions for reduction of light level at night.

E. Anesthetizing locations. Each operating and delivery room shall have at least three receptacles. In locations where mobile x-ray is used, an additional receptacle, distinctively marked for x-ray use, shall be provided. (See subsection G of this section for receptacle requirements when capacitive discharge mobile x-ray units are used.)

F. As a minimum, each patient room shall have duplex grounding type receptacles as follows: (i) one located on each side of the head of each bed; (ii) one for television, if used; and (iii) one on each other wall. Nurseries shall have not less than one duplex grounded receptacle for each bassinet. Receptacles in pediatric units shall be of the safety type or shall be protected by five milliamperes ground fault interrupters.

G. Duplex grounded receptacles for general use shall be installed approximately 50'0" (15.24 m) apart in all corridors and within 25'0" (7.62 m) of ends of corridors. Receptacles in corridors of pediatric units shall be of the safety type or shall be protected by five milliamperes ground fault interrupters or shall be controlled by switches located at a nurses' station or other supervised location. Single polarized receptacles marked for use of x-ray only shall be located in corridors of patient areas so that mobile equipment may be used in any location within a patient room without exceeding a cord length of 50'0" (15.24 m) attached to the equipment. If the same mobile x-ray unit is used in operating rooms and in nursing areas, all receptacles for x-ray use shall be of a configuration that one plug will fit the receptacles in all locations. Where capacitive discharge or battery powered x-ray units are used, these polarized receptacles are not required.

12 VAC 5-410-1120. Equipment installation in special areas. (Repealed.)

A. Installation in anesthetizing locations. All electrical equipment and devices, receptacles, and wiring shall comply with NFPA Standard 70, except that a line isolation monitor will be permitted, which alarms at a total hazard current of five milliamperes.

B. Fixed and mobile x-ray equipment installations shall conform to Article 517 of NFPA Standard 70.

C. At least two x-ray film illuminator units shall be installed in each operating room, emergency treatment room, and in the X-ray viewing room of the radiology department.

D. The electrical circuit(s) to equipment in wet areas shall be provided with five milliamperes ground fault interrupters. Where ground fault interrupters are used in critical areas, provision shall be made to ensure that other essential equipment will not be affected by a single interruption.

E. In areas such as intensive units (and special nurseries, when indicated by the program) where a patient may be treated with an internal probe or catheter connected to the heart, the ground system shall comply with Article 517-84, 517-86, and 517-88 of NFPA 70.

12 VAC 5-410-1130. Nurses' calling system. (Repealed.)

A. In general patient areas, each room shall be served by at least one calling station and each bed shall be provided with a call button. Two call buttons serving adjacent beds may be served by one calling station. Calls shall register with floor staff and shall activate a visible signal in the corridor at the patient door, in the clean workroom, the soiled workroom, and the nourishment station of the nursing unit. In multicorridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two or more calling stations, indicating lights shall be provided at each station. Nurses' calling systems which provide two-way voice

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communication shall be equipped with an indicating light at each calling station which lights and remains lighted as long as the voice circuit is operating.

B. A nurses' call emergency button shall be provided for patient use at each patient's toilet, bath, sitz bath, and shower room. Such a button shall be usable by a collapsed patient lying on the floor (inclusion of a pull cord will satisfy this item).

C. In areas such as intensive care where patients are under constant surveillance, the nurses' calling system may be limited to a bedside station that will activate a signal that can be readily seen by the nurse.

D. A nurses' emergency calling station which may be used by nurses to summon assistance shall be provided in each operating, delivery, recovery, emergency treatment, and intensive care room, in nurseries, renal dialysis units, and in supervised nursing units for mental patients.

12 VAC 5-410-1140. Emergency electrical system. (Repealed.)

A. To provide electricity during an interruption of the normal electric supply, an emergency source of electricity shall be provided and connected to certain circuits for lighting and power. Where stored fuel is required, capacity shall be such as to permit continuous operation for at least 24 hours.

B. The source of this emergency electric service shall be as follows:

1. An emergency generating set when the normal service is supplied by one or more central station transmission lines.
2. An emergency generating set or a central station transmission line when the normal electric supply is generated on the premises.

C. The required emergency generating set, including the prime mover and generator, shall be located on the premises. The generator set shall be self-sufficient insofar as possible without dependency on public utilities that may be subject to cut off or outages. A system of prime movers which are ordinarily used to operate other equipment and alternately used to operate the emergency generators will be permitted provided that the number and arrangement of the prime movers are such that when one of them is out of service (due to breakdown or for routine maintenance) the prime movers can operate the required emergency generators, and provided that the connection time requirements of subsection E of this section are met.

D. Emergency electrical service shall be provided to the distribution systems as follows:

1. Circuits for the safety of patients and personnel:
 - a. Illumination of means of egress are as required in NFPA Standard 101.
 - b. Illumination for exit signs and exit directional signs as required in NFPA Standard 101 and basic task illumination for critical elements of equipment such as pumps, elevator machinery, generator sets, etc.
 - c. Alarm systems including fire alarms activated at manual stations, water flow alarm devices of sprinkler

system if electrically operated, fire and smoke detecting systems, and alarms required for nonflammable medical gas systems if installed.

d. Paging or speaker systems if intended for communication during emergency. Radio transceivers where installed for emergency use shall be capable of operating for at least one hour upon total failure of both normal and emergency power.

e. General illumination and selected receptacles in the vicinity of the generator set.

2. Circuits essential to care, treatment, and protection of patients.

a. Task illumination and selected receptacles in infant nurseries; medicine dispensing areas; cardiac catheterization laboratories; angiographic laboratories; labor operating, delivery, and recovery rooms; dialysis units; intensive care areas; emergency treatment rooms; basic laboratory functions; and nurses' stations.

b. Corridor duplex receptacles in patient areas.

c. Nurses' calling system.

d. Blood bank refrigeration.

e. Equipment necessary for maintaining telephone service.

f. Each patient area in which life support systems are used shall have access to both normal and emergency power directly or by extension cords of not more than 50'0" (15.24m) in length.

3. Circuits which serve necessary equipment. The connection to the following emergency electric services shall be delayed automatic except for heating, ventilation, fire pump, and elevators which may be either delayed automatic or manual.

a. Equipment for heating the operating, delivery, labor, recovery, intensive care, renal dialysis, nursery, and general patient rooms, except that service for heating of general patient rooms will not be required under either of the following conditions: (i) if the design temperature is higher than 20°F (-7°C) based on the Median of Extremes as shown in the ASHRAE Handbook of Fundamentals, or (ii) if the hospital is served by two or more electrical services supplied from separate generators or a utility distribution network having multiple power input sources and arranged to provide mechanical and electrical separation so that a fault between the hospital and the generating sources will not likely cause an interruption of the hospital service feeders.

b. Elevator service that will reach every patient floor. Throwover facilities shall be provided to allow temporary operation of any elevator for the release of persons who may be trapped between floors.

c. Ventilation of operating and delivery rooms.

d. Central suction systems service serving medical and surgical functions.

~~e. Equipment which must be kept in operation to prevent damage to the building or its contents.~~

~~f. Fire pump if installed.~~

~~E. The emergency electrical system shall be so controlled that after interruption of the normal electric power supply, the generator is brought to full voltage and frequency. It must be connected within 10 seconds through one or more primary automatic transfer switches to emergency lighting systems; alarm systems; blood banks; nurses calling systems; equipment necessary for maintaining telephone service; and task illumination and receptacles in operating, delivery, emergency, recovery, and cardiac catheterization rooms, intensive care nursing areas, nurseries, renal dialysis unit, and other critical patient areas. All other lighting and equipment required to be connected to the emergency system shall either be connected through the above described primary automatic transfer switches or through other automatic or manual transfer switches. Receptacles connected to the emergency system shall be distinctively marked. Storage battery-powered lights provided to augment the emergency lighting or for continuity of lighting during the interim of transfer switching immediately following an interruption of the normal service supply, shall not be used as a substitute for the requirement of a generator. Where stored fuel is required for emergency generator operation, the storage capacity shall be sufficient for not less than 24-hour continuous operation.~~

~~F. Local codes and regulations may have additional requirements which should be considered.~~

~~G. Fire protection systems shall be provided as described in NFPA 101.~~

12 VAC 5-410-1250. Laboratory and pathology services.

A. Laboratory and pathology services each patient admitted to the outpatient surgical hospital shall receive appropriate laboratory testing *according to 42 CFR Part 493*.

B. All tissue removed shall be submitted for histological examination by a pathologist and a written report of his examination provided to the attending physician. The report of findings shall be filed in the patient's clinical record.

12 VAC 5-410-1260. Medical records.

A. Medical records. An accurate and complete clinical record or chart shall be maintained on each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, when applicable, but not be limited to the following:

1. Patient identification;
2. Admitting information, including patient history and physical examination;
3. Signed consent;
4. Confirmation of pregnancy, if applicable;
5. Physician orders;
6. Laboratory tests, pathologist's report of tissue, and radiologist's report of x-rays;

7. Anesthesia record;
8. Operative record;
9. Surgical medication and medical treatments;
10. Recovery room notes;
11. Physician and nurses' progress notes,
12. Condition at time of discharge,
13. Patient instructions, preoperative and postoperative;
14. Names of referral physicians or agencies.

B. Provisions shall be made for the safe storage of medical records or accurate and legible reproductions thereof *according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act, or HIPPA (42 USC § 1320d et seq.)*.

C. All medical records, either original or accurate reproductions, shall be preserved for a minimum of five years following discharge of the patient.

1. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.
2. Birth and death information shall be retained for 10 years in accordance with § 32.1-274 of the Code of Virginia.
3. Record of abortions and proper information for the issuance of a fetal death certificate shall be furnished the Division of Vital Records, Virginia Department of Health, within 10 days after the abortion.

12 VAC 5-410-1290. Environment and maintenance.

A. All parts of the outpatient surgical hospital and its premises shall be kept clean, neat, and free of litter and rubbish.

B. Hazardous cleaning solutions, compounds, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other materials.

C. Accumulated waste, including all contaminated sharps, dressings, or similar infectious waste, shall be disposed of in a manner compliant with the OSHA Bloodborne Pathogens standard (29 CFR 1910.1030).

12 VAC 5-410-1310. ~~Physical plant; fire and safety; lighting and electrical; plumbing; sewage and waste disposal; water supply. (Repealed.)~~

~~A. Each outpatient hospital shall establish a monitoring program for the internal enforcement of all applicable fire and safety laws and regulations.~~

~~B. Policies and procedures shall be established to minimize the hazards in the use and operation of all electrical equipment. All electrical appliances used by the outpatient surgical hospital shall have the Underwriters Laboratories label or be approved by the local electrical inspection authority.~~

~~C. All plumbing material and plumbing systems or parts thereof shall meet the minimum requirements of the Uniform Statewide Building Code. All plumbing shall be installed in~~

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~~such a manner as to prevent back-siphonage or cross-connections between potable and nonpotable water supplies.~~

~~D. Existing and new facilities shall be connected to an approved sewage system.~~

~~E. Pathological and bacteriological wastes, dressings, and other contaminated wastes shall be incinerated in an approved incinerator or by other methods of disposal as approved by the licensing agency.~~

~~F. Water shall be obtained from an approved water supply system. The water shall be distributed to conveniently located taps and fixtures throughout the facility and shall be adequate in volume and pressure for all hospital purposes, including fire fighting.~~

12 VAC 5-410-1320. Narrative programs. (Repealed.)

~~A. The owner or his representative shall provide a brief narrative which describes the functional space requirements, staffing patterns, departmental relationship, and other basic information relating to the fulfillment of the institution's objective.~~

~~B. The narrative shall indicate the manner in which the services are to be made available to the outpatients. When services are to be shared or purchased, appropriate modifications or deletions in space and equipment requirements shall be considered to avoid duplication. In many instances, minimum requirements are not intended in any way to restrict innovations and improvements in design or construction techniques. Plans and specifications which contain deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled. Request to waive any specific requirements shall be submitted to the licensing agency for approval prior to development of working drawings and specifications.~~

~~C. The extent (number and type) of the diagnostic, clinical, and administrative facilities to be provided shall be determined by the services contemplated and the estimated patient load as described in the narrative program.~~

12 VAC 5-410-1330. Applicable requirements. (Repealed.)

~~If the outpatient surgical hospital is a physical part of an inpatient hospital and is intended to serve inpatients as well as outpatients, the applicable requirements of Part II and Part III of this chapter must be met.~~

12 VAC 5-410-1340. Parking. (Repealed.)

~~In the absence of a formal parking study, vehicle parking for outpatient surgical hospitals shall be provided at the ratio of two parking spaces for each treatment room and each examining room plus sufficient parking spaces to accommodate the maximum number of staff on duty at one time. Exceptions may be made with approval of the licensing agency for outpatient surgical hospitals located in areas with high population density if adequate public parking is available or if the hospital is accessible to a public transportation system.~~

12 VAC 5-410-1350. Codes; fire safety; zoning; conversions construction standards.

~~A. All construction of new buildings and additions alterations or repairs to existing buildings for occupancy as a "free-standing" outpatient hospital shall conform to state and local codes, zoning and building ordinances, and the Statewide Uniform Building Code requirements applicable to type of occupancy. All codes applicable to the outpatient surgical hospital shall be noted on the preliminary and working drawings.~~

~~*In addition, hospitals shall be designed and constructed according to sections 1 through 6 and 9 of the 2001 Guidelines for Design and Construction of Hospital and Health Care Facilities of the American Institute of Architects. However, the requirements of the Uniform Statewide Building Code and local zoning and building ordinances shall take precedence.*~~

~~B. Conversions of existing buildings to outpatient surgical hospital occupancy will be considered only in those buildings which meet or can be remodeled to meet the requirements of the Statewide Uniform Building Code. All buildings shall be inspected and approved as required by the appropriate building regulatory entity. Approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose.~~

~~C. The use of an incinerator shall require permitting from the nearest regional office of the Department of Environmental Quality.~~

~~D. Water shall be obtained from an approved water supply system. Outpatient surgery centers shall be connected to sewage systems approved by the Department of Health or the Department of Environmental Quality.~~

~~E. Each outpatient surgery center shall establish a monitoring program for the internal enforcement of all applicable fire and safety laws and regulations.~~

~~F. All radiological machines shall be registered with the Office of Radiological Health of the Virginia Department of Health. Installation, calibration and testing of machines and storage facilities shall comply with 12 VAC 5-480.~~

~~G. Pharmacy services shall comply with Chapter 33 (§ 54.1-3300 et seq.) of Title 54.1 of the Code of Virginia and 18 VAC 110-20.~~

12 VAC 5-410-1360. Site requirements and location. (Repealed.)

~~A. The site shall meet local zoning regulations.~~

~~B. Facilities not located on the ground floor of a building shall be served by an elevator(s) capable of accommodating a standard stretcher.~~

~~C. Facilities shall be located in buildings providing emergency electrical service. The emergency electrical service may be provided by an auxiliary generator, or, if available from the power company, two separate lines, each supplied from a separate generating source. The emergency electrical service shall have the capability to cover at least the operating,~~

~~procedure, and recovery room(s) lighting and electrical equipment.~~

~~D. The sanitation, water supply, sewage, and disposal facilities shall comply with the applicable state and local codes and ordinances.~~

~~E. Adequate fire protection facilities or fire department services shall be available.~~

12 VAC 5-410-1370. General. (Repealed.)

~~During the early phase of architectural planning, prime consideration shall be given to patient traffic from the patient parking area to admissions and through the service area to discharge offices and to areas for patient pick up. Personnel traffic patterns from other areas to the service area, as well as those related to internal operations, including supply distribution shall be considered.~~

12 VAC 5-410-1380. Drawings and specifications.

~~A. Preliminary drawings and outline specifications shall be submitted to the licensing agency with a program narrative description for review and approval prior to starting final working drawings and specifications. All new construction or for additions, alterations or renovations to any existing building shall be dated, stamped with licensure seal and signed by the architect. The architect shall certify that the drawings and specifications were prepared to conform to building code requirements. The certification shall be forwarded to the center.~~

~~B. The final working drawings and specifications shall be submitted to the licensing agency for review and approval prior to release of contract documents for bidding. Additional approval may include a Certificate of Public Need.~~

~~C. The licensing agency shall be notified of the award of contracts, of the date when construction has been completed, and at least 30 days prior to the estimated date of occupancy. Upon completion of the construction, the outpatient surgery center shall maintain a complete set of legible "as is" drawings showing all construction, fixed equipment, and mechanical and electrical systems, as installed or built.~~

~~D. Minor alterations or remodeling changes which do not affect the structural integrity of the building, or change functional operation, or which do not affect safety, need not be submitted for approval.~~

~~E. The preparation and submission of drawings and specifications shall be executed by or under the immediate supervision of an architect registered in the Commonwealth of Virginia.~~

Article 3. Design Requirements.

12 VAC 5-410-1390. Administration and public areas. (Repealed.)

~~A. Entrance to the building shall be located at grade level, sheltered from the weather and able to accommodate wheelchairs, if applicable.~~

~~B. The same room may serve more than one function. The design shall assure that adequate space is available for all administrative services.~~

~~C. The reception area may be considered a part of administrative services. Adequate space near the entrance shall be provided for receiving and registering patients. Work space shall provide privacy for obtaining confidential information and discussing financial arrangements.~~

~~D. Adequate waiting space shall be provided for at least one family member or friend per patient. Facilities shall include public toilets, public telephone(s), drinking fountains(s), and wheelchair storage.~~

~~E. Adequate space to assure privacy for both males and females shall be provided in dressing rooms and patient lockers, toilet and bathing facilities, preoperative preparation, medication administration, and patient holding areas.~~

~~F. If the program calls for services requiring special patient counseling, private space shall be provided for this service.~~

~~G. Facilities and space may be provided for preparation of light nourishment, refrigeration and ice machine. Handwashing facilities shall be provided in the room.~~

~~H. Space for general storage for office supplies, sterile supplies, pharmacy and housekeeping supplies shall be provided.~~

~~I. Adequate janitor's closet(s) with floor receptor or service sink shall be provided.~~

12 VAC 5-410-1400. Clinical areas. (Repealed.)

~~A. The size and design of units shall be in accordance with individual programs but the following basic elements shall be incorporated in all facilities, where applicable.~~

~~B. The plumbing, heating, and electrical systems for the surgical suite shall meet all applicable parts specified in 12 VAC 5-410-820.~~

~~C. The architectural design of the facilities shall provide a sufficient number of rooms for the projected case load and types of procedures to be performed. Operating rooms shall have minimum dimensions of 16' X 18'. One smaller room may be reserved for minor local excisions but that room shall be no less than 160 square feet (14.88 sq. m).~~

~~D. Scrub sinks shall be provided. Scrub facilities shall be arranged to minimize any incidental splatter on nearby personnel or supply carts.~~

~~E. The locker and dressing areas shall be located so that personnel enter from uncontrolled areas and exit directly into the surgical suite. Locker space shall be provided for each employee, and a toilet, shower, and dressing area shall be provided in each personnel dressing room.~~

~~F. The recovery room shall have handwashing facilities, medication storage space, clerical work space, storage for clerical supplies, linens, and patient care supplies and equipment, and an adjoining toilet which shall have a water closet and handwashing lavatory.~~

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~~G. The preoperative preparation area may be designed and equipped for examination. Each room shall have a handwashing lavatory and be equipped for patient examination.~~

~~H. Separate work and storage rooms shall be provided for clean and sterile holding and for instrument or equipment clean-up functions.~~

~~I. Unless the narrative program and governing body prohibit, in writing, the use of flammable anesthetics a separate anesthesia storage room shall be provided for storage of flammable gases.~~

~~J. Anesthesia workroom and equipment storage facilities with adequate ventilation, work counter and sink shall be provided.~~

~~K. Sufficient clerical control stations shall be appropriately designed and located. Suitable space shall be provided for the following activities: (i) traffic control of the area; (ii) clerical functions related to room or case scheduling and record maintenance; (iii) personnel functions; and (iv) nursing activities related to medication administration and treatments.~~

~~L. Private and adequate space to accommodate the total number of doctors who may be dictating at the same time shall be provided. This space may be located adjacent to but not inside the nurses' station, lounge, or doctors' dressing area.~~

~~M. A janitor's closet which meets the requirements of 12 VAC 5-410-820 E-17 of this chapter shall be provided.~~

12 VAC 5-410-1410. Laboratory and radiology services. (Repealed.)

~~Space and equipment requirements shall be determined by the workload described in the narrative program. These services may be provided within the outpatient surgical hospital or through an effective contractual arrangement with nearby facilities. If laboratory or radiology services or both are not provided by contractual agreement all applicable parts of 12 VAC 5-410-290, 12 VAC 5-410-300, 12 VAC 5-410-310 and 12 VAC 5-410-400 of this chapter shall apply.~~

12 VAC 5-410-1420. General requirements. (Repealed.)

~~A. Minimum public corridor width shall be 5'0" (1.52m).~~

~~B. Each building shall have at least two exits remote from each other. Other details as to exits and fire safety shall be in accordance with the Virginia Statewide Fire Prevention Code (13 VAC 5-50-10 et seq.).~~

~~C. Items such as drinking fountains, telephone booths, vending machines and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width below the required width.~~

~~D. Toilet rooms which may be used by patients shall be equipped with doors and hardware which will permit access from the outside in any emergency.~~

~~E. The minimum width of doors for patient access to examination and treatment rooms shall be 3'0" (.91m).~~

~~F. No door shall swing into a corridor in a manner that might obstruct traffic flow or reduce the required corridor width,~~

~~except doors to space such as small closets which are not subject to occupancy.~~

~~G. Rooms containing ceiling mounted equipment and those have ceiling mounted surgical light fixtures shall have height required to accommodate the equipment or fixture. All other rooms shall have not less than 8'0" (2.43 m) ceiling except that corridors, storage rooms, toilet rooms and other minor rooms shall not be less than 7'8" (2.23 m).~~

~~H. Cubicle curtains and draperies shall be noncombustible or rendered flame retardant.~~

~~I. Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved.~~

~~J. Wall finishes shall be washable and, in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.~~

EDITOR'S NOTE: Appendices A, B and C are repealed and are not set out.

DOCUMENTS INCORPORATED BY REFERENCE

~~"2000 Hospital Accreditation Standards," Joint Commission on Accreditation of Healthcare Organizations, January 2000.~~

~~"Recommended Dietary Allowances," National Research Council, National Academy of Sciences, 10th Edition, 1989.~~

~~NFPA Standard No. 99, "Standard for Health Care Facilities," National Fire Protection Association (NFPA), 1993 Edition.~~

~~NFPA Standard No. 232, "Protection of Records," National Fire Protection Association (NFPA), 1994 Edition.~~

~~NFPA Standard No. 82, "Standard on Incinerators and Waste and Linen Handling Systems and Equipment," National Fire Protection Association (NFPA), 1994 Edition.~~

~~"Control of Communicable Diseases in Man," American Public Health Association, Fifteenth Edition, 1990.~~

~~"Guidelines for Perinatal Care," American Academy of Pediatrics and American College of Obstetricians and Gynecologists, Third Edition, 1992.~~

~~"Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients," American Academy of Pediatrics, 1993.~~

~~NFPA Standard No. 80, "Fire Doors and Fire Windows," National Fire Protection Association (NFPA), 1992 Edition.~~

~~NFPA Standard No. 90A, "Installation of Air Conditioning and Ventilating Systems," National Fire Protection Association (NFPA), 1993 Edition.~~

~~NFPA Standard No. 101, "Life Safety Code," National Fire Protection Association (NFPA), 1994 Edition.~~

~~NFPA Standard No. 255, "Test Methods Surface Burning -- Building Materials," National Fire Protection Association (NFPA), 1990 Edition.~~

~~NFPA Standard No. 258, "Standard Research Test Method for Determining Smoke Generation of Solid Materials," National Fire Protection Association (NFPA), 1994 Edition.~~

~~NFPA Standard No. 701, "Fire Tests for Flame-Resistant Textiles and Films," National Fire Protection Association (NFPA), 1989 Edition.~~

~~UL Standard No. 181, "Factory-Made Air Ducts and Air Connectors," Underwriters Laboratories, Inc. (UL), Eighth Edition, 1994.~~

~~Guidelines for Design and Construction of Hospital and Health Care Facilities, The American Institute of Architects, Washington, D.C., 2001 Edition.~~

VA.R. Doc. No. R06-117; Filed November 18, 2005, 3:25 p.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Titles of Regulations: **12 VAC 30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-130).**

12 VAC 30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12 VAC 30-60-61).

12 VAC 30-130. Amount, Duration and Scope of Selected Services (amending 12 VAC 30-130-860 through 12 VAC 30-130-890).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Date: January 25, 2006.

Agency Contact: Catherine Hancock, Project Manager, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 225-4272, FAX (804) 786-1680, or e-mail catherine.hancock@dmas.virginia.gov.

Summary:

The amendments implement coverage of new community-based, residential mental health services as mandated by Item 325 QQQ of the 2003 Appropriation Act. Amendments differentiate service intensity into two separate levels of service (A and B) and designate the highest intensity level of residential treatment programs as Level C. This regulation also describes provider requirements for the various levels of service and adds the requirement that a physician sign and date the plan of care.

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

12 VAC 30-50-130. Skilled nursing facility services, EPSDT, and family planning.

A. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

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

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

1. 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, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

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

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

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

5. Community mental health services.

a. Intensive in-home services to children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks.

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

c. *Community-Based Services for Children and Adolescents under 21 (Level A).*

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- (1) *Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.*
- (2) *In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by a licensed mental health professional.*
- (3) *Individuals must be discharged from this service when other less intensive services may achieve stabilization.*
- (4) *Authorization is required for Medicaid reimbursement.*
- (5) *Room and board costs are not reimbursed. Facilities that only provide independent living services are not reimbursed.*
- (6) *Providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Education under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22 VAC 42-10).*
- (7) *Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management.*
- (8) *The facility/group home must coordinate services with other providers.*
- d. *Therapeutic Behavioral Services (Level B).*
- (1) *Such services must be therapeutic services rendered in a residential setting that provides structure for daily activities, psychoeducation, therapeutic supervision and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.*
- (2) *Authorization is required for Medicaid reimbursement.*
- (3) *Room and board costs are not reimbursed. Facilities that only provide independent living services are not reimbursed.*
- (4) *Providers must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22 VAC 42-10).*
- (5) *Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.*
- (6) *The child must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.*
- (7) *Individuals must be discharged from this service when other less intensive services may achieve stabilization.*
6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:
- a. A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership.
- b. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12 VAC 30-50-100, 12 VAC 30-50-105, and 12 VAC 30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12 VAC 30-130-850 et seq.) of this chapter.
- c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with 42 CFR Part 441 Subpart D, as contained in 42 CFR 441.151 (a) and (b) and 441.152 through 441.156. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.
- C. Family planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.
2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

12 VAC 30-60-61. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health services for children.

A. Intensive in-home services for children and adolescents.

1. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

- a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.
- b. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.
- c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

2. At admission, an appropriate assessment is made by the LMHP or the QMHP and approved by the LMHP, documenting that service needs can best be met through intervention provided typically but not solely in the client's residence. An Individual Service Plan (ISP) must be fully completed within 30 days of initiation of services.

3. Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present. In some circumstances, such as lack of privacy or unsafe conditions, services may be provided in the community if supported by the needs assessment and ISP.

4. These services shall be provided when the clinical needs of the child put the child at risk for out-of-home placement:

- a. When services that are far more intensive than outpatient clinic care are required to stabilize the child in the family situation, or
- b. When the child's residence as the setting for services is more likely to be successful than a clinic.

5. Services may not be billed when provided to a family while the child is not residing in the home.

6. Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The child and responsible parent/guardian must be available and in agreement to participate in the transition.

7. At least one parent or responsible adult with whom the child is living must be willing to participate in the intensive in-home services with the goal of keeping the child with the family.

8. The enrolled provider must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services as a provider of intensive in-home services.

9. Services must be provided by an LMHP or a QMHP as defined in 12 VAC 30-50-226. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in 12 VAC 30-50-226.

10. The billing unit for intensive in-home service is one hour. Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per client/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the client and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans must incorporate a discharge plan which identifies transition from intensive in-home to less intensive or nonhome based services.

11. The provider must ensure that the maximum staff-to-caseload ratio fully meets the needs of the individual.

12. Since case management services are an integral and inseparable part of this service, case management services may not be billed separately for periods of time when intensive in-home services are being provided.

13. Emergency assistance shall be available 24 hours per day, seven days a week.

B. Therapeutic day treatment for children and adolescents.

1. Therapeutic day treatment is appropriate for children and adolescents who meet one of the following:

- a. Children and adolescents who require year-round treatment in order to sustain behavior or emotional gains.
- b. Children and adolescents whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:

- (1) This programming during the school day; or
- (2) This programming to supplement the school day or school year.

c. Children and adolescents who would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.

d. Children and adolescents who (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality.

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e. Children in preschool enrichment and early intervention programs when the children's emotional/behavioral problems are so severe that they cannot function in these programs without additional services.

2. Such services must not duplicate those services provided by the school.

3. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

b. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.

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

4. The enrolled provider of therapeutic day treatment for child and adolescents services must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services to provide day support services.

5. Services must be provided by an LMHP, a QMHP or a QPPMH who is supervised by a QMHP or LMHP.

6. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

7. The program must operate a minimum of two hours per day and may offer flexible program hours (i.e., before or after school or during the summer). One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

8. Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

9. Services shall be provided following a diagnostic assessment that is authorized by an LMHP. Services must be provided in accordance with an ISP which must be fully completed within 30 days of initiation of the service.

C. Community-Based Services for Children and Adolescents under 21 (Level A).

1. *The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 while asleep. The program director supervising the program/group home must be, at minimum, a qualified mental health professional (as defined in 12 VAC 35-105-20) with a bachelor's degree and have at least one year of direct work with mental health clients. The program director must be employed full time.*

2. *At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, defined in 12 VAC 30-50-226.*

3. *Authorization is required for Medicaid reimbursement. DMAS shall monitor the services rendered. All Community-Based Services for Children and Adolescents under 21 (Level A) must be authorized prior to reimbursement for these services. Services rendered without such authorization shall not be covered. Reimbursement shall not be made for this service when other less intensive services may achieve stabilization.*

4. *Services must be provided in accordance with an Individual Service Plan (ISP) (plan of care), which must be fully completed within 30 days of authorization for Medicaid reimbursement.*

D. Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B).

1. *The staff ratio must be at least 1 to 4 during the day and at least 1 to 8 while asleep. The clinical director must be a licensed mental health professional. The caseload of the clinical director must not exceed 16 clients including all sites for which the clinical director is responsible. The program director must be full time and be a qualified mental health professional with a bachelor's degree and at least one year's clinical experience.*

2. *At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, as defined in 12 VAC 30-50-226. The program/group home must coordinate services with other providers.*

3. *All Therapeutic Behavioral Services (Level B) must be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.*

4. *Services must be provided in accordance with an ISP (plan of care), which must be fully completed within 30 days of authorization for Medicaid reimbursement.*

E. Utilization review. Utilization reviews for Community-Based Services for Children and Adolescents under 21 (Level A) and Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) shall include determinations whether providers meet all DMAS requirements.

12 VAC 30-130-860. Service coverage; eligible individuals; service certification.

A. Residential treatment programs (*Level C*) shall be 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address the special mental health and behavioral needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services must include, but shall not be limited to, assessment and evaluation, medical treatment (including drugs), individual and group counseling, and family therapy necessary to treat the child.

B. Residential treatment programs (*Level C*) shall provide a total, 24 hours per day, specialized form of highly organized, intensive and planned therapeutic interventions that shall be utilized to treat some of the most severe mental, emotional,

and behavioral disorders. Residential treatment is a definitive therapeutic modality designed to deliver specified results for a defined group of problems for children or adolescents for whom outpatient day treatment or other less intrusive levels of care are not appropriate, and for whom a protected, structured milieu is medically necessary for an extended period of time.

C. Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) and Community-Based Services for Children and Adolescents under 21 (Level A) must be therapeutic services rendered in a residential type setting such as a group home or program that provides structure for daily activities, psychoeducation, therapeutic supervision and mental health care to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). The child or adolescent must have a medical need for the service arising from a condition due to mental, behavioral or emotional illness, that results in significant functional impairments in major life activities.

D. Active treatment shall be required. Residential Treatment services, Therapeutic Behavioral and Community-Based Services for Children and Adolescents under age 21 shall be designed to serve the mental health needs of children. In order to be reimbursed for Residential Treatment (Level C), Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), and Community-Based Services for Children and Adolescents under 21 (Level A), the facility must provide active mental health treatment beginning at admission and it must be related to the recipient's principle diagnosis and admitting symptoms. To the extent that any recipient needs mental health treatment and his needs meet the medical necessity criteria for the service, he will be approved for these services. The service definitions These services do not include interventions and activities designed only to meet the supportive nonmental health special needs, including but not limited to personal care, habilitation or academic educational needs of the recipients.

E. An eligible individual eligible for Residential Treatment Services (Level C) is a recipient under the age of 21 years whose treatment needs cannot be met by ambulatory care resources available in the community, for whom proper treatment of his psychiatric condition requires services on an inpatient basis under the direction of a physician, and.

An individual eligible for Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) is a child, under the age of 21 years, for whom proper treatment of his psychiatric condition requires less intensive treatment in a structured, therapeutic residential program under the direction of a Licensed Mental Health Professional.

An individual eligible for Community-Based Services for Children and Adolescents under 21 (Level A) is a child, under the age of 21 years, for whom proper treatment of his psychiatric condition requires less intensive treatment in a structured, therapeutic residential program under the direction of a qualified mental health professional. The services for all three levels can reasonably be expected to improve his the child's or adolescent's condition or prevent further regression so that the services will no longer be needed.

F. In order for Medicaid to reimburse for Residential Treatment to be provided to a recipient, (Level C), Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), and Community-Based Services for Children and Adolescents under 21 (Level A), the need for the service must be certified according to the standards and requirements set forth in subdivisions 1 and 2 of this subsection. At least one member of the independent certifying team must have pediatric mental health expertise.

1. For an individual who is already a Medicaid recipient when he is admitted to a facility or program, certification must [:

a.] Be made by an independent certifying team that [:-a-] includes a licensed physician; who:

b- (1) Has competence in diagnosis and treatment of pediatric mental illness; and

c- (2) Has knowledge of the recipient's mental health history and current situation.

b. Be signed and dated by a physician and the team.

2. For a recipient who applies for Medicaid while an inpatient in the facility or program, the certification must:

a. Be made by the team responsible for the plan of care;

b. Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and

c. Be signed and dated by a physician member of and the team.

12 VAC 30-130-870. Preauthorization.

A. Authorization for Residential Treatment (Level C) shall be required within 24 hours of admission and shall be conducted by DMAS or its utilization management contractor using medical necessity criteria specified by DMAS. At preauthorization, an initial length of stay shall be assigned and the residential treatment provider shall be responsible for obtaining authorization for continued stay. Reimbursement for residential treatment will be implemented on January 1, 2000. For cases already in care, DMAS will reimburse beginning January 1, 2000, or from the date when the required documentation is received and approved if the provider has a valid Medicaid provider agreement in effect on that date.

B. DMAS will not pay for admission to or continued stay in residential facilities (Level C) that were not authorized by DMAS.

C. Information that is required in order to obtain admission preauthorization for Medicaid payment shall include:

1. A completed state-designated uniform assessment instrument approved by the department.

2. A certification of the need for this service by the team described in 12 VAC 30-130-860 that:

a. The ambulatory care resources available in the community do not meet the specific treatment needs of the recipient;

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b. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

c. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will not be needed.

3. Additional required written documentation shall include all of the following:

a. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, effective October 1, 1996), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation), Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

b. A description of the child's behavior during the seven days immediately prior to admission;

c. A description of alternative placements tried or explored and the outcomes of each placement;

d. The child's functional level and clinical stability;

e. The level of family support available; and

f. The initial plan of care as defined and specified at 12 VAC 30-130-890.

D. Continued stay criteria for Residential Treatment (Level C): information for continued stay authorization (Level C) for Medicaid payment must include:

1. A state uniform assessment instrument, completed no more than 90 days prior to the date of submission;

2. Documentation that the required services are provided as indicated;

3. Current (within the last 30 days) information on progress related to the achievement of treatment goals. The treatment goals must address the reasons for admission, including a description of any new symptoms amenable to treatment;

4. Description of continued impairment, problem behaviors, and need for Residential Treatment level of care.

~~D.~~ *E. Denial of service may be appealed by the recipient consistent with 12 VAC 30-110-10 et seq.; denial of reimbursement may be appealed by the provider consistent with the Administrative Process Act (§ 9-6-14:4.1 2.2-4000 et seq. of the Code of Virginia).*

F. DMAS will not pay for services for Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), and Community-Based Services for Children and Adolescents under 21 (Level A) that are not prior authorized by DMAS.

G. Authorization for Level A and Level B residential treatment shall be required within three business days of admission. Authorization for services shall be based upon the medical necessity criteria described in 12 VAC 30-50-130. The authorized length of stay must not exceed six months and may be reauthorized. The provider shall be responsible for

documenting the need for a continued stay and providing supporting documentation.

H. Information that is required in order to obtain admission authorization for Medicaid payment must include:

1. A current completed state-designated uniform assessment instrument approved by the department. The state designated uniform assessment instrument must indicate at least two areas of moderate impairment for Level B and two areas of moderate impairment for Level A. A moderate impairment is evidenced by, but not limited to:

a. Frequent conflict in the family setting, for example, credible threats of physical harm.

b. Frequent inability to accept age appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

c. Severely limited involvement in social support; which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

d. Impaired ability to form a trusting relationship with at least one caretaker in the home, school or community.

e. Limited ability to consider the effect of one's inappropriate conduct on others, interactions consistently involving conflict, which may include impulsive or abusive behaviors.

2. A certification of the need for the service by the team described in 12 VAC 30-130-860 that:

a. The ambulatory care resources available in the community do not meet the specific treatment needs of the child;

b. Proper treatment of the child's psychiatric condition requires services in a community-based residential program; and

c. The services can reasonably be expected to improve the child's condition or prevent regression so that the services will not be needed.

3. Additional required written documentation must include all of the following:

a. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, effective October 1, 1996), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation), Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

b. A description of the child's behavior during the 30 days immediately prior to admission;

c. A description of alternative placements tried or explored and the outcomes of each placement;

d. The child's functional level and clinical stability;

e. The level of family support available; and

f. *The initial plan of care as defined and specified at 12 VAC 30-130-890.*

i. *Denial of service may be appealed by the child consistent with 12 VAC 30-110; denial of reimbursement may be appealed by the provider consistent with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).*

J. *Continued stay criteria for Levels A and B:*

1. *The length of the authorized stay shall be determined by DMAS or its contractor.*

2. *A current Individual Service Plan (ISP) (plan of care) and a current (within 30 days) summary of progress related to the goals and objectives on the ISP (plan of care) must be submitted for continuation of the service.*

3. *For reauthorization to occur, the desired outcome or level of functioning has not been restored or improved, over the time frame outlined in the child's ISP (plan of care) or the child continues to be at risk for relapse based on history or the tenuous nature of the functional gains and use of less intensive services will not achieve stabilization. Any one of the following must apply:*

a. *The child has achieved initial service plan (plan of care) goals but additional goals are indicated that cannot be met at a lower level of care.*

b. *The child is making satisfactory progress toward meeting goals but has not attained ISP goals, and the goals cannot be addressed at a lower level of care.*

c. *The child is not making progress, and the service plan (plan of care) has been modified to identify more effective interventions.*

d. *There are current indications that the child requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.*

K. *Discharge criteria for Levels A and B.*

1. *Reimbursement shall not be made for this level of care if either of the following applies:*

a. *The level of functioning has improved with respect to the goals outlined in the service plan (plan of care) and the child can reasonably be expected to maintain these gains at a lower level of treatment; or*

b. *The child no longer benefits from service as evidenced by absence of progress toward service plan goals for a period of 60 days.*

12 VAC 30-130-880. Provider qualifications.

A. *Providers must provide all Residential Treatment Services (Level C) as defined within this part and set forth in 42 CFR Part 441 Subpart D.*

B. *Providers of Residential Treatment Services (Level C) must be:*

1. *A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a*

psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations;

2. *A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a psychiatric unit of an acute general hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or*

3. *A psychiatric facility that is (i) accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Quality and Leadership in Supports for People with Disabilities, or the Council on Accreditation of Services for Families and Children and (ii) licensed by DMHMRSAS as a residential treatment program for children and adolescents.*

C. *Providers of Community-Based Services for Children and Adolescents under 21 (Level A) must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Education under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22 VAC 42-10).*

D. *Providers of Therapeutic Behavioral Services (Level B) must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22 VAC 42-10).*

12 VAC 30-130-890. Plans of care; review of plans of care.

A. *For Residential Treatment Services (Level C), an initial plan of care must be completed at admission and a Comprehensive Individual Plan of Care must be completed no later than 14 days after admission.*

B. *Initial plan of care (Level C) must include:*

1. *Diagnoses, symptoms, complaints, and complications indicating the need for admission;*

2. *A description of the functional level of the recipient;*

3. *Treatment objectives with short-term and long-term goals;*

4. *Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;*

5. *Plans for continuing care, including review and modification to the plan of care; and*

6. *Plans for discharge, and*

7. *Signature and date by the physician.*

C. *The Comprehensive Individual Plan of Care (CIPOC) for Level C must meet all of the following criteria:*

1. *Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and must reflect the need for inpatient psychiatric care;*

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2. Be developed by an interdisciplinary team of physicians and other personnel specified under subsection F of this section, who are employed by, or provide services to, patients in the facility in consultation with the recipient and his parents, legal guardians, or appropriate others in whose care he will be released after discharge;
 3. ~~Include~~ State treatment objectives that must include measurable short-term and long-term goals *and objectives, with target dates for achievement*;
 4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and
 5. Describe *comprehensive* discharge plans and coordination of inpatient services and post-discharge plans with related community services to ensure continuity of care upon discharge with the recipient's family, school, and community.
- D. Review of the Comprehensive Individual Plan of Care for Level C. The CIPOC must be reviewed every 30 days by the team specified in subsection F of this section to:
1. Determine that services being provided are or were required on an inpatient basis; and
 2. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.
- E. The development and review of the plan of care for Level C as specified in this section satisfies the facility's utilization control requirements for recertification and establishment and periodic review of the plan of care, as required in 42 CFR 456.160 and 456.180.
- F. Team developing the Comprehensive Individual Plan of Care for Level C. The following requirements must be met:
1. At least one member of the team must have expertise in pediatric mental health. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of all of the following:
 - a. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
 - b. Assessing the potential resources of the recipient's family;
 - c. Setting treatment objectives; and
 - d. Prescribing therapeutic modalities to achieve the plan's objectives.
 2. The team must include, at a minimum, either:
 - a. A board-eligible or board-certified psychiatrist;
 - b. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
 - c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.
 3. The team must also include one of the following:
 - a. A psychiatric social worker;
 - b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;
 - c. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals; or
 - d. A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.
- G. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement.
- H. *For Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), the initial plan of care must be completed at admission by the licensed mental health professional (LMHP) and a comprehensive individual plan of care (CIPOC) must be completed by the LMHP no later than 30 days after admission. The assessment must be signed and dated by the LMHP.*
- I. *For Community-Based Services for Children and Adolescents under 21 (Level A), the initial plan of care must be completed at admission by the QMHP and a CIPOC must be completed by the QMHP no later than 30 days after admission. The individualized plan of care must be signed and dated by the program director.*
- J. *Initial plan of care for Levels A and B must include:*
1. *Diagnoses, symptoms, complaints, and complications indicating the need for admission;*
 2. *A description of the functional level of the child;*
 3. *Treatment objectives with short-term and long-term goals;*
 4. *Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;*
 5. *Plans for continuing care, including review and modification to the plan of care; and*
 6. *Plans for discharge.*
- K. *The CIPOC for Levels A and B must meet all of the following criteria:*
1. *Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child's situation and must reflect the need for residential psychiatric care;*
 2. *The CIPOC for both levels must be based on input from school, home, other healthcare providers, the child and family (or legal guardian);*

3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the child's family, school, and community.

L. Review of the CIPOC for Levels A and B. The CIPOC must be reviewed, signed, and dated every 30 days by the QMHP for Level A and by the LMHP for Level B. The review must include:

- 1. The response to services provided;
- 2. Recommended changes in the plan as indicated by the child's overall response to the plan of care interventions; and
- 3. Determinations regarding whether the services being provided continue to be required.

Updates must be signed and dated by the service provider.

M. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement.

DOCUMENTS INCORPORATED BY REFERENCE

Virginia Medicaid Nursing Home Manual, Department of Medical Assistance Services.

Virginia Medicaid Rehabilitation Manual, Department of Medical Assistance Services.

Virginia Medicaid Hospice Manual, Department of Medical Assistance Services.

Virginia Medicaid School Division Manual, Department of Medical Assistance Services.

ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, ASAM PPC-2R, Second Edition, revised 2001, American Society of Addiction Medicine.

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IV, October 1996, American Psychiatric Association.

VA.R. Doc. No. R04-194; Filed December 7, 2005, 10:03 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD FOR CONTRACTORS

Title of Regulation: **18 VAC 50-22. Board for Contractors Regulations (amending 18 VAC 50-22-10, 18 VAC 50-22-**

20, 18 VAC 50-22-30, 18 VAC 50-22-50, 18 VAC 50-22-60, and 18 VAC 50-22-260; repealing 18 VAC 50-22-270).

Statutory Authority: §§ 54.1-201 and 54.1-1102 of the Code of Virginia.

Effective Date: February 1, 2006.

Agency Contact: Eric Olson, Executive Director, Board for Contractors, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, or e-mail eric.olson@dpor.virginia.gov.

Summary:

The amendments (i) remove the alarm/security systems specialty classification from the regulations; (ii) require tradesmen to supervise helpers and laborers; (iii) increase the license reinstatement period from six months to one year; (iv) remove the requirement that contracts include the expiration date of the contractor's license; and (v) clarify the language in a number of places regarding the definition or the scope of several specialties and the fee schedule.

18 VAC 50-22-10. General definitions.

The following words and terms when used in this chapter, unless a different meaning is provided or is plainly required by the context, shall have the following meanings:

"Affidavit" means a written statement of facts, made voluntarily, and confirmed by the oath or affirmation of the party making it, taken before a notary or other person having the authority to administer such oath or affirmation.

"Business entity" means a sole proprietorship, partnership, corporation, limited liability company, limited liability partnership, or any other form of organization permitted by law.

"Controlling financial interest" means the direct or indirect ownership or control of more than 50% ownership of a firm.

"Firm" means any business entity recognized under the laws of the Commonwealth of Virginia.

"Formal vocational training" means courses in the trade administered at an accredited educational facility; or formal training, approved by the department, conducted by trade associations, businesses, military, correspondence schools or other similar training organizations.

"Full-time employee" means an employee who spends a minimum of 30 hours a week carrying out the work of the licensed contracting business.

"Helper" or "laborer" means a person who assists a licensed tradesman and who is not an apprentice as defined in 18 VAC 50-30-10.

"Licensee" means a firm holding a license issued by the Board for Contractors to act as a contractor, as defined in § 54.1-1100 of the Code of Virginia.

"Net worth" means assets minus liabilities. For purposes of this chapter, assets shall not include any property owned as tenants by the entirety.

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"Reciprocity" means an arrangement by which the licensees of two states are allowed to practice within each other's boundaries by mutual agreement.

"Reinstatement" means having a license restored to effectiveness after the expiration date has passed.

"Renewal" means continuing the effectiveness of a license for another period of time.

"Responsible management" means the following individuals:

1. The sole proprietor of a sole proprietorship;
2. The partners of a general partnership;
3. The managing partners of a limited partnership;
4. The officers of a corporation;
5. The managers of a limited liability company;
6. The officers or directors of an association or both; and
7. Individuals in other business entities recognized under the laws of the Commonwealth as having a fiduciary responsibility to the firm.

"Sole proprietor" means any individual, not a corporation, who is trading under his own name, or under an assumed or fictitious name pursuant to the provisions of §§ 59.1-69 through 59.1-76 of the Code of Virginia.

"Supervision" means providing guidance or direction of a delegated task or procedure by a tradesman licensed in accordance with Chapter 11 (§ 54.1-1100 et seq.) of Title 54.1 of the Code of Virginia, being accessible to the helper or laborer, and periodically observing and evaluating the performance of the task or procedure.

"Supervisor" means the licensed master or journeyman tradesman who has the responsibility to ensure that the installation is in accordance with the applicable provisions of the Virginia Uniform Statewide Building Code and provides supervision to helpers and laborers as defined in this chapter.

"Tenants by the entirety" means a tenancy which is created between a husband and wife and by which together they hold title to the whole with right of survivorship so that, upon death of either, the other takes whole to exclusion of the deceased's remaining heirs.

18 VAC 50-22-20. Definitions of license classifications.

The following words and terms, when used in this chapter, unless a different meaning is provided or is plainly required by the context, shall have the following meanings:

"Building contractors" (Abbr: BLD) means those individuals whose contracts include construction on real property owned, controlled or leased by another person of commercial, industrial, institutional, governmental, residential (single-family, two-family or multifamily) and accessory use buildings or structures. This classification also provides for remodeling, repair, improvement or demolition of these buildings and structures. A holder of this license can do general contracting.

If the BLD contractor performs specialty services, all required specialty designations shall be obtained. The building

classification includes but is not limited to the functions carried out by the following specialties:

- Billboard/sign contracting
- Commercial improvement contracting
- Farm improvement contracting
- Home improvement contracting
- Landscape service contracting
- Marine facility contracting
- Modular manufactured building contracting
- Recreational facility contracting

"Electrical contractors" (Abbr: ELE) means those individuals whose contracts include the construction, repair, maintenance, alteration, or removal of electrical systems under the National Electrical Code. This classification provides for all work covered by the National Electrical Code including electrical work covered by the alarm/security systems contracting (ALS), electronic/communication service contracting (ESC) and fire alarm systems contracting (FAS) specialties. A firm holding an electrical license is responsible for meeting all applicable tradesman licensing standards.

"Highway/heavy contractors" (Abbr: H/H) means those individuals whose contracts include construction, repair, improvement, or demolition of the following:

- Bridges
- Dams
- Drainage systems
- Foundations
- Parking lots
- Public transit systems
- Rail roads
- Roads
- Runways
- Streets
- Structural signs & lights
- Tanks

The functions carried out by these contractors include but are not limited to the following:

- Building demolition
- Clearing
- Concrete work
- Excavating
- Grading
- Nonwater well drilling
- Paving
- Pile driving
- Road marking
- Steel erection

These contractors also install, maintain, or dismantle the following:

1. Power systems for the generation and primary and secondary distribution of electric current ahead of the customer's meter;
2. Pumping stations and treatment plants;
3. Telephone, telegraph, or signal systems for public utilities; and

4. Water, gas, and sewer connections to residential, commercial, and industrial sites, subject to local ordinances.

This classification may also install backflow prevention devices incidental to work in this classification when the installer has received formal vocational training approved by the board that included instruction in the installation of backflow prevention devices.

"HVAC contractors" (Abbr: HVA) means those individuals whose work includes the installation, alteration, repair, or maintenance of heating systems, ventilating systems, cooling systems, steam and hot water heaters, heating systems, boilers, process piping, and mechanical refrigeration systems, including tanks incidental to the system. This classification does not provide for fire suppression installations, sprinkler system installations, or gas piping. A firm holding a HVAC license is responsible for meeting all applicable tradesman licensure standards. This classification may install backflow prevention devices incidental to work in this classification.

"Plumbing contractors" (Abbr: PLB) means those individuals whose contracts include the installation, maintenance, extension, or alteration, or removal of all piping, fixtures, appliances, and appurtenances in connection with any of the following:

- Backflow prevention devices
- Boilers
- Hot water baseboard ~~heating~~ *heating* systems
- Hot water heaters
- Hydronic systems
- Limited area sprinklers (as defined by BOCA)
- Process piping
- Public/private water supply systems within or adjacent to any building, structure or conveyance
- Sanitary or storm drainage facilities
- Steam heating systems
- Storage tanks incidental to the installation of related systems
- Venting systems related to plumbing

These contractors also install, maintain, extend or alter the following:

- Liquid waste systems
- Sewerage systems
- Storm water systems
- Water supply systems

This classification does not provide for gas piping or the function of fire sprinkler contracting as noted above. A firm holding a plumbing license is responsible for meeting all applicable tradesman licensure standards.

"Specialty contractors" means those individuals whose contracts are for specialty services which do not generally fall within the scope of any other classification within this chapter.

18 VAC 50-22-30. Definitions of specialty services.

The following words and terms, when used in this chapter, unless a different meaning is provided or is plainly required by the context, shall have the following meanings:

~~"Alarm/security systems contracting" (Abbr: ALS) means that service which provides for the installation, repair, improvement, or removal of alarm systems or security systems annexed to real property. This classification covers only burglar and security alarm installations. A firm holding an ALS license is responsible for meeting all applicable rules and regulations adopted by each locality. The ELE classification also provides for this function.~~

"Alternative energy system contracting" (Abbr: AES) means that service which provides for the installation, repair or improvement, from the customer's meter, of alternative energy generation systems, supplemental energy systems and associated equipment annexed to real property. No other classification or specialty service provides this function. This specialty does not provide for electrical, plumbing, gas fitting, or HVAC functions.

"Asbestos contracting" (Abbr: ASB) means that service which provides for the installation, removal, or encapsulation of asbestos containing materials annexed to real property. No other classification or specialty service provides for this function.

"Asphalt paving and sealcoating contracting" (Abbr: PAV) means that service which provides for the installation of asphalt paving and/or sealcoating on subdivision streets and adjacent intersections, driveways, parking lots, tennis courts, running tracks, and play areas, using materials and accessories common to the industry. This includes height adjustment of existing sewer manholes, storm drains, water valves, sewer cleanouts and drain grates, and all necessary excavation and grading. The H/H classification also provides for this function.

"Billboard/sign contracting" (Abbr: BSC) means that service which provides for the installation, repair, improvement, or dismantling of any billboard or structural sign permanently annexed to real property. H/H and BLD are the only other classifications that can perform this work except that a contractor in this specialty may connect or disconnect signs to existing electrical circuits. No trade related plumbing, electrical, or HVAC work is included in this function.

"Blast/explosive contracting" (Abbr: BEC) means that service which provides for the use of explosive charges for the repair, improvement, alteration, or demolition of any real property or any structure annexed to real property.

"Commercial improvement contracting" (Abbr: CIC) means that service which provides for repair or improvement to nonresidential property and multifamily property as defined in the Virginia Uniform Statewide Building Code. The BLD classification also provides for this function. The CIC classification does not provide for the construction of new buildings, accessory buildings, electrical, plumbing, HVAC, or gas work.

"Concrete contracting" (Abbr: CEM) means that service which provides for all work in connection with the processing, proportioning, batching, mixing, conveying and placing of concrete composed of materials common to the concrete industry. This includes but is not limited to finishing, coloring, curing, repairing, testing, sawing, grinding, grouting, placing of film barriers, sealing and waterproofing. Construction and

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assembling of forms, molds, slipforms, pans, centering, and the use of rebar is also included. The BLD and H/H classifications also provide for this function.

"Electronic/communication service contracting" (Abbr: ESC) means that service which provides for the installation, repair, improvement, or removal of electronic or communications systems annexed to real property including telephone wiring, computer cabling, sound systems, data links, data and network installation, television and cable TV wiring, antenna wiring, and fiber optics installation, all of which operate at 50 volts or less. A firm holding an ESC license is responsible for meeting all applicable tradesman licensure standards. The ELE classification also provides for this function.

"Elevator/escalator contracting" (Abbr: EEC) means that service which provides for the installation, repair, improvement or removal of elevators or escalators permanently annexed to real property. A firm holding an EEC license is responsible for meeting all applicable tradesman licensure standards. No other classification or specialty service provides for this function.

"Environmental monitoring well contracting" (Abbr: EMW) means that service which provides for the construction of a well to monitor hazardous substances in the ground.

"Environmental specialties contracting" (Abbr: ENV) means that service which provides for installation, repair, removal, or improvement of pollution control and remediation devices. No other specialty provides for this function. This specialty does not provide for electrical, plumbing, gas fitting, or HVAC functions.

"Equipment/machinery contracting" (Abbr: EMC) means that service which provides for the installation or removal of equipment or machinery including but not limited to conveyors or heavy machinery. *Boilers exempted by the Virginia Uniform Statewide Building Code but regulated by the Department of Labor and Industry are also included in this specialty.* This specialty does not provide for any electrical, plumbing, process piping or HVAC functions.

"Farm improvement contracting" (Abbr: FIC) means that service which provides for the installation, repair or improvement of a nonresidential farm building or structure, or nonresidential farm accessory-use structure, or additions thereto. The BLD classification also provides for this function. The FIC specialty does not provide for any electrical, plumbing, HVAC, or gas fitting functions.

"Fire alarm systems contracting" (Abbr: FAS) means that service which provides for the installation, repair, or improvement of fire alarm systems which operate at 50 volts or less. The ELE classification also provides for this function. A firm with an FAS license is responsible for meeting all applicable tradesman licensure standards.

"Fire sprinkler contracting" (Abbr: SPR) means that service which provides for the installation, repair, alteration, addition, testing, maintenance, inspection, improvement, or removal of sprinkler systems using water as a means of fire suppression when annexed to real property. This specialty does not provide for the installation, repair, or maintenance of other types of fire suppression systems. The PLB classification

allows for the installation of limited area sprinklers as defined by BOCA. This specialty may engage in the installation of backflow prevention devices in the fire sprinkler supply main and sprinkler system when the installer has received formal vocational training approved by the board that included instruction in the installation of backflow prevention devices.

"Fire suppression contracting" (Abbr: FSP) means that service which provides for the installation, repair, improvement, or removal of fire suppression systems including but not limited to halon and other gas systems; dry chemical systems; and carbon dioxide systems annexed to real property. No other classification provides for this function. The FSP specialty does not provide for the installation, repair, or maintenance of water sprinkler systems.

"Gas fitting contracting" (Abbr: GFC) means that service which provides for the installation, repair, improvement, or removal of gas piping and appliances annexed to real property. A firm with a GFC license is responsible for meeting all applicable tradesman licensure standards.

"Home improvement contracting" (Abbr: HIC) means that service which provides for repairs or improvements to one-family and two-family residential buildings or structures annexed to real property. The BLD classification also provides for this function. The HIC specialty does not provide for electrical, plumbing, HVAC, or gas fitting functions. It does not include high rise buildings, buildings with more than two dwelling units, or new construction functions beyond the existing building structure other than decks, patios, driveways and utility out buildings.

"Landscape irrigation contracting" (Abbr: ISC) means that service which provides for the installation, repair, improvement, or removal of irrigation sprinkler systems or outdoor sprinkler systems. The PLB and H/H classifications also provide for this function. This specialty may install backflow prevention devices incidental to work in this specialty when the installer has received formal vocational training approved by the board that included instruction in the installation of backflow prevention devices.

"Landscape service contracting" (Abbr: LSC) means that service which provides for the alteration or improvement of a land area not related to any other classification or service activity by means of excavation, clearing, grading, construction of retaining walls for landscaping purposes, or placement of landscaping timbers. The BLD classification also provides for this function.

"Lead abatement contracting" (Abbr: LAC) means that service which provides for the removal or encapsulation of lead-containing materials annexed to real property. No other classification or specialty service provides for this function, except that the PLB classification and HVA classifications may provide this service incidental to work in ~~that classification~~ *those classifications*.

"Liquefied petroleum gas contracting" (Abbr: LPG) means that service which includes the installation, maintenance, extension, alteration, or removal of all piping, fixtures, appliances, and appurtenances used in transporting, storing or utilizing liquefied petroleum gas. This excludes hot water heaters, boilers, and central heating systems that require a

HVA or PLB license. ~~No other classification or specialty service~~ *The GFC specialty* also provides for this function. A firm holding a LPG license is responsible for meeting all applicable tradesman licensure standards.

"Marine facility contracting" (Abbr: MCC) means that service which provides for the construction, repair, improvement, or removal of any structure the purpose of which is to provide access to, impede, or alter a body of surface water. The BLD and H/H classifications also provide for this function. The MCC specialty does not provide for the construction of accessory structures or electrical, HVAC or plumbing functions.

"Masonry contracting" (Abbr: BRK) means that service which includes the installation of brick, concrete block, stone, marble, slate or other units and products common to the masonry industry, including mortarless type masonry products. This includes installation of grout, caulking, tuck pointing, sand blasting, mortar washing, parging and cleaning and welding of reinforcement steel related to masonry construction. The BLD classification and HIC and CIC specialties also provide for this function.

"Modular/manufactured building contracting" (Abbr: MBC) means that service which provides for the installation or removal of a modular or manufactured building manufactured under ANSI standards. This classification does not cover foundation work; however, it does allow installation of piers covered under HUD regulations. It does allow a licensee to do internal tie ins of plumbing, gas and electrical or HVAC equipment. It does not allow for installing additional plumbing, electrical, or HVAC work such as installing the service meter, or installing the outside compressor for the HVAC system. The H/H and BLD classifications also provide for this function.

"Natural gas fitting provider contracting" (Abbr: NGF) means that service which provides for the incidental repair, testing, or removal of natural gas piping or fitting annexed to real property. This does not include new installation of gas piping for hot water heaters, boilers, central heating systems, or other natural gas equipment which requires a HVA or PLB license. ~~No other classification or specialty service~~ *The GFC specialty* also provides for this function. A firm holding a NGF license is responsible for meeting all applicable tradesman licensure standards.

"Painting and wallcovering contracting" (Abbr: PTC) means that service which provides for the application of materials common to the painting and decorating industry for protective or decorative purposes, the installation of surface coverings such as vinyls, wall papers, and cloth fabrics. This includes surface preparation, caulking, sanding and cleaning preparatory to painting or coverings and includes both interior and exterior surfaces. The BLD classification and the HIC and CIC specialties also provide for this function.

"Radon mitigation contracting" (Abbr: RMC) means that service which provides for additions, repairs or improvements to buildings or structures, for the purpose of mitigating or preventing the effects of radon gas. This function can only be performed by a firm holding the BLD classification or CIC (for other than one-family and two-family dwellings), FIC (for nonresidential farm buildings) or HIC (for one-family and two-

family dwellings) specialty services. No electrical, plumbing, gas fitting, or HVAC functions are provided by this specialty.

"Recreational facility contracting" (Abbr: RFC) means that service which provides for the construction, repair, or improvement of any recreational facility, excluding paving and the construction of buildings, plumbing, electrical, and HVAC functions. The BLD classification also provides for this function.

"Refrigeration contracting" (Abbr: REF) means that service which provides for installation, repair, or removal of any refrigeration equipment (excluding HVAC equipment). No electrical, plumbing, gas fitting, or HVAC functions are provided by this specialty. This specialty is intended for those contractors who repair or install coolers, refrigerated casework, ice-making machines, drinking fountains, cold room equipment, and similar hermetic refrigeration equipment. The HVAC classification also provides for this function.

"Roofing contracting" (Abbr: ROC) means that service which provides for the installation, repair, removal or improvement of materials common to the industry that form a watertight, weather resistant surface for roofs and decks. This includes roofing system components when installed in conjunction with a roofing project, application of dampproofing or waterproofing, and installation of roof insulation panels and other roof insulation systems above roof deck. The BLD classification and the HIC and CIC specialties also provide for this function.

"Sewage disposal systems contracting" (Abbr: SDS) means that service which provides for the installation, repair, improvement, or removal of septic tanks, septic systems, and other on-site sewage disposal systems annexed to real property.

"Swimming pool construction contracting" (Abbr: POL) means that service which provides for the construction, repair, improvement or removal of in-ground swimming pools. The BLD classification and the RFC specialty also provide for this function. No trade related plumbing, electrical, backflow or HVAC work is included in this specialty.

"Vessel construction contracting" (Abbr: VCC) means that service which provides for the construction, repair, improvement, or removal of nonresidential vessels, tanks, or piping that hold or convey fluids other than sanitary, storm, waste, or potable water supplies. The H/H classification also provides for this function.

"Water well/pump contracting" (Abbr: WWP) means that service which provides for the installation of a water well system, which includes construction of a water well to reach groundwater, as defined in § 62.1-255 of the Code of Virginia, and the installation of the well pump and tank, including pipe and wire, up to and including the point of connection to the plumbing and electrical systems. No other classification or specialty service provides for construction of water wells. This regulation shall not exclude PLB, ELE or HVAC from installation of pumps and tanks.

Note: Specialty contractors engaging in construction which involves the following activities or items or similar activities or

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items may fall under the CIC, HIC and/or FIC specialty services, or they may fall under the BLD classification.

Appliances	Fiberglass	Rigging
Awnings	Fireplaces	Rubber linings
Blinds	Fireproofing	Sandblasting
Bricks	Fixtures	Scaffolding
Bulkheads	Floor coverings	Screens
Cabinetry	Flooring	Sheet metal
Carpentry	Floors	Shutters
Carpeting	Glass	Siding
Casework	Glazing	Skylights
Ceilings	Grouting	Storage bins and lockers
Chimneys	Grubbing	Stucco
Chutes	Guttering	Temperature controls
Conduit rodding	Insulation	Terrazzo
Curtains	Interior decorating	Tile
Curtain walls	Lubrication	Vaults
Decks	Metal work	Vinyl flooring
Doors	Millwrighting	Wall panels
Drapes	Mirrors	Wall tile
Drywall	Miscellaneous iron	Waterproofing
Epoxy	Ornamental iron	Weatherstripping
Exterior decoration	Partitions	Welding
Facings	Protective coatings	Windows
Fences	Railings	Wood floors

18 VAC 50-22-50. Requirements for a Class B license.

A. A firm applying for a Class B license must meet the requirements of this section.

B. A firm shall name a designated employee who meets the following requirements:

1. Is at least 18 years old;
2. Is a full-time employee of the firm as defined in this chapter [, or is a member of responsible management as defined in this chapter];
3. Has passed a board-approved examination as required by § 54.1-1108 of the Code of Virginia or has been exempted from the exam requirement in accordance with § 54.1-1108.1 of the Code of Virginia; and
4. Has followed all rules established by the board or by the testing service acting on behalf of the board with regard to conduct at the examination. Such rules shall include any written instructions communicated prior to the examination date and any oral or written instructions given at the site on the date of the exam.

C. For every classification or specialty in which the firm seeks to be licensed, the firm shall name a qualified individual who meets the following requirements:

1. Is at least 18 years old;
2. Has a minimum of three years experience in the classification or specialty for which he is the qualifier;
3. Is a full-time employee of the firm as defined in this chapter or is a member of the responsible management of the firm;
4. Where appropriate, has passed the trade-related examination or has completed an education and training program approved by the board and required for the classifications and specialties listed below:

Blast/explosive contracting
Electrical
Fire sprinkler
Gas fitting
HVAC
Plumbing
Radon mitigation
Water well drilling

5. Has obtained, pursuant to the tradesman regulations, a master tradesman license as required for those classifications and specialties listed in 18 VAC 50-22-20 and 18 VAC 50-22-30.

D. Each firm shall submit information on its financial position. Excluding any property owned as tenants by the entirety, the firm shall state a net worth or equity of \$15,000 or more.

E. Each firm shall provide information for the five years prior to application on any outstanding, past-due debts and judgments; outstanding tax obligations; defaults on bonds; or pending or past bankruptcies. The firm, its designated employee, qualified individual or individuals, and all members of the responsible management of the firm shall submit information on any past-due debts and judgments or defaults on bonds directly related to the practice of contracting as defined in Chapter 11 (§ 54.1-1100 et seq.) of Title 54.1 of the Code of Virginia.

F. The firm, the designated employee, the qualified individual, and all members of the responsible management of the firm shall disclose at the time of application any current or previous substantial identities of interest with any contractor licenses issued in Virginia or in other jurisdictions and any disciplinary actions taken on these licenses. This includes but is not limited to any monetary penalties, fines, suspension, revocation, or surrender of a license in connection with a disciplinary action. The board, in its discretion, may deny licensure to any applicant when any of the parties listed above have had a substantial identity of interest (as deemed in § 54.1-1110 of the Code of Virginia) with any firm that has had a license suspended, revoked, voluntarily terminated or surrendered in connection with a disciplinary action in Virginia or any other jurisdiction.

G. In accordance with § 54.1-204 of the Code of Virginia, each applicant shall disclose the following information about the firm, designated employee, all members of the responsible management, and the qualified individual or individuals for the firm:

1. All misdemeanor convictions within three years of the date of application; and
2. All felony convictions during their lifetime.

Any plea of nolo contendere shall be considered a conviction for purposes of this subsection. The record of a conviction received from a court shall be accepted as prima facie evidence of a conviction or finding of guilt. The board, in its discretion, may deny licensure to any applicant in accordance with § 54.1-204 of the Code of Virginia.

18 VAC 50-22-60. Requirements for a Class A license.

A. A firm applying for a Class A license shall meet all of the requirements of this section.

B. A firm shall name a designated employee who meets the following requirements:

1. Is at least 18 years old;
2. Is a full-time employee of the firm as defined in this chapter [or is a member of the responsible management of the firm as defined in this chapter];
3. Has passed a board-approved examination as required by § 54.1-1106 of the Code of Virginia or has been exempted from the exam requirement in accordance with § 54.1-1108.1 of the Code of Virginia; and
4. Has followed all rules established by the board or by the testing service acting on behalf of the board with regard to conduct at the examination. Such rules shall include any written instructions communicated prior to the examination date and any oral or written instructions given at the site on the day of the exam.

C. For every classification or specialty in which the firm seeks to be licensed, the firm shall name a qualified individual who meets the following requirements:

1. Is at least 18 years old;
2. Has a minimum of five years of experience in the classification or specialty for which he is the qualifier;
3. Is a full-time employee of the firm as defined in this chapter or is a member of the firm as defined in this chapter or is a member of the responsible management of the firm;
4. Where appropriate, has passed the trade-related examination or has completed an education and training program approved by the board and required for the classifications and specialties listed below:

Blast/explosive contracting
Electrical
Fire sprinkler
Gas fitting
HVAC
Plumbing
Radon mitigation
Water well drilling

5. Has obtained, pursuant to the tradesman regulations, a master tradesman license as required for those classifications and specialties listed in 18 VAC 50-22-20 and 18 VAC 50-22-30.

D. Each firm shall submit information on its financial position. Excluding any property owned as tenants by the entirety, the firm shall state a net worth or equity of \$45,000.

E. The firm shall provide information for the five years prior to application on any outstanding, past-due debts and judgments; outstanding tax obligations; defaults on bonds; or pending or past bankruptcies. The firm, its designated employee, qualified individual or individuals, and all members of the responsible management of the firm shall submit

information on any past-due debts and judgments or defaults on bonds directly related to the practice of contracting as defined in Chapter 11 (§ 54.1-1100 et seq.) of Title 54.1 of the Code of Virginia.

F. The firm, the designated employee, the qualified individual, and all members of the responsible management of the firm shall disclose at the time of application any current or previous substantial identities of interest with any contractor licenses issued in Virginia or in other jurisdictions and any disciplinary actions taken on these licenses. This includes but is not limited to, any monetary penalties, fines, suspensions, revocations, or surrender of a license in connection with a disciplinary action. The board, in its discretion, may deny licensure to any applicant when any of the parties listed above have had a substantial identity of interest (as deemed in § 54.1-1110 of the Code of Virginia) with any firm that has had a license suspended, revoked, voluntarily terminated, or surrendered in connection with a disciplinary action in Virginia or in any other jurisdiction.

G. In accordance with § 54.1-204 of the Code of Virginia, each applicant shall disclose the following information about the firm, all members of the responsible management, the designated employee and the qualified individual or individuals for the firm:

1. All misdemeanor convictions within three years of the date of application; and
2. All felony convictions during their lifetime.

Any plea of nolo contendere shall be considered a conviction for purposes of this subsection. The record of a conviction received from a court shall be accepted as prima facie evidence of a conviction or finding of guilt. The board, in its discretion, may deny licensure to any applicant in accordance with § 54.1-204 of the Code of Virginia.

EDITOR'S NOTICE: The proposed amendments to 18 VAC 50-20-100, 18 VAC 50-22-140, 18 VAC 50-22-170 and 18 VAC 50-22-250 that were published in 21:19 VA.R. 2494-2505 May 30, 2005 became effective on August 1, 2005, as part of a separate regulatory action that was published in 21:20 VA.R. 2696-2698 June 13, 2005. Since the amendments as proposed have already taken effect, these sections have been removed.

18 VAC 50-22-260. Filing of charges; prohibited acts.

A. All complaints against contractors may be filed with the Department of Professional and Occupational Regulation at any time during business hours, pursuant to § 54.1-1114 of the Code of Virginia.

B. The following are prohibited acts:

1. Failure in any material way to comply with provisions of Chapter 1 (§ 54.1-100 et seq.) or Chapter 11 (§ 54.1-1100 et seq.) of Title 54.1 of the Code of Virginia or the regulations of the board.
2. Furnishing substantially inaccurate or incomplete information to the board in obtaining, renewing, reinstating, or maintaining a license.

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3. Failure of the responsible management, designated employee, or qualified individual to report to the board, in writing, the suspension or revocation of a contractor license by another state or conviction in a court of competent jurisdiction of a building code violation.
4. Publishing or causing to be published any advertisement relating to contracting which contains an assertion, representation, or statement of fact that is false, deceptive, or misleading.
5. Negligence and/or incompetence in the practice of contracting.
6. Misconduct in the practice of contracting.
7. A finding of improper or dishonest conduct in the practice of contracting by a court of competent jurisdiction.
8. Failure of all those who engage in residential contracting, excluding subcontractors to the contracting parties and those who engage in routine maintenance or service contracts, to make use of a legible written contract clearly specifying the terms and conditions of the work to be performed. For the purposes of this chapter, residential contracting means construction, removal, repair, or improvements to single-family or multiple-family residential buildings, including accessory-use structures as defined in § 54.1-1100 of the Code of Virginia. Prior to commencement of work or acceptance of payments, the contract shall be signed by both the consumer and the licensee or his agent.
9. Failure of those engaged in residential contracting as defined in this chapter to comply with the terms of a written contract which contains the following minimum requirements:
 - a. When work is to begin and the estimated completion date;
 - b. A statement of the total cost of the contract and the amounts and schedule for progress payments including a specific statement on the amount of the down payment;
 - c. A listing of specified materials and work to be performed, which is specifically requested by the consumer;
 - d. A "plain-language" exculpatory clause concerning events beyond the control of the contractor and a statement explaining that delays caused by such events do not constitute abandonment and are not included in calculating time frames for payment or performance;
 - e. A statement of assurance that the contractor will comply with all local requirements for building permits, inspections, and zoning;
 - f. Disclosure of the cancellation rights of the parties;
 - g. For contracts resulting from a door-to-door solicitation, a signed acknowledgment by the consumer that he has been provided with and read the Department of Professional and Occupational Regulation statement of protection available to him through the Board for Contractors;
 - h. Contractor's name, address, license number, ~~expiration date~~, class of license, and classifications or specialty services; and
 - i. Statement providing that any modification to the contract, which changes the cost, materials, work to be performed, or estimated completion date, must be in writing and signed by all parties.
10. Failure to make prompt delivery to the consumer before commencement of work of a fully executed copy of the contract as described in subdivisions 8 and 9 of this subsection for construction or contracting work.
11. Failure of the contractor to maintain for a period of five years from the date of contract a complete and legible copy of all documents relating to that contract, including, but not limited to, the contract and any addenda or change orders.
12. Refusing or failing, upon request, to produce to the board, or any of its agents, any document, book, record, or copy of it in the licensee's possession concerning a transaction covered by this chapter or for which the licensee is required to maintain records.
13. Failing to respond to an investigator or providing false, misleading or incomplete information to an investigator seeking information in the investigation of a complaint filed with the board against the contractor.
14. Abandonment defined as the unjustified cessation of work under the contract for a period of 30 days or more.
15. The intentional and unjustified failure to complete work contracted for and/or to comply with the terms in the contract.
16. The retention or misapplication of funds paid, for which work is either not performed or performed only in part.
17. Making any misrepresentation or making a false promise that might influence, persuade, or induce.
18. Assisting another to violate any provision of Chapter 1 (§ 54.1-100 et seq.) or Chapter 11 (§ 54.1-1100 et seq.) of Title 54.1 of the Code of Virginia, or this chapter; or combining or conspiring with or acting as agent, partner, or associate for another.
19. Allowing a firm's license to be used by another.
20. Acting as or being an ostensible licensee for undisclosed persons who do or will control or direct, directly or indirectly, the operations of the licensee's business.
21. Action by the firm, responsible management as defined in this chapter, designated employee or qualified individual to offer, give, or promise anything of value or benefit to any federal, state, or local employee for the purpose of influencing that employee to circumvent, in the performance of his duties, any federal, state, or local law, regulation, or ordinance governing the construction industry.
22. Where the firm, responsible management as defined in this chapter, designated employee or qualified individual has been convicted or found guilty, after initial licensure, regardless of adjudication, in any jurisdiction, of any felony or of any misdemeanor, there being no appeal pending

therefrom or the time of appeal having elapsed. Any plea of guilty or nolo contendere shall be considered a conviction for the purposes of this subdivision. The record of a conviction received from a court shall be accepted as prima facie evidence of a conviction or finding of guilt.

23. Failure to inform the board in writing, within 30 days, that the firm, a member of responsible management as defined in this chapter, its designated employee, or its qualified individual has pleaded guilty or nolo contendere or was convicted and found guilty of any felony or of a Class 1 misdemeanor or any misdemeanor conviction for activities carried out while engaged in the practice of contracting.

24. Having been disciplined by any county, city, town, or any state or federal governing body including action by the Virginia Department of Health, which action shall be reviewed by the board before it takes any disciplinary action of its own.

25. Failure to abate a violation of the Virginia Uniform Statewide Building Code, as amended.

26. Failure of a contractor to comply with the notification requirements of the Virginia Underground Utility Prevention Act, Chapter 10.3 (§ 56-265.14 et seq.) of Title 56 of the Code of Virginia (Miss Utility).

27. Practicing in a classification, specialty service, or class of license for which the contractor is not licensed.

28. Failure to satisfy any judgments.

29. Contracting with an unlicensed or improperly licensed contractor or subcontractor in the delivery of contracting services.

30. Failure to honor the terms and conditions of a warranty.

31. Failure to obtain written change orders, which are signed by both the consumer and the licensee or his agent, to an already existing contract.

32. *Failure to ensure that supervision, as defined in this chapter, is provided to all helpers and laborers assisting licensed tradesman.*

18 VAC 50-22-270. Accountability of licensee. (Repealed.)

~~Whenever a licensee offers or performs any services in Virginia related to his profession, regardless of the necessity to hold a license to perform that service, he shall be subject to the provisions of this chapter.~~

VA.R. Doc. No. R03-118; Filed December 2, 2005, 2:41 p.m.

BOARD OF NURSING

Title of Regulation: 18 VAC 90-25. Regulations Governing Certified Nurse Aides (amending 18 VAC 90-25-80).

Statutory Authority: § 54.1-2400 and Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia.

Effective Date: January 25, 2006.

Agency Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, 6603 West Broad Street, 5th Floor,

Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, or e-mail jay.douglas@dhp.virginia.gov.

Summary:

The amendment increases the biennial renewal fee for certified nurse aides from \$45 to \$50.

Summary of Public Comment and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

18 VAC 90-25-80. Renewal or reinstatement of certification.

A. Renewal of certification.

1. No less than 30 days prior to the expiration date of the current certification, a notice for renewal shall be mailed by the board to the last known address of each currently registered certified nurse aide.

2. The certified nurse aide shall submit a completed application with the required fee of ~~\$45~~ \$50 and verification of performance of nursing-related activities for compensation within the two years immediately preceding the expiration date.

3. Failure to receive the application for renewal shall not relieve the certificate holder of the responsibility for renewing the certification by the expiration date.

4. A certified nurse aide who has not performed nursing-related activities for compensation during the two years preceding the expiration date of the certification shall repeat and pass the nurse aide competency evaluation prior to applying for recertification.

5. The board shall also charge a fee of \$25 for a returned check.

B. Reinstatement of certification.

1. An individual whose certification has lapsed for more than 90 days shall file the required application and renewal fee and provide:

a. Verification of performance of nursing-related activities for compensation in the two years prior to the expiration date of the certificate and within the preceding two years; or

b. When nursing activities have not been performed during the preceding two years, evidence of having repeated and passed the nurse aide competency evaluation.

2. An individual who has previously had a finding of abuse, neglect or misappropriation of property is not eligible for reinstatement of his certification, except as provided in subsection C of this section.

C. If a finding of neglect was made against a certificate holder based on a single occurrence, an individual may petition for removal of the finding of neglect provided:

1. A period of at least one year has passed since the finding was made; and

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2. The individual seeking reinstatement demonstrates sufficient evidence that employment and personal history do not reflect a pattern of abusive behavior or neglect.

NOTICE: The forms used in administering 18 VAC 90-25, Regulations Governing Certified Nurse Aides, are not being published; however, the name of each form is listed below. The forms are available for public inspection at the Department of Health Professions, 6603 West Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Instructions for Application for Nurse Aide Certification by Endorsement (rev. 12/02).

Application for Nurse Aide Certification by Endorsement (rev. 12/02).

Nurse Aide Certification Verification Form (rev. 12/02).

Instructions for Applicant for Advanced Certified Nurse Aide Registration (eff. 2/03).

Application for Certification as Advanced Certified Nurse Aide (eff. 2/03).

Instructions for Application for Reinstatement of Nurse Aide Certification (rev. 12/02).

Application for Reinstatement of Nurse Aide Certification (rev. 12/02).

Instructions for Application for Reinstatement of Advanced Nurse Aide Certification (eff. 2/03).

Application for Reinstatement of Advanced Nurse Aide Certification (eff. 2/03).

Application to Establish Nurse Aide Education Program (rev. 12/02).

Application to Establish an Advanced Certification Nurse Aide Education Program (eff. 12/02).

Nurse Aide Education Program Evaluation Report (rev. 11/02).

Nurse Aide Education Program-On-site Review Report (rev. 11/02).

Advanced Certification Nurse Aide Education Program-On-site Review Report (eff. 12/02).

Evaluation of On-Site Visitor (rev. 12/02).

Request for Statistical Information (rev. 12/02).

Renewal Notice (eff. 4/05).

Renewal Notice and Application, 1401, Certified Nurse Aide (rev. 12/02).

Renewal Notice and Application, Advanced Certified Nurse Aide (eff. 12/02).

VA.R. Doc. No. R05-09; Filed December 6, 2005, 11:35 a.m.

FAST-TRACK REGULATIONS

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

TITLE 1. ADMINISTRATION

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

Title of Regulation: 1 VAC 55-20. Commonwealth of Virginia Health Benefits Program (amending 1 VAC 55-20-320).

Statutory Authority: § 2.2-2818 of the Code of Virginia.

Public Hearing Date: N/A -- Public comments may be submitted until February 27, 2006.

(See Calendar of Events section for additional information)

Effective Date: March 15, 2006.

Agency Contact: Charles Reed, Associate Director, Department of Human Resource Management, 101 N. Fourteenth Street, Richmond, VA 23219, telephone (804) 786-3124, FAX (804) 371-0231, or e-mail charles.reed@dhrm.virginia.gov.

Basis: Section 2.2-2818 of the Code of Virginia authorizes the Department of Human Resource Management to establish a plan for providing health benefits to state employees and their eligible dependents.

Purpose: The Department of Human Resource Management (DHRM) has found that employees find the provision to claim a child on their federal income tax return confusing in that it is often impossible to ascertain exactly when a dependent child is no longer considered eligible to be claimed on their taxes. Compounding the problem, IRS Section 125 requires membership changes to be made on a prospective basis and within a reasonable time period measured from the date that ineligibility occurred. Due to the uncertainty surrounding dependent eligibility and the IRS time limitations, employees may be placed in the situation where a dependent is no longer eligible for coverage, but they must continue to pay for the higher membership level until the next plan open enrollment. Furthermore, the current regulations make it very difficult to monitor compliance, since the plan does not have access to the information that is required to make such dependent eligibility determinations.

The above results in an inequity in that employees in identical circumstances may or may not be covering a child based on the employee's understanding of the eligibility criteria.

Substance: Currently, the regulations stipulate that dependent children covered by these plans must be eligible to be claimed by the employee as a dependent on his federal income tax return. The amended regulations would remove this stipulation (as allowed by the federal Working Families Tax Relief Act (WFTRA)), setting dependency criteria based on relationship, residency, age, and self-support. This amendment continues to allow unmarried natural or legally adopted children, stepchildren, as well as "other covered

children" defined in the regulations to remain as covered dependents until the end of the year in which they turn age 23, so long as they live in the home with the employee (or away at school) and depend upon the employee for more than one-half of their support.

Issues: The primary advantage of this amendment is that it creates a plan rule that is easily understood and adhered to by plan members. The rule would continue to provide health benefit coverage for dependent children who want to continue their education, but who have to work due to economic necessity. This would be especially beneficial to our lower paid employees.

Currently, natural or adopted children who are otherwise eligible for coverage may be covered by the employee whether or not they live with the employee. The amended regulations require that the child live with the employee, or if the employee is divorced, with the child's other parent. This is necessary in order to avoid the possibility of the employee incurring imputed income by the child not meeting the definition of a qualifying child under WFTRA. However, these regulations will not affect any state order that requires the employee to cover a child under the plan.

Rationale for Using Fast-Track Process: Currently, the regulations governing the eligibility of dependent children are confusing to the employee. Therefore, it is DHRM's opinion that they cannot be fairly administered. The usual regulatory process can take a year or longer to have an amendment approved. DHRM believes that this amendment is noncontroversial, that it does not have any fiscal impact, and will have a positive effect on employee morale.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H 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 impacts.

Summary of the proposed regulation. The proposed amendments will no longer require that a child be claimed as a dependent on the federal income tax return in order for a state employee to provide health benefits to that child. Instead, pursuant to the federal Working Families Tax Relief Act, the proposed regulations will establish dependency criteria based on relationship, residency, and self-support in order for a state employee to provide health benefits to a child.

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Estimated economic impact. Currently, the regulations require that a state employee claim a child on the federal income tax return in order to provide health benefits to that child. This requirement has created confusion as to when a child is eligible to receive health benefits under the employee's health coverage. For example, the Internal Revenue Service does not allow a person to claim a child as dependent if that child is earning over \$3,500 a year. In addition, the membership changes to the state health benefits plan are made on a prospective basis. Therefore, in order for an employee to determine if a child is eligible for health benefits, he or she must accurately estimate in advance whether the child will be making over \$3,500 in that year. Moreover, because the Department of Human Resource Management (the department) does not have access to information such as a child's income, eligibility determination for dependency solely relies on self-reported information making it impossible for the department to monitor compliance with this requirement.

Also, as of December 2004, the federal Working Families Tax Relief Act removed the Internal Revenue Service requirement that a qualifying child be claimed as a dependent on their federal income tax return and established the dependency criteria based on relationship, residency, age, and self-support. The proposed changes will adopt the same dependency criteria for a qualifying child.

According to the department, the only effect of these changes is that the Commonwealth will no longer require an employee to claim a child on the federal income tax return to provide health benefits to that child. Because the eligibility determination for dependency solely relies on self-reported information and because it is impossible for the department to monitor compliance with this requirement, employees are not expected to show a significant behavioral response in their self reporting of information to this change. Thus, the proposed change is not expected to create a significant economic impact in practice other than the benefits that may result from clarified and enforceable regulations.

Businesses and entities affected. The proposed regulations apply to approximately 83,000 state employees. Of these, approximately 33,000 are estimated to have health coverage for a dependent child.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. No significant impact on employment is expected.

Effects on the use and value of private property. The proposed regulations are not expected to have a significant impact on the use and value of private property.

Small businesses: costs and other effects. The proposed regulations are not expected to create any administrative or other costs for small businesses.

Small businesses: alternative method that minimizes adverse impact. The proposed regulations will not affect small businesses.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Department of Human Resource Management has reviewed the Economic

Impact Analysis prepared by the Department of Planning and Budget and concurs with its assessment.

Summary:

The current definition of a dependent was based on IRS regulations that allowed an employee to cover certain dependents without incurring imputed income based on the state's contribution to the plan. The Working Families Tax Relief Act (WFTRA) went into effect in December 2004 and redefined who is considered a qualifying dependent for tax purposes under IRS § 152. WFTRA removes the requirement that a qualifying child be claimed by an employee as a dependent on their federal income tax return and sets up dependency criteria based on relationship, residency, age, and self-support. These amended regulations bring the state regulations in line with WFTRA.

1 VAC 55-20-320. Eligible employees.

A. State employees.

1. Full-time salaried, classified employees and faculty as defined in 1 VAC 55-20-20 are eligible for membership in the health benefits program. A full-time salaried employee is one who is scheduled to work at least 32 hours per week or carries a faculty teaching load considered to be full time at his institution.

2. Certain full-time employees in auxiliary enterprises (such as food services, bookstores, laundry services, etc.) at the University of Virginia, Virginia Military Institute and the College of William and Mary as well as other state institutions of higher learning are also considered state employees even though they do not receive a salaried state paycheck. The Athletic Department of Virginia Polytechnic Institute and State University is an example of a local auxiliary whose members are eligible for the program.

3. Certain full-time employees of the Medical College of Virginia Hospital Authority are eligible for the program as long as they are on the authority's payroll and were enrolled in the program on November 1, 1996. They may have payroll deductions for health benefits premiums even if they rotate to the Veterans' Administration Hospital or other acute care facility.

4. Other employees identified in the Code of Virginia as eligible for the program.

5. Classified positions include employees who are fully covered by the Virginia Personnel Act, employees excluded from the Virginia Personnel Act by subdivision 16 of § 2.2-2905 of the Code of Virginia, and employees on a restricted appointment. A restricted appointment is a classified appointment to a position that is funded at least 10% from gifts, grants, donations, or other sources that are not identifiable as continuing in nature. An employee on a restricted appointment must receive a state paycheck in order to be eligible.

B. Local employees.

1. Full-time employees of participating local employers are eligible to participate in the program. A full-time employee

is one who meets the definition set forth by the local employer in the employer application.

2. Part-time employees of local employers may participate in the plan if the local employer elects and the election does not discriminate among part-time employees. In order for the local employer to cover part-time employees, the local employer must provide to the department a definition of what constitutes a part-time employee.

The department reserves the right to establish a separate plan for part-time employees.

C. Unavailability of employer-sponsored coverage.

1. Employees, officers, and teachers without access to employer-sponsored health care coverage may participate in the plan. The employers of such employees, officers, and teachers must apply for participation and certify that other employer-sponsored health care coverage is not available. The employers shall collect contributions from such individuals and timely remit them to the department or its designee, act as a channel of communication with the covered employee and otherwise assist the department as may be necessary. The employer shall act as fiduciary with respect to such contributions and shall be responsible for any interest or other charges imposed by the department in accordance with these regulations.

2. Local employees living outside the service area of the plan offered by their local employer shall not be considered as local employees whose local employers do not offer a health benefits plan. For example, a local employee who lives in North Carolina and works in Virginia may live outside the service area of the HMO offered by his employer; however, he may not join the program individually.

3. Employer sponsorship of a health benefits plan will be broadly construed. For example, an employer will be deemed to sponsor health care coverage for purposes of this section and 1 VAC 55-20-260 if it utilizes § 125 of the Internal Revenue Code or any similar provision to allow employees, officers, or teachers to contribute their portion of the health care contribution on a pretax basis.

4. Individual employees and dependents who are eligible to join the program under the provisions of this subsection must meet all of the eligibility requirements pertaining to state employees except the identity of the employer.

D. Retirees.

1. Retirees are not eligible to enroll in the state retiree health benefits group outside of the opportunities provided in this section.

2. Retirees are eligible for membership in the state retiree group if a completed enrollment form is received within 31 days of separation for retirement. Retirees who remain in the health benefits group through a spouse's state employee membership may enroll in the retiree group at one of three later times: (i) future open enrollment, (ii) within 31 days of a qualifying mid-year event, or (iii) within 31 days of being removed from the active state employee spouse's membership.

3. Membership in the retiree group may be provided to an employee's spouse or dependents who were covered in the active employee group at the time of the employee's death in service.

4. Retirees who have attained the age of 65 or are otherwise covered or eligible for Medicare may enroll in certain plans as determined by the department provided that they apply for such coverage within 31 days of their separation from active service for retirement. Medicare will be the primary payor and the program shall serve as a supplement to Medicare's coverage.

5. Retirees who are ineligible for Medicare must apply for coverage within 31 days of their separation from active service for retirement. In order to receive coverage, the individual must meet the retirement requirements of his employer and receive an immediate annuity.

6. Local employers may offer retiree coverage at their option.

E. Dependents.

1. The following family members may be covered if the employee elects:

a. The employee's spouse.

~~b. The employee's unmarried natural or legally-adopted children.~~

~~c. Unmarried stepchildren living with the employee in a parent-child relationship and dependent on the employee for federal tax purposes.~~

~~d. Adult incapacitated children as long as the child was covered by the plan and the incapacitation existed prior to the termination of coverage due to the child attaining the limiting age.~~

~~e. Adult incapacitated children of new employees, provided that:~~

~~(1) The enrollment form is submitted within 31 days of hire;~~

~~(2) The child has been covered continuously by group employer coverage since the disability first occurred; and~~

~~(3) The disability commenced prior to the child attaining the limiting age of the plan.~~

~~The enrollment form must be accompanied by a letter from a physician explaining the nature of the incapacitation, date of onset and certifying that the dependent is not capable of self-support. This extension of coverage must be approved by the plan in which the employee is enrolled.~~

~~f. Other children on an exception basis. Generally, an exception will not be granted unless:~~

~~(1) A court orders the eligible employee to assume permanent custody of the child; and~~

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~~(2) Both of the child's natural parents are deceased, missing, or incarcerated or a court order has found the parents incapable of caring for the child.~~

~~Local employers and state agencies do not have the authority to grant exceptions. If the circumstances appear to meet the criteria, the facts of the case must be sent in writing to the department for a determination. Minor children who are adopted, regardless of relationship to the employee, enjoy the same benefits as natural children. Natural or adopted children who are otherwise eligible for coverage may be covered by the employee whether or not they live with the employee.~~

~~Children of the spouse of an eligible employee may not be covered as a dependent in the health benefits program unless they live with the employee and meet the criteria for family membership, as given in previous paragraphs.~~

~~A child who is self-supporting for federal income tax purposes is ineligible to be covered under the employee's family membership. A child who is otherwise eligible to be covered by family membership may be covered until such time as he becomes self-supporting.~~

~~Coverage for a dependent child stops at the end of the month in which the child marries.~~

~~g. Special rules.~~

~~(1) There are certain categories of persons who may not be covered as dependents under the program. These include: dependent siblings, grandchildren, nieces, nephews, and most other children except where the criteria for "other children" are satisfied (see 1 VAC 55-20-320 E 1 f). Parents, grandparents, aunts and uncles are not eligible for coverage regardless of dependency status.~~

~~(2) Under the health benefits program, eligible children may be covered to the end of the year in which they turn age 23 regardless of student status, if the child lives at home, is not married and is not self-supporting. In the case of natural or adopted children, living at home may mean living with the other parent if the employee is divorced. Also, a child who is away at school may be covered.~~

~~Children may be covered regardless of the age if incapable of self-support because of a severe physical or mental incapacitation, which was diagnosed while coverage was in force. An enrollment form for continued coverage for a disabled child is required within 31 days prior to the child's age attainment (above) to maintain coverage (see 1 VAC 55-20-330).~~

~~The marriage must be recognized as legal in the Commonwealth of Virginia.~~

~~b. Children. Under the health benefits program, the following eligible children may be covered to the end of the year in which they turn age 23 regardless of student status (age requirement is waived for adult incapacitated children), if the child lives at home or is away at school, is not married and receives over one-half of his support from the employee.~~

(1) Natural and adopted children. In the case of natural or adopted children, living at home may mean living with the other parent if the employee is divorced.

Also, if the biological parents are divorced, the support test is met if a natural or adopted child receives over one-half of his support from either parent or a combination of support from both parents. However, in order for the noncustodial parent to cover the child, the noncustodial parent must be entitled to claim the child as a dependent on his federal income tax return, or the custodial parent must sign a written declaration that he will not claim the child as a dependent on his federal income tax return.

(2) Stepchildren. Unmarried stepchildren living with the employee in a parent-child relationship. However, stepchildren may not be covered as a dependent unless their principal place of residence is with the employee and the child is a member of the employee's household. A stepchild must receive over one-half of his support from the employee.

(3) Incapacitated children. Adult children who are incapacitated due to a physical or mental health condition, as long as the child was covered by the plan and the incapacitation existed prior to the termination of coverage due to the child attaining the limiting age. The employee must make written application, along with proof of incapacitation, prior to the child reaching the limiting age. Such extension of coverage must be approved by the plan and is subject to periodic review. Should the plan find that the child no longer meets the criteria for coverage as an incapacitated child, the child's coverage will be terminated at the end of the month following notification from the plan to the enrollee.

Adult incapacitated children of new employees may also be covered, provided that:

(a) The enrollment form is submitted within 31 days of hire;

(b) The child has been covered continuously by group employer coverage since the disability first occurred; and

(c) The disability commenced prior to the child attaining the limiting age of the plan.

The enrollment form must be accompanied by a letter from a physician explaining the nature of the incapacitation, date of onset and certifying that the dependent is not capable of self-support. This extension of coverage must be approved by the plan in which the employee is enrolled.

(4) Other children. A child in which a court has ordered the employee to assume sole permanent custody. The principal place of residence must be with the employee, and the child must be a member of the employee's household.

Additionally, if the employee or spouse shares custody with the minor child who is the parent of the "other

child," then the other child may be covered. The other child, the parent of the other child, and the spouse who has custody must be living in the same household as the employee.

When a child loses eligibility, coverage terminates at the end of the month in which the event that causes the loss of eligibility occurs.

There are certain categories of persons who may not be covered as dependents under the program. These include dependent siblings, grandchildren, nieces, and nephews except where the criteria for "other children" are satisfied. Parents, grandparents, aunts and uncles are not eligible for coverage regardless of dependency status.

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TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Titles of Regulations: **12 VAC 30-120. Waivered Services (amending 12 VAC 30-120-280 and 12 VAC 30-120-370).**

12 VAC 30-141. Family Access to Medical Insurance Security Plan (amending 12 VAC 30-141-660).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public Hearing Date: N/A -- Public comments may be submitted until February 24, 2006.

(See Calendar of Events section for additional information)

Effective Date: April 3, 2006.

Agency Contact: Daniel Plain, Managed Care Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-7958, FAX (804) 786-1680, or e-mail daniel.plain@dmas.virginia.gov.

Basis: Sections 32.1-325 and 32.1-351 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and the Title XXI Plan (FAMIS), respectively. Section 32.1-324 of the Code of Virginia authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the board's requirements, and § 32.1-351 K provides the Board this same authority with respect to the Title XXI Plan. The Medicaid authority as established by § 1902(a) of the Social Security Act (42 USC 1396a) provides governing authority for payments for services.

Purpose: This regulatory action is not expected to have a direct effect on the health, safety, and welfare of either Medicaid recipients or the citizens of the Commonwealth. This regulation proposes to exempt Medicaid and FAMIS children enrolled in the Birth Injury Fund from concurrent

enrollment in managed care or primary care case management. This action will promote consistency of coverage with providers to ensure continuity of care and will prevent potential decision barriers to continued medical treatment.

Substance: The Birth Injury Fund ("BIF" or "the Fund") was established by the General Assembly to address the needs of children who suffered severe brain injury due to birth trauma. There are significant difficulties in establishing comprehensive coverage for enrollees in Medicaid or FAMIS enrollees who receive their medical care through primary care case management (PCCM) or managed care organizations (MCOs) that are also participants in the BIF. In addition, with respect to MCOs, not all medical providers used by the Fund meet all of the credentialing requirements of the various Medicaid and FAMIS MCOs, further complicating MCO coordination of benefits.

This regulatory change will not have an impact on any BIF participant's Medicaid or FAMIS eligibility. It will not exclude BIF participants from enrollment in Medicaid or FAMIS. This action simply excludes BIF participants from Medicaid or FAMIS PCCM or managed care while maintaining their Medicaid or FAMIS enrollment through the fee-for-service model. This action will assure access and continuity of care for BIF enrollees, as well as ending any conflict or confusion concerning appropriate providers or coordination of benefits.

Issues: The primary advantage to the Commonwealth of these suggested regulatory amendments is that BIF participants who are also enrolled in Medicaid or FAMIS will have comprehensive coverage without disruption. In addition, this action will simplify DMAS contract administration for Medicaid and FAMIS primary care physicians and managed care organizations.

There are no disadvantages to the general public in the implementation of these suggested changes, and the department projects no negative issues in implementing these proposed changes.

Rationale for Using Fast-Track Process: DMAS is proposing this action as a fast-track action as the most expedient way to address the difficulties inherent in coordinating payment between two programs that cover the same children in certain instances. DMAS does not expect objections to this proposed action since it resolves an outstanding issue that affects a small number of children in Virginia.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H 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

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property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The Board of Medical Assistance Services (board) proposes to exempt those children who are concurrently enrolled in the Virginia Birth-Related Neurological Injury Compensation Program and either the Medical Assistance Program (Medicaid) or the children's health insurance program offered pursuant to Title XXI of the Social Security Act (called FAMIS in Virginia) from any managed care requirement.

Estimated economic impact. In 1987, the Virginia General Assembly established the Virginia Birth-Related Neurological Injury Compensation Program (§ 38.2-5000 et seq. of the Code of Virginia). This program (referred to as the Birth Injury Fund) provides payment for the high cost medical needs of children who sustain brain injuries during their birth. A small number of children who participate in this fund have concurrent coverage under the managed care or primary care case management (PCCM) component of either the Virginia Medicaid program or Virginia's Family Access To Medical Insurance Security Plan (FAMIS). Primary care physicians and managed care organizations providing care to either FAMIS and/or Medicaid recipients have had difficulty coordinating benefits for children covered by the Birth Injury Fund. Both the Birth Injury Fund program and the managed care organizations have case managers; it has been confusing for affected individuals to work with multiple case managers.

In order to address this difficulty, the board proposes to exempt Birth Injury Fund enrolled children from Medicaid and FAMIS managed care and PCCM. These children will receive Medicaid services through the fee-for-service model rather than through managed care. According to the Department of Medical Assistance Services (DMAS), the children in question are unlikely to be affected in terms of services received. Statewide, managed care organizations will lose about four clients per year.¹ Over the time covered, the costs for managed care organizations concerning Birth Injury Fund children could either exceed or be less than Medicaid reimbursement in practice. In either case the difference will be small. Thus, the proposed exemption of Birth Injury Fund children from Medicaid and FAMIS managed care and PCCM will not significantly affect the managed care organizations' profits. Given the decrease in confusion and perhaps duplicative efforts by case managers and no reduction in services or profits or increase in costs, the proposed amendments should create a net benefit.

Businesses and entities affected. The proposed amendments will affect the children who are both participants in the Birth Injury Fund and have had concurrent coverage under the managed care or primary care case management component of either the Virginia Medicaid program or FAMIS. According to DMAS, there were four such individuals over the past year. The proposed amendments also affect the managed care organizations where these children have been covered.

Localities particularly affected. The proposed amendments do not disproportionately affect any particular locality.

Projected impact on employment. The proposed amendments do not significantly affect employment.

Effects on the use and value of private property. About a handful of managed care organizations may serve one or two fewer clients. This will not significantly affect the value of these organizations.

Small businesses: costs and other effects. Three or four managed care organizations may serve one or two fewer clients. These organizations will most likely not be small businesses. Regardless of their size, their net costs will not likely be significantly affected.

Small businesses: alternative method that minimizes adverse impact. Small businesses are not adversely affected by the proposed amendments.

Agency's Response to the 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 this regulation.

Summary:

This regulatory action exempts Medicaid and FAMIS children enrolled in the Birth Injury Fund from concurrent enrollment in managed care or primary care case management.

12 VAC 30-120-280. MEDALLION clients.

A. DMAS shall determine enrollment in MEDALLION. Enrollment in MEDALLION is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. Clients of MEDALLION shall be individuals receiving Medicaid as ABD, AFDC or AFDC-related categorically needy and medically needy (except those becoming eligible through spend-down) and except for foster care children, whether or not receiving cash assistance grants.

B. Exclusions.

1. The following individuals shall be excluded from participation in MEDALLION, or excluded from continued enrollment if any of the following apply:

a. Individuals who are inpatients in state mental hospitals and skilled nursing facilities, or reside in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or a long-stay hospital;

b. Individuals who are enrolled in § 1915c home and community-based waivers, the family planning waiver, or the Family Access to Medical Insurance Security Plan (FAMIS);

c. Individuals who are participating in foster care or subsidized adoption programs, who are members of spend-down cases, or who are refugees or who receive client medical management services;

d. Individuals receiving Medicare;

e. Individuals who are enrolled in DMAS-authorized residential treatment or treatment foster care programs; and

¹ Source: Department of Medical Assistance Services.

- f. Individuals whose coverage is retroactive only; and
- g. *Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.*

2. A client may be excluded from participating in MEDALLION if any of the following apply:

- a. The client is not accepted to the caseload of any participating PCP.
- b. The client's enrollment in the caseload of assigned PCP has been terminated, and other PCPs have declined to enroll the client.
- c. The individual receives hospice services in accordance with DMAS criteria.

C. Client enrollment process.

1. All ABD, AFDC or AFDC-related recipients excepting those meeting one of the exclusions of subsection B of this section shall be enrolled in MEDALLION.

2. Newly eligible individuals shall not participate in MEDALLION until completion of the Medicaid enrollment process. This shall include initial enrollment in the Medicaid program at the time of eligibility determination by Department of Social Services staff, or any subsequent reenrollment in the Medicaid program that may occur.

3. During the preassignment period and registration as MEDALLION clients, recipients shall be provided Medicaid-covered services via the fee-for-service delivery mechanism administered by DMAS.

4. Once clients are fully registered as MEDALLION clients, they will receive MEDALLION identification material in addition to the Medicaid card.

D. PCP selection. Clients shall be given the opportunity to select the PCP of their choice.

1. Clients shall notify DMAS of their PCP selection within 45 days of receiving their MEDALLION enrollment notification letter. If notification is not received by DMAS within that timeframe, DMAS shall select a PCP for the client.

2. The selected PCP shall be a MEDALLION enrolled provider.

3. The PCP will provide 24-hour, seven day/week access, which shall include as a minimum a 24-hour, seven day/week telephone number to be provided to each MEDALLION client.

4. DMAS shall review client requests in choosing a specific PCP for appropriateness and to ensure client accessibility to all required medical services.

5. Individuals who lose then regain eligibility for MEDALLION within 60 days will be reassigned to their previous PCP without going through the preassignment and selection process.

E. Mandatory assignment of PCP.

1. The MEDALLION program enrolls clients with a primary care provider (PCP) who acts as a care coordinator, provides primary and preventive care, and authorizes most specialty services. The client is required to select a PCP from a list of available PCPs in his service area. If the client does not select a PCP, the client defaults to the department's pre-assignment option. Clients can access any program provider for specialty services if they obtain the necessary authorization from their PCP.

2. Each site having two or more separately identifiable provider groups shall be divided into separate regions for client assignment. Clients shall initially be assigned to a PCP according to the region in which they reside. Should insufficient PCPs exist within the client's specific region, clients shall be assigned a PCP in an adjacent region.

3. Each PCP shall be assigned a client, or family group if appropriate, until the maximum number of clients the PCP has elected to serve or the PCP/client limit has been reached or until there are no more clients suitable for assignment to that PCP, or all clients have been assigned.

F. Changing PCPs. MEDALLION clients will have the initial 90 calendar days following the effective date of enrollment with a MEDALLION PCP to change PCPs without cause. After the initial 90-day assignment period, the recipient will remain with the PCP for at least 12 months unless cause to change PCPs is shown pursuant to subdivision 1 or 2 of this subsection. After 12 months the recipient will have the option to select another PCP. Recipients will be given at least 60 days notice prior to the end of this enrollment period (and all future enrollment periods) during which time recipients can select another PCP. Open enrollment periods will occur annually.

1. Requests for change of PCP "for cause" are not subject to the 12-month limitation, but shall be reviewed and approved by DMAS staff on an individual basis. Examples of changing providers "for cause" may include but shall not be necessarily limited to:

a. Client has a special medical need which cannot be met in his service area or by his PCP.

b. Client has a pre-existing relationship with a Medicaid provider rendering care for a special medical need.

c. Mutual decision by both client and provider to sever the relationship.

d. Provider or client moves to a new residence, causing transportation difficulties for the client.

e. Provider cannot establish a rapport with the client.

f. Performance or nonperformance of service to the recipient by a provider that is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care.

g. Other reasons as determined by DMAS through written policy directives.

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2. The existing PCP shall continue to retain the client in the caseload, and provide services to the client until a new PCP is assigned or selected.

3. PCPs may elect to release MEDALLION clients from their caseloads for cause with review and approval by DMAS on a case-by-case basis. In such circumstances, subdivision F 2 of this section shall apply.

G. Prior authorization.

1. Clients shall contact their assigned PCP or designated covering provider to obtain authorization prior to seeking nonemergency care.

2. Emergency services and family planning services shall be provided without delay or prior authorization. However, the emergency nature of the treatment shall be documented by the provider providing treatment and should be reported to the PCP after treatment is provided. Clients should inform the PCP of any emergency treatment received.

H. Enrollee rights.

1. Each primary care provider must comply with any and all applicable federal and state laws and regulations regarding enrollee rights including, but not limited to, the applicable sections of 42 CFR 438.100 et seq., Title VI of the Civil Rights Act of 1964, and other applicable laws regarding privacy and confidentiality, and ensure that their staff and affiliated providers take those rights into account when furnishing services to enrollees.

2. Each enrollee shall be free to exercise his rights, and the exercise of those rights shall not adversely affect the way the primary care provider or DMAS treats the enrollee.

12 VAC 30-120-370. Medallion II enrollees.

A. DMAS shall determine enrollment in Medallion II. Enrollment in Medallion II is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. DMAS reserves the right to exclude from participation in the Medallion II managed care program any recipient who has been consistently noncompliant with the policies and procedures of managed care or who is threatening to providers, MCOs, or DMAS. There must be sufficient documentation from various providers, the MCO, and DMAS of these noncompliance issues and any attempts at resolution. Recipients excluded from Medallion II through this provision may appeal the decision to DMAS.

B. The following individuals shall be excluded from participating in Medallion II. Individuals not meeting the exclusion criteria must participate in the Medallion II program.

1. Individuals who are inpatients in state mental hospitals;
2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for the mentally retarded;
3. Individuals who are placed on spend-down;
4. Individuals who are participating in the family planning waiver, and in federal waiver programs for home-based and community-based Medicaid coverage;

5. Individuals who are participating in foster care or subsidized adoption programs;

6. Individuals under age 21 who are enrolled in DMAS authorized residential treatment or treatment foster care programs;

7. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the recipient, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid;

8. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;

9. Individuals who receive hospice services in accordance with DMAS criteria;

10. Individuals with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP);

11. Individuals requesting exclusion who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge;

12. Individuals who request exclusion during preassignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less. The client's physician must certify the life expectancy;

13. Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion II enrollment;

14. Individuals who have an eligibility period that is less than three months;

15. Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program; and

16. Individuals who have an eligibility period that is only retroactive; and

17. *Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established*

pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

C. Medallion II managed care plans shall be offered to recipients, and recipients shall be enrolled in those plans, exclusively through an independent enrollment broker under contract to DMAS.

D. Clients shall be enrolled as follows:

1. All eligible persons, except those meeting one of the exclusions of subsection B of this section, shall be enrolled in Medallion II.

2. Clients shall receive a Medicaid card from DMAS, and shall be provided authorized medical care in accordance with DMAS' procedures after Medicaid eligibility has been determined to exist.

3. Once individuals are enrolled in Medicaid, they will receive a letter indicating that they may select one of the contracted MCOs. These letters shall indicate a preassigned MCO, determined as provided in subsection E of this section, in which the client will be enrolled if he does not make a selection within a period specified by DMAS of not less than 30 days.

4. Any newborn whose mother is enrolled with an MCO at the time of birth shall be considered an enrollee of that same MCO for the newborn enrollment period. This requirement does not preclude the enrollee, once he is assigned a Medicaid identification number, from disenrolling from one MCO to another in accordance with subdivision F 1 of this section.

The newborn's continued enrollment with the MCO is not contingent upon the mother's enrollment. Additionally, if the MCO's contract is terminated in whole or in part, the MCO shall continue newborn coverage if the child is born while the contract is active, until the newborn receives a Medicaid number or for the newborn enrollment period, whichever timeframe is earlier. Infants who do not receive a Medicaid identification number prior to the end of the newborn enrollment period will be disenrolled. Newborns who remain eligible for participation in Medallion II will be reenrolled in an MCO through the preassignment process upon receiving a Medicaid identification number.

5. Individuals who lose then regain eligibility for Medallion II within 60 days will be reenrolled into their previous MCO without going through preassignment and selection.

E. Clients who do not select an MCO as described in subdivision D 3 of this section shall be assigned to an MCO as follows:

1. Clients are assigned through a system algorithm based upon the client's history with a contracted MCO.

2. Clients not assigned pursuant to subdivision 1 of this subsection shall be assigned to the MCO of another family member, if applicable.

3. All other clients shall be assigned to an MCO on a basis of approximately equal number by MCO in each locality.

4. In areas where there is only one contracted MCO, recipients have a choice of enrolling with the contracted MCO or the PCCM program. All eligible recipients in areas where one contracted MCO exists, however, are automatically assigned to the contracted MCO. Individuals are allowed 90 days after the effective date of new or initial enrollment to change from either the contracted MCO to the PCCM program or vice versa.

F. Following their initial enrollment into an MCO or PCCM program, recipients shall be restricted to the MCO or PCCM program until the next open enrollment period, unless appropriately disenrolled or excluded by the department.

1. During the first 90 calendar days of enrollment in a new or initial MCO, a client may disenroll from that MCO to enroll into another MCO or into PCCM, if applicable, for any reason. Such disenrollment shall be effective no later than the first day of the second month after the month in which the client requests disenrollment.

2. During the remainder of the enrollment period, the client may only disenroll from one MCO into another MCO or PCCM, if applicable, upon determination by DMAS that good cause exists as determined under subsection H of this section.

G. The department shall conduct an annual open enrollment for all Medallion II participants. The open enrollment period shall be the 60 calendar days before the end of the enrollment period. Prior to the open enrollment period, DMAS will inform the recipient of the opportunity to remain with the current MCO or change to another MCO, without cause, for the following year. In areas with only one contracted MCO, recipients will be given the opportunity to select either the MCO or the PCCM program. Enrollment selections will be effective on the first day of the next month following the open enrollment period. Recipients who do not make a choice during the open enrollment period will remain with their current MCO selection.

H. Disenrollment for cause may be requested at any time.

1. After the first 90 days of enrollment in an MCO, clients must request disenrollment from DMAS based on cause. The request may be made orally or in writing to DMAS and must cite the reasons why the client wishes to disenroll. Cause for disenrollment shall include the following:

a. A recipient's desire to seek services from a federally qualified health center which is not under contract with the recipient's current MCO, and the recipient (i) requests a change to another MCO that subcontracts with the desired federally qualified health center or (ii) requests a change to the PCCM, if the federally qualified health center is contracting directly with DMAS as a PCCM;

b. Performance or nonperformance of service to the recipient by an MCO or one or more of its providers which is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care;

c. Lack of access to a PCP or necessary specialty services covered under the State Plan or lack of access

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to providers experienced in dealing with the enrollee's health care needs;

d. A client has a combination of complex medical factors that, in the sole discretion of DMAS, would be better served under another contracted MCO or PCCM program, if applicable, or provider;

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

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

g. The enrollee needs related services to be performed at the same time; not all related services are available within the network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; or

h. Other reasons as determined by DMAS through written policy directives.

2. DMAS shall determine whether cause exists for disenrollment. Written responses shall be provided within a timeframe set by department policy; however, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the enrollee files the request, in compliance with 42 CFR 438.56.

3. Cause for disenrollment shall be deemed to exist and the disenrollment shall be granted if DMAS fails to take final action on a valid request prior to the first day of the second month after the request.

4. The DMAS determination concerning cause for disenrollment may be appealed by the client in accordance with the department's client appeals process at 12 VAC 30-110-10 through 12 VAC 30-110-380.

5. The current MCO shall provide, within two working days of a request from DMAS, information necessary to determine cause.

12 VAC 30-141-660. Assignment to managed care.

A. *Except for children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia*, all eligible enrollees shall be assigned in managed care through the department or the central processing unit (CPU) under contract to DMAS. FAMIS recipients, during the pre-assignment period to a PCP or MCHIP, shall receive Title XXI benefits via fee-for-service utilizing a FAMIS card issued by DMAS. After assignment to a PCP or MCHIP, benefits and the delivery of benefits shall be administered specific to the type of managed care program in which the recipient is enrolled.

1. MCHIPs shall be offered to enrollees in certain areas.

2. In areas with one contracted MCHIP, all enrollees shall be assigned to that contracted MCHIP.

3. In areas with multiple contracted MCHIPs or in PCCM areas without contracted MCHIPs, enrollees shall be assigned through a random system algorithm; provided

however, all children within the same family shall be assigned to the same MCHIP or primary care provider (PCP), as is applicable.

4. In areas without contracted MCHIPs, enrollees shall be assigned to the primary care case management program (PCCM) or into the fee-for-service component. *All children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program shall be assigned to the fee-for-service component.*

5. Enrolled individuals residing in PCCM areas without contracted MCHIPs or in areas with multiple MCHIPs, will receive a letter indicating that they may select one of the contracted MCHIPs or primary care provider (PCP) in the PCCM program, in each case, which serve such area. Enrollees who do not select an MCHIP/PCP as described above, shall be assigned to an MCHIP/PCP as described in subdivision 3 of this section.

6. Individuals assigned to an MCHIP or a PCCM who lose and then regain eligibility for FAMIS within 60 days will be re-assigned to their previous MCHIP or PCP.

B. Following their initial assignment to a MCHIP/PCP, those enrollees shall be restricted to that MCHIP/PCP until their next annual eligibility redetermination, unless appropriately disenrolled by the department.

1. During the first 90 calendar days of managed care assignment, an enrollee may request re-assignment for any reason from that MCHIP/PCP to another MCHIP/PCP serving that geographic area. Such re-assignment shall be effective no later than the first day of the second month after the month in which the enrollee requests re-assignment.

2. Re-assignment is available only in areas with the PCCM program or where multiple MCHIPs exist. If multiple MCHIPs exist, enrollees may only request re-assignment to another MCHIP serving that geographic area. In PCCM areas, an enrollee may only request re-assignment to another PCP serving that geographic area.

3. After the first 90 calendar days of the assignment period, the enrollee may only be re-assigned from one MCHIP/PCP to another MCHIP/PCP upon determination by DMAS that good cause exists pursuant to subsection C of this section.

C. Disenrollment for good cause may be requested at any time.

1. After the first 90 days of assignment in managed care, enrollees may request disenrollment from DMAS based on good cause. The request must be made in writing to DMAS and cite the reasons why the enrollee wishes to be re-assigned. The department shall establish procedures for good cause re-assignment through written policy directives.

2. DMAS shall determine whether good cause exists for re-assignment.

VA.R. Doc. No. R06-134; Filed December 7, 2005, 9:56 a.m.

EMERGENCY REGULATIONS

TITLE 4. CONSERVATION AND NATURAL RESOURCES

MARINE RESOURCES COMMISSION

Title of Regulation: 4 VAC 20-20. Pertaining to the Licensing of Fixed Fishing Devices (amending 4 VAC 20-20-20 and 4 VAC 20-20-50).

Statutory Authority: §§ 28.2-201 and 28.2-210 of the Code of Virginia.

Effective Dates: December 1, 2005, through December 30, 2005.

Agency Contact: Deborah R. Cawthon, Agency Regulatory Coordinator, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, FAX (757) 247-2002, or e-mail debbie.cawthon@mrc.virginia.gov.

Summary:

This amendments define the National Marine Fisheries Service Prohibited Pound Net Leader Area and exempt pound net fishermen affected by the federal rule that prohibits the use of all pound net leaders set with the inland end of the leader greater than 10 horizontal feet from the mean low water line from May 6 through July 15 from the priority rights requirements necessary for renewal of a pound net license.

4 VAC 20-20-20. Definitions.

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

"Fixed fishing device" means any fishing device used for the purpose of catching fish and requiring the use of more than two poles or stakes which have been pushed or pumped into the bottom.

"Fyke net" means a round stationary net distended by a series of hoops or frames, covered by web netting or wire mesh and having one or more internal funnel-shaped throats whose tapered ends are directed away from the mouth of the net. The net, leader or runner is held in place by stakes or poles which have been pushed or pumped into the bottom and has one or two wings and a leader or runner to help guide the fish into the net.

"National Marine Fisheries Service Prohibited Pound Net Leader Area" means the area where the National Marine Fisheries Service prohibits the use of all pound net leaders, set with the inland end of the leader greater than 10 horizontal feet from the mean low water line, from May 6 to July 15 each year in the Virginia waters of the mainstem Chesapeake Bay, south of 37°19.0' N. lat. and west of 76°13.0' W. long., and all waters south of 37°13.0' N. lat. to the Chesapeake Bay Bridge Tunnel at the mouth of the Chesapeake Bay, and the James and York rivers downstream of the first bridge in each tributary.

"Officer" means the marine patrol officer in charge of the district within which the fixed fishing device is located.

"Pound net" means a stationary fishing device supported by stakes or poles which have been pushed or pumped into the bottom consisting of an enclosure identified as the head or pocket with a netting floor, a heart, and a straight wall, leader or runner to help guide the fish into the net.

"Staked gill net" means a fixed fishing device consisting of an upright fence of netting fastened to poles or stakes which have been pushed or pumped into the bottom.

4 VAC 20-20-50. Priority rights; renewal by current licensee.

A. Applications for renewal of license for existing fixed fishing devices may be accepted by the officer beginning at 9 a.m. on December 1 of the current license year through noon on January 10 of the next license year providing the applicant has met all requirements of law and this chapter. Any location not relicensed during the above period of time shall be considered vacant and available to any qualified applicant after noon on January 10.

B. Except as provided in ~~subsection~~ *subsections C, D, and E* of this section, a currently licensed fixed fishing device must have been fished during the current license year, ~~except as provided in subsection D of this section,~~ in order for the licensee to maintain his priority right to such location. It shall be mandatory for the licensee to notify the officer, on forms provided by the commission, when the fixed fishing device is ready to be fished in the location applied for, by a complete system of nets and poles, except as provided in subsection D of this section, for the purpose of visual inspection by the officer. Either the failure of the licensee to notify the officer when the fixed fishing device is ready to be fished or the failure by the licensee actually to fish the licensed device, by use of a complete system of nets and poles, except as provided in subsection D of this section, shall terminate his right or privilege to renew the license during the period set forth in subsection A of this section of this chapter, and he shall not become a qualified applicant for such location until 9 a.m. on February 1. Any application received from an unqualified applicant under this subsection shall be considered as received at 9 a.m. on February 1; however, in the event of the death of a current license holder, the priority right to renew the currently held locations of the deceased licensee shall not expire by reason of failure to fish said locations during the year for which they were licensed, but one additional year shall be and is hereby granted to the personal representative or lawful beneficiary of the deceased licensee to license the location in the name of the estate of the deceased licensee for purposes of fishing said location or making valid assignment thereof.

C. During the effective period of 4 VAC 20-530, which establishes a moratorium on the taking and possession of American shad in the Chesapeake Bay and its tributaries, any person licensed during 1993 to set a staked gill net who chooses not to set that net during the period of the moratorium may maintain his priority right to the stake net's 1993 location by completing an application for a fixed fishing device and

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submitting it to the officer. No license fee shall be charged for the application.

D. During 2004, current pound net licensees shall not be required to fish their pound nets or establish a complete system of nets and poles in order to renew their licenses or maintain their priority rights to such locations for 2005.

E. Beginning in 2005 current pound net licensees with a licensed pound net located in the National Marine Fisheries Service Prohibited Pound Net Leader Area shall not be required to fish their pound nets or establish a complete system of nets and poles in order to renew their licenses or maintain their priority rights to such locations for any subsequent year until such time that this prohibited area is no longer in effect.

VA.R. Doc. No. R06-119; Filed November 30, 2005, 9:29 a.m.

Title of Regulation: 4 VAC 20-720. Pertaining to Restrictions on Oyster Harvest (amending 4 VAC 20-720-70).

Statutory Authority: §§ 28.2-201, 28.2-210, and 28.2-507 of the Code of Virginia.

Effective Dates: December 1, 2005, through December 30, 2005.

Agency Contact: Katherine V. Leonard, Administrative and Program Specialist, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2120, FAX (757) 247-8101, or e-mail kathy.leonard@mrc.virginia.gov.

Summary:

The amendment allows the harvesting of oysters from public grounds in the Coan, Lower Machodoc, Nomini and Yeocomico rivers by hand scrape.

4 VAC 20-720-70. Gear restrictions.

A. It shall be unlawful for any person to harvest oysters in the James River Seed Areas, including the Deep Water Shoal State Replenishment Seed Area; the James River Jail Island and Point of Shoals Clean Cull Areas; or the Rappahannock River Hand Tong Area; the Corrotoman River Hand Tong Area; the Nomini and Lower Machodoc rivers; the Coan River; the Yeocomico River; the Piankatank River; and Little Wicomico River, except by hand or ordinary tong or as described in subsection F of this section. It shall be unlawful for any person to have a hand scrape on board a boat that is harvesting or attempting to harvest oysters from public grounds by hand tong, except as described in subsection F of this section.

B. It shall be unlawful to harvest oysters from the seaside of the Eastern Shore, except by hand.

C. It shall be unlawful to harvest oysters from the hand scrape areas in the Rappahannock River; James River, Great Wicomico River, Upper Chesapeake Bay, and York River, except by hand scrape.

D. It shall be unlawful for any person to have more than one hand scrape on board any boat that is harvesting oysters or attempting to harvest oysters from public grounds. It shall be unlawful for any person to have a hand tong on board a boat that is harvesting or attempting to harvest oysters from public grounds by hand scrape, except as described in subsection F of this section.

E. It shall be unlawful to harvest oysters from the Pocomoke and Tangier Sounds Management Area and Deep Rock Dredge Area except by a standard oyster dredge.

F. It shall be lawful to harvest oysters from the Coan, Lower Machodoc, Nomini and Yeocomico rivers, by hand scrape.

VA.R. Doc. No. R06-121; Filed November 30, 2005, 9:33 a.m.

Title of Regulation: 4 VAC 20-910. Pertaining to Scup (Porgy) (amending 4 VAC 20-910-45).

Statutory Authority: §§ 28.2-201 and 28.2-210 of the Code of Virginia.

Effective Dates: December 1, 2005, through December 30, 2005.

Agency Contact: Deborah R. Cawthon, Agency Regulatory Coordinator, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, FAX (757) 247-2002, or e-mail debbie.cawthon@mrc.virginia.gov.

Summary:

The amendment reduces the possession limit of scup from 3,500 pounds to 3,000 pounds from November 1 through December 31 of each year, as required by the Atlantic States Marine Fisheries Commission.

4 VAC 20-910-45. Possession limits and harvest quotas.

A. During the period January 1 through April 30 of each year, it shall be unlawful for any person to do any of the following:

1. Possess aboard any vessel in Virginia more than 30,000 pounds of scup.
2. Land in Virginia more than a total of 30,000 pounds of scup during each consecutive 14-day landing period, with the first 14-day period beginning on January 2.

B. When it is projected and announced that 80% of the coastwide quota for this period has been attained, it shall be unlawful for any person to possess aboard any vessel or to land in Virginia more than a total of 1,000 pounds of scup.

C. During the period November 1 through December 31 of each year, it shall be unlawful for any person to possess aboard any vessel or to land in Virginia more than 3,000 pounds of scup.

D. During the period May 1 through October 31 of each year, the commercial harvest and landing of scup in Virginia shall be limited to 7,862 pounds.

E. For each of the time periods set forth in this section, the Marine Resources Commission will give timely notice to the industry of calculated poundage possession limits and quotas

and any adjustments thereto. It shall be unlawful for any person to possess or to land any scup for commercial purposes after any winter period coastwide quota or summer period Virginia quota has been attained and announced as such.

F. It shall be unlawful for any buyer of seafood to receive any scup after any commercial harvest or landing quota has been attained and announced as such.

G. It shall be unlawful for any person fishing with hook and line, rod and reel, spear, gig or other recreational gear to possess more than 50 scup. When fishing is from a boat or vessel where the entire catch is held in a common hold or container, the possession limit shall be for the boat or vessel and shall be equal to the number of persons on board legally eligible to fish multiplied by 50. The captain or operator of the boat or vessel shall be responsible for any boat or vessel possession limit. Any scup taken after the possession limit has been reached shall be returned to the water immediately.

VA.R. Doc. No. R06-118; Filed November 30, 2005, 9:30 a.m.



TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Titles of Regulations: **12 VAC 30-30. Groups Covered and Agencies Responsible for Eligibility Determination (adding 12 VAC 30-30-60).**

12 VAC 30-40. Eligibility Conditions and Requirements (amending 12 VAC 30-40-10).

12 VAC 30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-530; adding 12 VAC 30-50-35 and 12 VAC 30-50-75).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Dates: January 1, 2006, through December 31, 2006.

Agency Contact: Jack Quigley, Policy and Research Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-1300, FAX (804) 786-1680, or e-mail jack.quigley@dmas.virginia.gov.

Preamble:

Section 2.2-4011 of the Administrative Process Act states that an emergency situation is (i) a situation involving an imminent threat to public health or safety; or (ii) a situation in which Virginia statutory law, the Virginia appropriation act, or federal law requires that a regulation shall be effective in 280 days or less from its enactment, or in which federal regulation requires a regulation to take effect no later than 280 days from its effective date. This suggested emergency regulation meets the standard of clause (ii) of

subsection A of § 2.2-4011 of the Code of Virginia as discussed below.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to individuals who are entitled to receive Medicare benefits under Part A or Part B, beginning on January 1, 2006. In response to this federal mandate the 2005 Session of the General Assembly mandated that the Medicaid agency promulgate "necessary regulations to implement the provisions of the Medicare Part D prescription drug benefit" and required DMAS to promulgate such regulations within 280 days of the enactment of Chapters 24 and 56 of the 2005 Acts of Assembly.

Currently, Virginia's Medicaid Program provides outpatient drugs for its Medicaid recipients, both the categorically needy and medically needy. Effective January 1, 2006, Medicaid recipients who are entitled to receive Medicare benefits under Part A or Part B will no longer receive their pharmacy benefits under the state's Medicaid Program, except for drugs that are excluded under the Medicare Prescription Drug Program. Virginia was required to submit State Plan Amendments to ensure that its State Medicaid Program pharmacy benefits are consistent with the requirements under Part D. DMAS also must ensure a continuum of coverage for medically necessary drugs and the transportation necessary to obtain those drugs.

The MMA also established the Low-Income Subsidy (LIS) to assist individuals who have low income and resources with payment of the premiums, deductibles, and co-payments required under Part D. The MMA requires both the Social Security Administration and the state Medicaid agency to accept and process applications for LIS. States must have the capacity to accept and provide assistance with such applications by July 1, 2005, for individuals who request such a determination by the state. In addition, the MMA requires the state to provide for screening of individuals who may be eligible for Medicare cost-sharing as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), or Qualified Individuals (QIs), and to offer enrollment to eligible individuals. These requirements appear both in the statute (§ 1935(a) of the Social Security Act) and in regulations at 42 CFR 423.774 and 423.904.

Virginia is required to ensure that these provisions are in place no later than January 1, 2006 to reflect its compliance with the MMA and to meet the criteria for receipt of any federal financial assistance claimed in conjunction with Virginia's compliance with the MMA. DMAS must continue to cover the drugs and services described in the amendments in order to maintain comparability of services.

12 VAC 30-30-60. Requirements relating to determining eligibility for Medicare prescription drug low-income subsidies.

The agency provides for making Medicare prescription drug low-income subsidy determinations under § 1935(a) of the Social Security Act.

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1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with § 1860D-14 of the Social Security Act;

a. The Social Security Administration's subsidy application (SSA-1020) will be used as the official application form for individuals to request that the state determine eligibility for the Low Income Subsidy.

b. The application must be filed at the local department of social services in the city or county where the applicant resides. A face-to-face interview is not required.

c. The applicant may be represented by an individual who is authorized to act on behalf of the applicant; if the applicant is incapacitated or incompetent, someone acting responsibly on his or her behalf; an individual of the applicant's choice who is requested by the applicant to act as his or her representative in the application process. The person acting responsibly on behalf of, or acting as the representative of, the applicant is required to attest to the accuracy of the information on the application.

d. Applications must be acted on within 45 days from the date the application is received by the local department of social services. A determination of eligibility or ineligibility must be made and the applicant must be sent written notice of his approval or denial of assistance under the Low Income Subsidy program as well as the reasons for such findings.

e. Redeterminations of eligibility must be made in the same manner and frequency as redeterminations are required under the State's Medicaid Plan.

f. Family size. The following persons are counted in the family size: the applicant; the applicant's spouse, if living with the applicant; and any persons who are related by blood, marriage or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support.

g. Financial requirements. Regulations at 20 CFR 416 Subparts K and L are used to evaluate income and resources for subsidy eligibility. Current SSI policy can be found in the online Program Operations Manual System (POMS) at <http://policy.ssa.gov/poms.nsf/aboutpoms>. Less restrictive rules the state uses for Medicaid determinations are not used for the low-income subsidy determination.

h. The subsidy applicant may appeal his or her low-income subsidy determination according to the appeal procedures found in the State's Medicaid State Plan.

2. The agency provides for informing the secretary of such determinations in cases in which such eligibility is established or redetermined;

3. The agency provides for screening of individuals for Medicare cost-sharing described in § 1905(p)(3) of the Act and offering enrollment to eligible individuals under the state plan or under a waiver of the state plan.

12 VAC 30-40-10. General conditions of eligibility.

Each individual covered under the plan:

1. Is financially eligible (using the methods and standards described in Parts II and III of this chapter) to receive services.

2. Meets the applicable nonfinancial eligibility conditions.

a. For the categorically needy:

(i) Except as specified under items (ii) and (iii) below, for AFDC-related individuals, meets the nonfinancial eligibility conditions of the AFDC program.

(ii) For SSI-related individuals, meets the nonfinancial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.

(iii) For financially eligible pregnant women, infants or children covered under §§ 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the nonfinancial criteria of § 1902(l) of the Act.

(iv) For financially eligible aged and disabled individuals covered under § 1902(a)(10)(A)(ii)(X) of the Act, meets the nonfinancial criteria of § 1902(m) of the Act.

b. For the medically needy, meets the nonfinancial eligibility conditions of 42 CFR 435.

c. For financially eligible qualified Medicare beneficiaries covered under § 1902(a)(10)(E)(i) of the Act, meets the nonfinancial criteria of § 1905(p) of the Act.

d. For financially eligible qualified disabled and working individuals covered under § 1902(a)(10)(E)(ii) of the Act, meets the nonfinancial criteria of § 1905(s).

3. Is residing in the United States and:

a. Is a citizen; or

b. Is a qualified alien as defined under Public Law 104-193 who arrived in the United States prior to August 22, 1996;

c. Is a qualified alien as defined under Public Law 104-193 who arrived in the United States on or after August 22, 1996, and whose coverage is mandated by Public Law 104-193;

d. Is an alien who is not a qualified alien, or who is a qualified alien who arrived in the United States on or after August 22, 1996, whose coverage is not mandated by Public Law 104-193 (coverage must be restricted to certain emergency services).

4. Is a resident of the state, regardless of whether or not the individual maintains the residence permanently or maintains it a fixed address.

The state has open agreement(s).

5. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or

publicly operated community residences that serve no more than 16 residents, or certain child care institutions.

6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met.

An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in § 1902(1)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the state plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

7. Is required, as a condition of eligibility, to furnish his social security account number (or numbers, if he has more than one number) except for aliens seeking medical assistance for the treatment of an emergency medical condition under § 1903(v)(2) of the Social Security Act (§ 1137(f)).

8. Is not required to apply for AFDC benefits under Title IV-A as a condition of applying for, or receiving Medicaid if the individual is a pregnant women, infant, or child that the state elects to cover under § 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

9. Is not required, as an individual child or pregnant woman, to meet requirements under § 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a state's AFDC plan, the agency determines if they are otherwise eligible under the state's Medicaid plan.)

10. Is required to apply for enrollment in an employer-based cost-effective group health plan (as determined by the state agency), if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

11. *Is required to apply for coverage under Medicare A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals*

required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or coinsurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

12 VAC 30-50-35. Requirements relating to payment for covered outpatient drugs for the categorically needy.

A. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D. The following excluded drugs are covered:

- a. Agents when used for anorexia, weight loss, weight gain (see specific drug categories below).*
- b. Agents when used for the symptomatic relief cough and colds (see specific drug categories below).*
- c. Prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below).*
- d. Nonprescription drugs (see specific drug categories below).*
- e. Barbiturates (see specific drug categories below).*
- f. Benzodiazepines (see specific drug categories below).*

B. Coverage of specific categories of excluded drugs will be in accordance with existing Medicaid policy as described in 12 VAC 30-50-520.

12 VAC 30-50-75. Requirements relating to payment for covered outpatient drugs for the medically needy.

A. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D. The following excluded drugs are covered:

- a. Agents when used for anorexia, weight loss, weight gain (see specific drug categories below).*
- b. Agents when used for the symptomatic relief cough and colds (see specific drug categories below).*
- c. Prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below).*

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d. *Nonprescription drugs (see specific drug categories below).*

e. *Barbiturates (see specific drug categories below).*

f. *Benzodiazepines (see specific drug categories below).*

B. Coverage of specific categories of excluded drugs will be in accordance with existing Medicaid policy as described in 12 VAC 30-50-520.

12 VAC 30-50-530. Methods of providing transportation.

A. DMAS will ensure necessary transportation for recipients to and from providers of covered medical services. DMAS shall cover transportation to covered medical services under the following circumstances:

1. Emergency air, ambulance transportation, and all other modes of transportation shall be covered as medical services under 42 CFR 431.53 and any other applicable federal Medicaid regulations. These modes include, but shall not be limited to, nonemergency air travel, nonemergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. DMAS may contract directly with providers of transportation or with brokers of transportation services, or both. DMAS may require that brokers not have a financial interest in transportation providers with whom they contract.

2. Medicaid provided transportation shall only be available when recipients have no other means of transportation available.

3. Recipients shall be furnished transportation services that are the most economical to adequately meet the recipients' medical needs.

4. Ambulances, wheelchair vans, taxicabs, and other modes of transportation must be licensed to provide services in the Commonwealth by the appropriate state or local licensing agency, or both. Volunteer/registered drivers must be licensed to operate a motor vehicle in the Commonwealth and must maintain automobile insurance.

B. DMAS will ensure necessary nonemergency transportation for full-benefit, dual eligible recipients to obtain medically necessary, noncovered Medicare Part D prescription drugs.

/s/ Mark R. Warner
Governor
December 1, 2005

VA.R. Doc. No. R06-133; Filed December 7, 2005, 9:58 a.m.

Title of Regulation: **12 VAC 30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12 VAC 30-80-30).**

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Dates: December 2, 2005, through December 1, 2006.

Agency Contact: William Lessard, Provider Reimbursement Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 225-4593, FAX (804) 786-1680, or e-mail william.lessard@dmass.virginia.gov.

Preamble:

Section 2.2-4011 of the Administrative Process Act states that an "emergency situation" is: (i) a situation involving an imminent threat to public health or safety or (ii) a situation in which Virginia statutory law, the Virginia appropriation act, or federal law requires that a regulation shall be effective in 280 days or less from its enactment, or in which federal regulation requires a regulation to take effect no later than 280 days from its effective date. This emergency regulation meets the standard of clause (ii) of subsection A of § 2.2-4011 of the Code of Virginia as discussed below.

Item 326 BBBB of the 2005 Appropriation Act provides that DMAS shall modify state regulations and the State Plan for Medical Assistance Services to make supplemental Medicaid payments to dentists who are faculty affiliated with the dental pediatric residency programs at Virginia Commonwealth University (VCU). The state budget also provides for the authority to enact emergency regulations contingent upon federal approval.

The purpose of this action is to provide additional funding for dental pediatric residency programs at VCU to replace cutbacks in funding from Medicare Graduate Medical Education (GME) programs. The amendment also establishes a methodology for calculating the supplemental payment. The supplemental payment amount shall be the difference between the Medicaid payments otherwise made for dentists and the lower of 136% of the Medicaid fee or charges. Commercial fees for dental services at VCU are approximately 136% of Medicaid fees.

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

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12 VAC 30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services (12 VAC 30-80-160 has obstetric/pediatric fees). Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public), except that reimbursement rates for designated physician services when performed in hospital outpatient settings shall be 50% of the reimbursement rate established for those services when performed in a physician's office. The following limitations shall apply to emergency physician services.

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

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

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

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

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

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

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in 12 VAC 30-80-160, rendered in emergency departments that DMAS determines are nonemergency care.

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

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

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

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

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

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

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

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

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

2. Dentists' services.

3. Mental health services including: (i) community mental health services; (ii) services of a licensed clinical psychologist; or (iii) mental health services provided by a physician.

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

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

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME).

a. For those items that have a national Healthcare Common Procedure Coding System (HCPCS) code, the rate for durable medical equipment shall be set at the Durable Medical Equipment Regional Carrier (DMERC) reimbursement level.

b. The rate paid for all items of durable medical equipment except nutritional supplements shall be the lower of the state agency fee schedule that existed prior to July 1, 1996, less 4.5%, or the actual charge.

c. The rate paid for nutritional supplements shall be the lower of the state agency fee schedule or the actual charge.

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

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12 VAC 30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment

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service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

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

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

7. Local health services, including services paid to local school districts.
8. Laboratory services (other than inpatient hospital).
9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).
10. X-Ray services.
11. Optometry services.
12. Medical supplies and equipment.
13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12 VAC 30-80-180.
14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.
15. Clinic services, as defined under 42 CFR 440.90.
16. Supplemental payments to state government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in this state plan, DMAS provides supplemental payments for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Supplemental payments will be made to Children's Specialty Services, a state government-owned and operated clinic.

b. The amount of the supplemental payment made to Children's Specialty Services is determined by calculating for all state government-owned or operated clinics the annual difference between the aggregate upper payment limit specified in 42 CFR 447.321 and determined according to the method described in subdivision 16 d and the amount otherwise actually paid for the services by the Medicaid program.

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

d. To determine the aggregate upper payment limit, Medicaid payments to state government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12 VAC 30-80-190 B 2) in regard to the state agency fee schedule for Resource Based Relative Value Scale (RBRVS). Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

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

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

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. A qualifying clinic is a clinic with estimated Medicaid payments in 2003 (including primary payments and copayments) of more than \$100,000 other than under this section and that serve areas covered by managed care prior to January 1, 1998.

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

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 18 d and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 18 b (1) for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision (2) of this subdivision 18 b by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

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

d. To determine the aggregate upper payment limit referred to in subdivision 18 b (3), Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12 VAC 30-80-190 B 2) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

19. Supplemental payments for dental services.

a. In addition to payments for dental services specified elsewhere in this State Plan, DMAS provides supplemental payments to dentists who are affiliated with the MCV-VCU Dental Faculty Practice for services furnished on or after July 1, 2005.

b. The supplemental payment amount shall be the difference between the Medicaid allowed amount for payments otherwise made for dentists and the lower of 136% of the Medicaid fee or charges. Payments shall be made quarterly.

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

/s/ Mark R. Warner
Governor
December 1, 2005

VA.R. Doc. No. R06-126; Filed December 2, 2005, 4:38 p.m.

STATE MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES BOARD

Title of Regulation: 12 VAC 35-45. Regulations for Providers of Mental Health, Mental Retardation, and Substance Abuse Residential Services for Children (adding 12 VAC 35-45-25).

Statutory Authority: §§ 37.2-203 of the Code of Virginia; Chapter 363 of the 2005 Acts of Assembly.

Effective Dates: December 2, 2005, through December 1, 2006.

Agency Contact: Leslie Anderson, Director, Office of Licensing, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 371-6885, FAX (804) 692-0066, or e-mail leslie.anderson@co.dmhmrzas.virginia.gov.

Preamble:

Chapter 363 of the 2005 Virginia Acts of Assembly (HB 2881) authorizes the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services to issue an order of summary suspension of a license to operate a group home or residential facility for children in cases of immediate and substantial threat to the health, safety, and welfare of residents. The legislation requires the State Mental Health, Mental Retardation and Substance Abuse Services Board to implement the provisions of the Act within 280 days of its enactment. The board is adopting these emergency regulations to comply with this legislation.

This action will add a new section to the existing Regulations for Providers of Mental Health, Mental Retardation and Substance Abuse Residential Services for Children, which establishes a process for issuing an order of summary suspension of the license. The existing regulations provide standards for licensing providers of residential treatment services for children with mental illness, mental retardation or substance use disorders and are an addendum to 22 VAC 42-10, which are generic standards governing a wide variety of residential facilities licensed by the Departments of Mental Health, Mental Retardation and Substance Abuse Services (Department), Social Services, Education, and Juvenile Justice. The standards in this addendum or "Mental Health Module" as it is operationally called, cover a wide range of residential services from small group homes to large residential treatment facilities.

The new section of the regulations establishes procedures for the commissioner to issue an order of summary suspension. It also includes the procedures for scheduling and conducting an administrative hearing when the commissioner issues an order of summary suspension, including the appointment of a hearing officer by the Executive Secretary of the Supreme Court.

12 VAC 35-45-25. Summary suspension.

A. In conjunction with any proceeding for revocation, denial, or other action, when conditions or practices exist that pose an immediate and substantial threat to the health, safety, and welfare of the residents, the commissioner may issue an order

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of summary suspension of the license to operate a residential facility for children when he believes the operation of the facility should be suspended during the pendency of such proceeding.

B. Prior to the issuance of an order of summary suspension, the department shall contact the Executive Secretary of the Supreme Court of Virginia to obtain the name of a hearing officer. The Department shall schedule the time, date, and location of the administrative hearing with the hearing officer.

C. The order of summary suspension shall take effect upon its issuance. It shall be delivered by personal service and certified mail, return receipt requested, to the address of record of the licensee as soon as practicable. The order shall set forth:

1. The time, date, and location of the hearing;
2. The procedures for the hearing;
3. The hearing and appeal rights; and
4. Facts and evidence that formed the basis for the order of summary suspension.

D. The hearing shall take place within three business days of the issuance of the order of summary suspension.

E. The department shall have the burden of proving in any summary suspension hearing that it had reasonable grounds to require the licensee to cease operations during the pendency of the concurrent revocation, denial, or other proceeding.

F. The administrative hearing officer shall provide written findings and conclusions, together with a recommendation as to whether the license should be summarily suspended, to the commissioner within five business days of the hearing.

G. The commissioner shall issue a final order of summary suspension or make a determination that the summary suspension is not warranted based on the facts presented and the recommendation of the hearing officer within seven business days of receiving the recommendation of the hearing officer.

H. The commissioner shall issue and serve on the residential facility for children or its designee by personal service or by certified mail, return receipt requested either:

1. A final order of summary suspension including (i) the basis for accepting or rejecting the hearing officer's recommendation, and (ii) notice that the residential facility for children may appeal the commissioner's decision to the appropriate circuit court no later than 10 days following issuance of the order; or
 2. Notification that the summary suspension is not warranted by the facts and circumstances presented and that the order of summary suspension is rescinded.
- I. The licensee may appeal the commissioner's decision on the summary suspension to the appropriate circuit court no more than ten days after issuance of the final order.

J. The outcome of concurrent revocation, denial, and other proceedings shall not be affected by the outcome of any

hearing pertaining to the appropriateness of the order of summary suspension.

K. At the time of the issuance of the order of summary suspension, the department shall contact the appropriate agencies to inform them of the action and the need to develop relocation plans for residents, and ensure that parents and guardians are informed of the pending action.

/s/ Mark R. Warner
Governor
December 1, 2005

VA.R. Doc. No. R06-124; Filed December 2, 2005, 11:27 a.m.

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Title of Regulation: 12 VAC 35-105. Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services (adding 12 VAC 35-105-925).

Statutory Authority: § 37.2-203 of the Code of Virginia; Chapter 7 of the 2005 Acts of Assembly.

Effective Dates: December 6, 2005, through December 5, 2006.

Agency Contact: Leslie Anderson, Director, Office of Licensing, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 371-6885, FAX (804) 692-0066, or e-mail leslie.anderson@co.dmhmrzas.virginia.gov.

Preamble:

Chapter 7 of the 2005 Virginia Acts of Assembly (SB 753) directs the State Mental Health Mental Retardation Substance Abuse Services Board to adopt regulations to establish standards for the issuance of new licenses to providers of treatment for persons with opioid addiction. This legislation also requires that the provisions of the Act become effective within 280 days of its enactment and imposes a moratorium on the issuance of licenses to such providers until standards are in place. The board is adopting these emergency regulations to comply with the Act.

The emergency regulations amend the existing Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services 12 VAC 35-105, by inserting a new section that provides specific standards for evaluating the need and appropriateness for the issuance of new licenses for providers of treatment of persons with opioid addiction through the use of methadone or other opioid replacements. As required by the legislation, these standards include consideration of demographic and geographic factors, the availability of qualified staff and support services, the suitability of the service site, and several other related attributes of a proposed service provider.

PART VI.
ADDITIONAL REQUIREMENTS FOR SELECTED
SERVICES.

Article 1.
Opioid Treatment Services.

12 VAC 35-105-925. Standards for the Evaluation of the Need for New Licenses for Providers of Services to Persons With Opioid Addiction.

A. Applicants requesting an initial license to provide a new service for the treatment of opioid addiction through the use of Methadone or any other controlled substance shall supply information to demonstrate the need for, and appropriateness of, the proposed service in accordance with this section.

B. Applicants shall demonstrate that the geographic and demographic parameters of the service area are reasonable and the proposed service is expected to serve a sufficient number of individuals to justify the service, as documented in subsection D of this section. For purposes of demonstrating need, applicants shall define a service area that is located entirely in Virginia and does not extend more than 100 miles from the proposed location of the service. Applicants also shall identify the number of individuals it seeks to be licensed to serve.

C. Applicants shall submit admission policies which give priority to individuals residing in the service area for admission and placement on waiting lists.

D. Applicants shall demonstrate that there are persons residing in its service area who have an opioid addiction who would benefit from the proposed service. The following information may be used by the applicant to document that individuals in the service area are known or reasonably expected to need the proposed service:

1. Numbers of persons on waiting lists for admission to any existing opioid addiction or other public substance abuse treatment program in the service area for the most recent available 12-month period;
2. Numbers of opioid use disorder cases (e.g., overdoses) originating from the proposed service area that have been treated in hospital emergency rooms for the most recent available 12-month period;
3. Projections of the number of persons in the service area who are likely to obtain services for opioid addiction, based on drug-use forecasting data;
4. Data reported on suicidal and accidental deaths related to opioid use in the proposed service area for the most recent available 12-month period;
5. Data regarding arrests from local law enforcement officials in the proposed service area related to illicit opioid activities;
6. Data on communicable diseases for the proposed service area related to injection drug abuse (e.g. HIV, AIDS, TB, and Hepatitis B and C);
7. Data on the availability of any evidence-based alternative service or services that have been proven effective in the

treatment of opioid addiction, and that are accessible to persons within the proposed service area, including services provided by physicians' offices; and

8. Letters of support from citizens, governmental officials, or health care providers, which indicate that there are conditions or problems associated with substance abuse in the community that demonstrate a need for opioid treatment services in the service area.

E. The Department shall determine whether a need exists for the proposed service based on the documentation provided in accordance with subsection D, and the consideration of the following standards:

1. Whether there are a sufficient number of persons in the proposed service area who are likely to need the specific opioid treatment service that the applicant intends to provide;
2. Whether the data indicate that evidence-based service capacity in the service area is not responsive to or sufficient enough to meet the needs of individuals with opioid addiction; and
3. Whether there is documentation of support to confirm the need for the proposed service in the proposed service area.

F. The proposed site of the service shall comply with Virginia Code § 37.2-406 and, with the exception of services that are proposed to be located in Planning District 8, shall not be located within one-half mile of a public or private licensed day care center or a public or private K-12 school.

G. In jurisdictions without zoning ordinances, the department shall request that the local governing body advise it as to whether the proposed site is suitable for and compatible with use as an office and the delivery of health care services. The department shall make this request when it notifies the local governing body of a pending application.

H. Applicants shall demonstrate that the building or space to be used to provide the proposed service is suitable for the treatment of opioid addiction by submitting documentation of the following:

1. The proposed site complies with the requirements of the local building regulatory entity;
2. The proposed site complies with local zoning laws or ordinances, including any required business licenses;
3. In the absence of local zoning ordinances, the proposed site is suitable for and compatible with use as offices and the delivery of health care services;
4. In jurisdictions where there are no parking ordinances, the proposed site has sufficient off-street parking to accommodate the needs of the individuals being served and prevent the disruption of traffic flow;
5. The proposed site can accommodate individuals during periods of inclement weather;
6. The proposed site complies with the Virginia Statewide Fire Prevention Code; and

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7. The applicant has a written plan to ensure security for storage of methadone at the site, which complies with regulations of the Drug Enforcement Agency (DEA), and the Virginia Board of Pharmacy.

I. Applicants shall submit information to demonstrate that there are sufficient personnel available to meet the following staffing requirements and qualifications:

1. The program director shall be licensed or certified by the applicable Virginia health regulatory board or by a nationally recognized certification board, or eligible for this license or certification with relevant training, experience, or both, in the treatment of persons with opioid addiction;

2. The medical director shall be a board certified addictionologist or have successfully completed or will complete within one year, a course of study in opiate addiction that is approved by the department;

3. A minimum of one pharmacist;

4. Nurses;

5. Counselors shall be licensed or certified by the applicable Virginia health regulatory board or by a nationally recognized certification board, or eligible for this license or certification; and

6. Personnel to provide support services.

J. Applicants shall submit a description for the proposed service that includes:

1. Proposed mission, philosophy, and goals of the provider;

2. Care, treatment, and services to be provided, including a comprehensive discussion of levels of care provided and alternative treatment strategies offered;

3. Proposed hours and days of operation;

4. Plans for on-site security; and

5. A diversion control plan for dispensed medications, including policies for use of drug screens.

K. Applicants shall, in addition to the requirements of 12 VAC 35-105-580 C 2, provide documentation of their capability to provide the following services and support directly or by arrangement with other specified providers when such services and supports are (i) requested by an individual being served; or (ii) identified as an individual need, based on the assessment conducted in accordance with 12 VAC 35-105-60 B and included in the individualized services plan:

1. Psychological services;

2. Social services;

3. Vocational services;

4. Educational services; and

5. Employment services.

L. Applicants shall submit documentation of contact with community services boards or behavioral health authorities in their service areas to discuss its plans for operating in the area and to develop joint agreements, as appropriate.

M. Applicants shall provide policies and procedures that require every six months, each individual served to be assessed by the treatment team to determine if that individual is appropriate for safe and voluntary medically supervised withdrawal, alternative therapies including other medication assisted treatments, or continued federally approved pharmacotherapy treatment for opioid addiction.

N. Applicants shall submit policies and procedures describing services it will provide to individuals who wish to discontinue opioid treatment services.

O. Applicants shall provide assurances that the service will have a community liaison responsible for developing and maintaining cooperative relationships with community organizations, other service providers, local law enforcement, local government officials, and the community at large.

P. The department, including the Office of Licensing, Office of Human Rights, or Office of Substance Abuse Services, shall conduct announced and unannounced reviews and complaint investigations, in collaboration with the state methadone authority, Board of Pharmacy, and DEA to determine compliance with the regulations.

/s/ Mark R. Warner
Governor
December 5, 2005

V.A.R. Doc. No. R06-127; Filed December 6, 2006, 12:36 p.m.

GENERAL NOTICES/ERRATA

DEPARTMENT OF ENVIRONMENTAL QUALITY

Total Maximum Daily Load (TMDL) for Back Creek in Pulaski County

The Virginia Department of Environmental Quality (DEQ), Department of Conservation and Recreation and New River-Highlands Resource Conservation & Development invite citizens to a public meeting to develop the Water Quality Implementation Plan (IP) to address fecal coliform bacteria impairments and sediment in the Back Creek in Pulaski County, Virginia. This Pulaski County stream was identified as impaired due to violations of Virginia's water quality standards for fecal coliform bacteria and General Standard (benthic). DEQ and DCR seek written and oral comments from interested persons on the development of the IP. The IP is a clean up plan that identifies ways to meet the pollution reductions outlined in the Total Maximum Daily Load (TMDL) studies. The TMDL's for these impairments were completed and approved by the Environmental Protection Agency (EPA) and the Virginia Water Control Board in 2004 and are available on DEQ's website at <http://www.deq.virginia.gov/tmdl>.

The initial public meeting on the development of the IP for the Back Creek impairments will be held on Thursday, January 12, 2006, at 6 p.m., New River Community College, Edwards Hall, Room 206, Dublin, Virginia.

The purpose of the meeting is to solicit public input on the development of an implementation plan for the fecal coliform and General Standard (benthic) impairments. Section 62.1-44.19.7 C of the Code of Virginia requires the development of an IP for approved TMDL's. The IP will include the corrective actions needed to reduce bacteria and sediment and their associated costs, benefits and environmental impacts. The IP also provides measurable goals and a timeline of expected achievement of water quality objectives. A fact sheet on the development of the IP is available upon request. The impaired segment addressed in the plan is:

Back Creek: 16.37 miles from mouth of New River to river mile 16.37 on Back Creek

How to comment: The public comment period for this public meeting will end on February 28, 2006. Oral comments will be accepted and addressed at the public meeting. Additional questions or information requests should be addressed to Jason Hill. Written comments and inquiries should include the name, address, and telephone number of the person submitting the comments and should be sent to Jason Hill, Virginia Department of Environmental Quality, 3019 Peters Creek Road, Roanoke, VA 24019, telephone (540) 562-6724, FAX (540) 562-6860, or e-mail jrhil@deq.virginia.gov.

Total Maximum Daily Load (TMDL) for Lancaster County

The Department of Environmental Quality (DEQ), Virginia Department of Health and the Department of Conservation and Recreation seek written and oral comments from

interested persons on the development of a Total Maximum Daily Load (TMDL) for fecal coliform bacteria in shellfish propagation waters located in Lancaster County, Virginia.

All impaired segments are located wholly within Lancaster County with the exception of the Lancaster Creek and Morattico segments, these are in part located in Richmond County. These areas are described in the following publications:

1) Growing Area 22 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Numbers 116, Rappahannock River: Beach Creek, effective 7 January 1992 and 27 December 2004 respectively.

2) Growing Area 22 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Numbers 94, Rappahannock River: Greenvale Creek, effective 7 November 1994, 21 October 1997, 30 October 1998, 5 February 2003, and 6 October 2005 respectively.

3) Growing Area 22 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Number 114, Rappahannock River: Paynes Creek, effective 27 April 1989.

4) Growing Area 23 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Numbers 121, Rappahannock River: Deep and Mulberry Creeks, effective 25 May 1989, 19 November 1991, 16 November 1992, 16 November 1994, 9 August 2000, 7 July 2001, 17 July 2002, 4 August 2003, 23 September 2004, and 17 August 2005 respectively.

5) Growing Area 23 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Numbers 121, Rappahannock River: Lancaster, Morattico, and Mulberry Creeks, effective 29 October 1986, 19 November 1991, 20 March 1992, 16 November 1994, 14 August 1995, 28 July 1998, 21 July 1999, 9 August 2000, 17 July 2001, 4 August 2003, and 23 September 2004 respectively.

The affected water body segments are identified in Virginia's 1998 § 303(d) TMDL Priority List and Report as impaired due to violations of the state's water quality standard for fecal coliform bacteria in shellfish waters. Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia, require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's 303(d) TMDL Priority List and Report.

The first public meeting on the development of the fecal coliform TMDL's has been rescheduled for January 5, 2006, from 7 to 9 p.m. at the Lancaster Courthouse, General District Room located at 8311 Mary Ball Road, in Lancaster, Virginia. In case of inclement weather, the meeting will be held on January 9, 2006. Directions can be obtained by calling Chris French at (804) 521-5124.

The public comment period will begin on January 5, 2006, and end at 5 p.m. on February 4, 2006. Questions or information requests should be addressed to Chris French and should

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include the name, address, and telephone number of the person submitting the comments. Requests should be sent to Chris French, Department of Environmental Quality, Piedmont Regional Office, Glen Allen, VA 23060, telephone (804) 527-5124, FAX (804)-527-5106, or e-mail rcfrench@deq.virginia.gov.

Total Maximum Daily Load (TMDL) for Northumberland County

The Department of Environmental Quality (DEQ), Virginia Department of Health and the Department of Conservation and Recreation seek written and oral comments from interested persons on the development of a Total Maximum Daily Load (TMDL) for fecal coliform bacteria in shellfish propagation waters located in Northumberland County, Virginia.

All impaired segments are located wholly within Northumberland County with the exception of the Mill Creek segments, these are in part located in Westmoreland County. These areas are described in the following publications:

- 1) Growing Area 14 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Numbers 123, Mill Creek and Cloverdale Creek, effective 7 June 1996, 2 June 1997, 5 June 1998, 15 May 2001, 24 June 2002, 4 August 2004, and 17 May 2005 respectively.
- 2) Growing Area 15 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Numbers 22, Dividing Creek and Prentiss Creek, effective 27 February 1997, 17 February 1999, 25 February 1998, 17 June 1999, 21 April 2000, 1 May 2002, 25 April 2003, and 3 May 2005 respectively.
- 3) Growing Area 13 and 14 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Number 89 and 220, Great Wicomico River, effective 30 May 1996, 28 May 1997, 19 May 1999, 26 April 2000, 15 March 2001, 3 April 2002, 4 April 2003, 16 April 2004, and 4 March 2005.

The affected water body segments are identified in Virginia's 1998 § 303(d) TMDL Priority List and Report as impaired due to violations of the state's water quality standard for fecal coliform bacteria in shellfish waters. Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia, require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report.

The first public meeting on the development of the fecal coliform TMDL's has been scheduled for January 12, 2006, from 7 to 9 p.m. at the Northumberland Public Library, located at 7204 Northumberland Hwy. in Heathsville, Virginia. In case of inclement weather, the meeting will be held on January 19, 2006. Directions can be obtained by calling Chris French at (804) 521-5124.

The public comment period will begin on January 12, 2006, and end at 5 p.m. on February 4, 2006. Questions or information requests should be addressed to Chris French

and should include the name, address, and telephone number of the person submitting the comments. Requests should be sent to Chris French, Department of Environmental Quality, Piedmont Regional Office, Glen Allen, VA, 23060, telephone (804) 527-5124, FAX (804)-527-5106, or e-mail rcfrench@deq.virginia.gov.

Total Maximum Daily Load (TMDL) for Westmoreland County

The Department of Environmental Quality (DEQ), Virginia Department of Health and the Department of Conservation and Recreation seek written and oral comments from interested persons on the development of a Total Maximum Daily Load (TMDL) for fecal coliform bacteria in shellfish propagation waters located in Westmoreland County, Virginia.

All impaired segments are located wholly within Westmoreland County with the exception of the Rosier Creek segment, this is in part located in King George County. These areas are described in the following publications:

- 1) Growing Area 1 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Numbers 88, Rosier Creek, effective 28 January 1997, 16 July 1997, 6 July 1999, 7 July 2000, 8 July 2002, 28 July 2003, 22 September 2004, and 16 August 2005 respectively.
- 2) Growing Area 2 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Numbers 1, Monroe Creek, effective 24 June 1996, 8 July 1997, 14 September 1998, 29 June 1999, 5 September 2002, 19 September 2003, 15 November 2004, and 23 September 2005 respectively.
- 3) Growing Area 3 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Number 146, Potomac River: Popes Creek, effective 27 April 1989, and 5 October 2005.
- 4) Growing Area 7 as described in Virginia Department of Health, Notice and Description of Shellfish Area Condemnation Numbers 28, Yeocomico River, effective 30 April 1996, 12 May 1997, 28 January 1997, 28 January 1998, 5 February 1999, 3 May 1999, 15 July 1999, 29 July 2000, 3 July 2001, 11 July 2002, 13 May 2003, 21 July 2004, and 2 May 2005 respectively.

The affected water body segments are identified in Virginia's 1998 § 303(d) TMDL Priority List and Report as impaired due to violations of the state's water quality standard for fecal coliform bacteria in shellfish waters. Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia, require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report.

The final public meeting on the development of the fecal coliform TMDL's will be held on January 10, 2006, from 7 to 9 p.m. at the Abraham and William Cooper Memorial Branch Library, 20 Washington Avenue, Colonial Beach, Virginia. Directions can be obtained by calling Chris French at (804)

521-5124. In case of inclement weather, the meeting will be held on January 19, 2006.

The public comment period will begin on January 10, 2006, and end on February 9, 2006. Questions or information requests should be addressed to Chris French and should include the name, address, and telephone number of the person submitting the comments. Requests should be sent to Chris French, Department of Environmental Quality, Piedmont Regional Office, Glen Allen, VA, 23060, telephone (804) 527-5124, FAX (804)-527-5106, or e-mail rcfrench@deq.virginia.gov.

BOARD OF PHARMACY

Notice of Periodic Review of Regulations

The Board of Pharmacy within the Department of Health Professions is conducting a periodic review of 18 VAC 110-20, Regulations Governing the Practice of Pharmacy.

The board is receiving comment on whether there is a need for amendments for consistency with changes in pharmacy practice and patient care. Regulations may be viewed online at www.townhall.virginia.gov or www.dhp.virginia.gov or copies will be sent upon request.

Comment begins December 26, 2005, and ends on February 24, 2006. If any member of the public would like to comment on these regulations, please send comments by the close of the comment period to Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 West Broad Street, Richmond, VA 23230-1712, e-mail elaine.yeatts@dhp.virginia.gov or FAX (804) 662-9114.

DEPARTMENT OF SOCIAL SERVICES

Notice of Periodic Review of Regulations

Pursuant to Executive Order Number 21 (2002), the Department of Social Services is currently reviewing 22 VAC 10-400, Funding Limitations for the Refugee Resettlement Program, to determine if it should be terminated, amended, or retained in its current form. The review will be guided by the principles listed in Executive Order Number 21 (2002) and the department's Plan for Review of Existing Agency Regulations.

The department seeks public comment regarding the regulation's interference in private enterprise and life, essential need of the regulation, less burdensome and intrusive alternatives to the regulation, specific and measurable goals that the regulation is intended to achieve, and whether the regulation is clearly written and easily understandable.

Written comments may be submitted until January 16, 2006, in care of Penelope Boyd, Policy Coordinator, Office of Newcomer Services, Division of Family Services, 7 North 8th Street, Richmond, VA 23219, by facsimile to (804) 726-7127, or by e-mail to penny.boyd@dss.virginia.gov.

WASTE MANAGEMENT BOARD

Proposed Consent Order for Rainwater Concrete

Purpose of notice: To invite citizens to comment on a proposed consent order for a facility in Lorton, Fairfax County, Virginia.

Public comment period: December 26, 2005, to January 25, 2006.

Consent order description: The Waste Management Board proposes to issue a consent order to Rainwater Concrete to address alleged violations of the Solid Waste Management Regulations. The location of the facility where the alleged violation occurred is 9917 Richmond Highway, Lorton, Virginia. The consent order describes a settlement to resolve late submissions following statistical exceedences of groundwater constituents, including chloroform, tetrachloroethene, trichloroethene, vinyl chloride, and beryllium; late submissions of a nature and extent study and proof of adequate financial assurance; improper lateral expansion; and operational plan deficiencies.

How to comment: DEQ accepts comments from the public by e-mail, fax or postal mail. All comments must include the name, address and telephone number of the person commenting and be received by DEQ within the comment period. The public may review the proposed consent order at the DEQ office named below or on the DEQ website at www.deq.virginia.gov.

Contact for public comments, document requests and additional information: Jennifer Sheedy, Department of Environmental Quality, Northern Virginia Regional Office, 13901 Crown Court, Woodbridge, VA 22193, telephone (703) 583-3938, FAX (703) 583-3841, or e-mail jlshedy@deq.virginia.gov.

STATE WATER CONTROL BOARD

Proposed Consent Special Order for Oak Grove Mennonite Church

Purpose of notice: To invite citizens to comment on a proposed amended consent order for a facility in Aroda, Virginia.

Public comment period: December 26, 2005, to January 25, 2006.

Consent order description: The State Water Control Board proposes to issue an amended consent order to Oak Grove Mennonite Church to address alleged violations of the Virginia Pollutant Discharge Elimination System Permit No. VA0063347. The location of the facility where the alleged violations occurred is at 1776 Elly Road. The amended consent order describes a settlement to resolve consent order violations for not completing construction of an upgraded sewage treatment plant on time.

How to comment: DEQ accepts comments from the public by e-mail, fax or postal mail. All comments must include the

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name, address and telephone number of the person commenting and be received by DEQ within the comment period. The public may review the proposed amended consent order at the DEQ office named below or on the DEQ website at www.deq.virginia.gov.

Contact for public comments, document requests and additional information: Carl Ciccarelli, Department of Environmental Quality, Northern Virginia Regional Office, 13901 Crown Court, Woodbridge, VA 22193, telephone (703) 583-3862, FAX (703) 583-3871, or e-mail cjiccarelli@deq.virginia.gov.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Mailing Address: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, FAX (804) 692-0625.

Forms for Filing Material for Publication in the Virginia Register of Regulations

All agencies are required to use the appropriate forms when furnishing material for publication in the Virginia Register of Regulations. The forms may be obtained from: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

Internet: Forms and other Virginia Register resources may be printed or downloaded from the Virginia Register web page: <http://register.state.va.us>.

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
RESPONSE TO PETITION FOR RULEMAKING-RR13
FAST-TRACK RULEMAKING ACTION-RR14

ERRATA

MARINE RESOURCES COMMISSION

Title of Regulation: 4 VAC 20-1090. Pertaining to Licensing Requirements and License Fees.

Publication: 22:4 VA.R. 579-582 October 31, 2005.

Correction to Final Regulation:

Page 580, 9 VAC 20-1090-20, subdivision 3, Saltwater Recreational Fishing License, row 6, after "Rental Boat, per boat, with maximum fee of" insert "\$500"

Page 582, 9 VAC 20-1090-30, subdivision 3, after "Saltwater Recreational Fishing" change "Licens" to "License"

Page 582, 9 VAC 20-1090-30, subdivision 3, Saltwater Recreational Fishing License, row 6, after "Rental Boat, per boat, with maximum fee of" insert "\$635"

VA.R. Doc. No. R06-65

CALENDAR OF EVENTS

Symbol Key

- † Indicates entries since last publication of the *Virginia Register*
♿ Location accessible to persons with disabilities
☎ Teletype (TTY)/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. If you are unable to find a meeting notice for an organization in which you are interested, please check the Commonwealth Calendar at www.vipnet.org or contact the organization directly.

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) 698-1500 or Senate Information and Constituent Services at (804) 698-7410 or (804) 698-7419/TTY☎, or visit the General Assembly web site's Legislative Information System (<http://leg1.state.va.us/lis.htm>) and select "Meetings."

VIRGINIA CODE COMMISSION

EXECUTIVE

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Virginia Horse Industry Board

January 31, 2006 - 10 a.m. -- Open Meeting
Department of Forestry, 900 Natural Resources Drive, 2nd Floor Meeting Room, Charlottesville, Virginia.♿

A meeting to discuss marketing and promotional projects for 2006-07, budget items, and the upcoming grant submission and review cycle. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact Andrea S. Heid at least five days before the meeting date so that suitable arrangements can be made.

Contact: Andrea S. Heid, Equine Marketing Specialist/Program Manager, Department of Agriculture and Consumer Services, 102 Governor St., 3rd Floor, Richmond, VA 23219, telephone (804) 786-5842, FAX (804) 371-7786, e-mail andrea.heid@vdacs.virginia.gov.

Virginia Irish Potato Board

† **January 18, 2006 - 7 p.m.** -- Open Meeting
Eastern Shore AREC, Painter Research Station, 33446 Research Drive, Painter, Virginia ♿

A meeting to (i) approve minutes of the last meeting; (ii) review the financial statement and annual budget; (iii) discuss promotion, research, and education programs; and (iv) review and evaluate grant proposals for the next fiscal year. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact Butch Nottingham at least five days before the meeting date so that suitable arrangements can be made.

Contact: Butch Nottingham, Program Manager, Virginia Irish Potato Board, P.O. Box 26, Onley, VA 23418, telephone (757) 787-5867, FAX (757) 787-5973, e-mail jnottingham@vdacs.state.va.us.

Virginia Sheep Industry Board

† **January 6, 2006 - 10:30 a.m.** -- Open Meeting
The Inn at Virginia Tech, 901 Prices Fork Road, Blacksburg, Virginia.♿

A meeting to (i) hear and move to approve the minutes of the last Sheep Industry Board meeting; (ii) hear the financial report; and (iii) receive reports from USDA Wildlife Services staff, the Virginia Food Festival, and the State Fair Market Lamb Show. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact Mike Carpenter at least five days before the meeting date so that suitable arrangements can be made.

Contact: Mike Carpenter, Program Director, Virginia Sheep Industry Board, 116 Reservoir St., Harrisonburg, VA 22801, telephone (540) 434-0779, FAX (540) 434-5607.

STATE AIR POLLUTION CONTROL BOARD

January 5, 2006 - 10 a.m. -- Open Meeting
Department of Environmental Quality, 629 East Main Street, Richmond, Virginia.♿

A public meeting to receive comments on the notice of intended regulatory action to amend the regulations for the control and abatement of air pollution concerning minor new source review. The NOIRA appears in the *Virginia Register* of Regulations on November 28, 2005. The comment period begins on November 28, 2005, and ends on January 5, 2006.

Contact: Gary Graham, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4103, FAX (804) 698-4510, e-mail gegraham@deq.virginia.gov.

Calendar of Events

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January 12, 2006 - 10 a.m. -- Public Hearing
Department of Environmental Quality, 629 East Main Street,
Richmond, Virginia. ☎

January 30, 2006 - Public comments may be submitted until
this date.

Notice is hereby given in accordance with § 2.2-4007 of the
Code of Virginia that the State Air Pollution Control Board
intends to amend regulations entitled **9 VAC 5-20, General
Provisions**, and **9 VAC 5-40, Existing Stationary
Sources (Rev. D04)**. The purpose of the proposed action is
to enlarge the scope of volatile organic compound and
nitrogen oxides emissions control areas in order to include
new ozone nonattainment areas.

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Contact: Gary Graham, Department of Environmental Quality,
P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-
4103, FAX (804) 698-4510 or e-mail
gegraham@deq.virginia.gov.

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January 12, 2006 - 1:30 p.m. -- Public Hearing
Department of Environmental Quality, 629 East Main Street,
Richmond, Virginia. ☎

January 30, 2006 - Public comments may be submitted until
this date.

Notice is hereby given in accordance with § 2.2-4007 of the
Code of Virginia that the State Air Pollution Control Board
intends to amend regulations entitled **9 VAC 5-40, Existing
Stationary Sources (Rev. H03)**. The purpose of the
proposed action is to reduce emissions of volatile organic
compounds (VOCs) and nitrogen oxides (NO_x) from open
burning and special incineration devices in Virginia's
emissions control areas in order to attain and maintain the
federal health-based air quality standard for ozone and
nitrogen oxides.

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Contact: Mary L. Major, Department of Environmental Quality,
P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-
4423, FAX (804) 698-4510 or e-mail
mlmajor@deq.virginia.gov.

ALCOHOLIC BEVERAGE CONTROL BOARD

† **January 3, 2006 - 9 a.m.** -- Open Meeting
† **January 17, 2006 - 9 a.m.** -- Open Meeting
† **February 6, 2006 - 9 a.m.** -- Open Meeting
† **February 21, 2006 - 9 a.m.** -- Open Meeting
† **March 6, 2006 - 9 a.m.** -- Open Meeting
† **March 20, 2006 - 9 a.m.** -- Open Meeting
Department of Alcoholic Beverage Control, 2901 Hermitage
Road, Richmond, Virginia. ☎

An executive staff meeting to receive and discuss reports
and activities from staff members and to discuss other
matters not yet determined.

Contact: W. Curtis Coleburn, III, Secretary to the Board,
Department of Alcoholic Beverage Control, 2901 Hermitage
Rd., Richmond, VA 23220, telephone (804) 213-4409, FAX
(804) 213-4411, (804) 213-4687/TTY ☎, e-mail
curtis.coleburn@abc.virginia.gov.

ALZHEIMER'S DISEASE AND RELATED DISORDERS COMMISSION

† **March 14, 2006 - 10 a.m.** -- Open Meeting
Department for the Aging, 1610 Forest Avenue, Richmond,
Virginia. ☎ (Interpreter for the deaf provided upon request)

A regular meeting.

Contact: Cecily Slasor, I and R Specialist, Alzheimer's
Disease and Related Disorders Commission, 1610 Forest
Ave., Ste. 100, Richmond, VA 23229, telephone (804) 662-
9338, FAX (804) 662-9354, toll-free (800) 552-3402, (804)
662-9333/TTY ☎, e-mail cecily.slasor@vda.virginia.gov.

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

† **January 12, 2006 - 9:30 a.m.** -- Open Meeting
† **January 30, 2006 - 9:30 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. ☎

A meeting of the Photogrammetry Committee to draft
regulation wording for consideration by the APELSCIDLA
Board in order to establish a regulatory program for
photogrammetrists pursuant to Chapter 440 of the 2005
Acts of Assembly. A portion of the board's business may be
discussed in closed session. Persons desiring to participate
in the meeting and requiring special accommodations or
interpretive services should contact the department at (804)
367-8514 at least 10 days prior to this meeting so that
suitable arrangements can be made. The department fully
complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Executive Director, Board for
Architects, Professional Engineers, Land Surveyors, Certified
Interior Designers and Landscape Architects, 3600 W. Broad
St., Richmond, VA 23230-4917, telephone (804) 367-8514,
FAX (804) 367-2475 or e-mail apelscidla@dpor.virginia.gov.

† **January 18, 2006 - 10 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, 4th Floor, Room 453, Richmond,
Virginia. ☎

An informal fact-finding conference.

Contact: Mark N. Courtney, Executive Director, Board for
Architects, Professional Engineers, Land Surveyors, Certified
Interior Designers and Landscape Architects, 3600 W. Broad
St., Richmond, VA 23230, telephone (804) 367-8514, FAX

(804) 367-2475, (804) 367-9753/TTY ☎, e-mail apelscidla@dpor.virginia.gov.

February 1, 2006 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. ♿

A meeting of the Architects Section to conduct board business. A portion of the board's business may be discussed in closed session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475 or e-mail apelscidla@dpor.virginia.gov.

February 7, 2006 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. ♿

A meeting of the Interior Designers Section to conduct board business. A portion of the board's business may be discussed in closed session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475 or e-mail apelscidla@dpor.virginia.gov.

February 8, 2006 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. ♿

A meeting of the Professional Engineers Section to conduct board business. A portion of the board's business may be discussed in closed session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475 or e-mail apelscidla@dpor.virginia.gov.

February 9, 2006 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. ♿

A meeting of the Landscape Architects Section to conduct board business. A portion of the board's business may be

discussed in closed session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475 or e-mail apelscidla@dpor.virginia.gov.

February 15, 2006 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. ♿

A meeting of the Land Surveyors Section to conduct board business. A portion of the board's business may be discussed in closed session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the department at (804) 367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475 or e-mail apelscidla@dpor.virginia.gov.

† March 16, 2006 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. ♿

A meeting of the full board to conduct board business. A portion of the board's business may be discussed in closed session. 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, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475 or e-mail apelscidla@dpor.virginia.gov.

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† March 16, 2006 - 9 a.m. -- Public Hearing
Department of Professional and Occupational Regulation,
3600 West Broad Street, 4th Floor, Richmond, Virginia. ♿

† March 16, 2006 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects is amending regulations entitled **18 VAC 10-20, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers**

Calendar of Events

and Landscape Architects Regulations. The purpose of the proposed action is to amend the entry requirements for landscape architects who possess an LAAB-accredited degree in landscape architecture to require them to obtain three years of acceptable experience before being granted certification. Applicants could still be approved to take, and sit for, the examination prior to obtaining the required three years of experience; however, certification would not be awarded until such time as the three years of acceptable experience is obtained, documented, submitted, reviewed and approved.

Statutory Authority: §§ 54.1-201, 54.1-404 and 54.1-411 of the Code of Virginia.

Contact: Mark N. Courtney, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8514, FAX (804) 367-2475 or e-mail apelscidla@dpor.virginia.gov.

ART AND ARCHITECTURAL REVIEW BOARD

† **January 6, 2006 - 10 a.m.** -- Open Meeting
Science Museum of Virginia, 2500 West Broad Street, Forum Room, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A monthly meeting to review projects submitted by state agencies. Art and Architectural Review Board submittal forms and submittal instructions can be downloaded by visiting the DGS Forms Center website at www.dgs.virginia.gov. Request form #DGS-30-905 or submittal instructions #DGS-30-906. The deadline for submitting project datasheets and other required information is two weeks prior to the meeting date.

Contact: Richard L. Ford, AIA Chairman, Art and Architectural Review Board, 101 Shockoe Slip, 3rd Floor, Richmond, VA 23219, telephone (804) 648-5040, FAX (804) 225-0329, (804) 786-6152/TTY , or e-mail rford@comarchs.com.

VIRGINIA BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

January 31, 2006 - 3 p.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Room 453, Richmond, Virginia. 

† **March 13, 2006 - 10 a.m.** -- Open Meeting
Wytheville Town Offices, Wytheville Municipal Building, 150 East Monroe Street, Conference Room B, Wytheville, Virginia.

An informal fact-finding conference.

Contact: David Dick, Assistant Director, Virginia Board for Asbestos, Lead, and Home Inspectors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail asbestos@dpor.virginia.gov.

AUCTIONEERS BOARD

January 12, 2006 - 10 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A meeting to conduct board business. A portion of the meeting may be held in closed session. Any person desiring to attend the meeting and requiring special accommodations or interpreter services should contact the board at least 10 days prior to the meeting so suitable arrangements can be made. The board fully complies with the Americans with Disabilities Act.

Contact: Marian H. Brooks, Regulatory Board Administrator, Auctioneers Board, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail auctioneers@dpor.virginia.gov.

BOARD FOR BARBERS AND COSMETOLOGY

January 12, 2006 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Room 453, Richmond, Virginia. 

An informal fact-finding conference.

Contact: William H. Ferguson, II, Assistant Director, Board for Barbers and Cosmetology, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8575, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail barbercosmo@dpor.virginia.gov.

† **February 6, 2006 - 9 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A general business meeting including consideration of regulatory issues as may be presented on the agenda. The meeting is open to the public; however, a portion of the board's business may be discussed in closed session. All meetings are subject to cancellation. Any person desiring to attend the meeting and requiring special accommodations or interpreter services should contact the board at least 10 days prior to the meeting so suitable arrangements can be made. The board fully complies with the Americans with Disabilities Act.

Contact: William H. Ferguson, II, Executive Director, Board for Barbers and Cosmetology, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-6295, (804) 367-9753/TTY , e-mail barbercosmo@dpor.virginia.gov.

BOARD FOR THE BLIND AND VISION IMPAIRED

January 10, 2006 - 1 p.m. -- Open Meeting
Department for the Blind and Vision Impaired, 397 Azalea Avenue, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting to review information regarding the Department for the Blind and Vision Impaired's activities and operations,

review expenditures from board endowment fund, and discuss other issues brought before the board.

Contact: Katherine C. Proffitt, Administrative Assistant, Department for the Blind and Vision Impaired, 397 Azalea Ave., Richmond, VA 23227, telephone (804) 371-3145, FAX (804) 371-3147, toll-free (800) 622-2155, (804) 371-3140/TTY ☎, e-mail kathy.proffitt@dbvi.virginia.gov.

BOARD FOR BRANCH PILOTS

February 1, 2006 - 8:30 a.m. -- Open Meeting
Virginia Port Authority, 600 World Trade Center, Norfolk, Virginia. ♿

A meeting of the examination administrators. The meeting is open to the public; however, a portion of the board's business may be discussed in closed session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the Department at 804-367-8514 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, Executive Director, Board for Branch Pilots, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail branchpilots@dpor.virginia.gov.

February 2, 2006 - 9:30 a.m. -- Open Meeting
Virginia Port Authority, 600 World Trade Center, Norfolk, Virginia. ♿

A meeting to conduct board business. The meeting is open to the public; however, a portion of the board's business may be discussed in closed session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the department at 804-367-8514 at least 10 days prior to this meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Executive Director, Board for Branch Pilots, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail branchpilots@dpor.virginia.gov.

CHILD DAY-CARE COUNCIL

† **January 12, 2006 - 10 a.m.** -- Open Meeting
Department of Social Services, 7 North 8th Street, 6th Floor, Conference Room, Richmond, Virginia. ♿

A regular meeting.

Contact: Pat Rengnerth, Board of Liaison, Office of Legislative and Regulatory Affairs, Department of Social Services, 7 N. 8th St., Room 5214, Richmond, VA 23219, telephone (804) 726-7905, FAX (804) 726-7906 or e-mail patricia.rengnerth@dss.virginia.gov.

STATE CHILD FATALITY REVIEW TEAM

† **January 6, 2006 - 10 a.m.** -- Open Meeting
† **March 10, 2006 - 10 a.m.** -- Open Meeting
Office of the Chief Medical Examiner, 400 East Jackson Street, Richmond, Virginia. ♿

The business portion of the State Child Fatality Review Team meeting, from 10 a.m. to 10:30 a.m., is open to the public. At the conclusion of the open meeting, the team will go into closed session for confidential case review.

Contact: Rae Hunter-Havens, Coordinator, State Child Fatality Review, 400 East Jackson St.; Richmond, VA 23219, telephone (804) 786-1047, FAX (804) 371-8595, toll-free (800) 447-1708, e-mail rae.hunter-havens@vdh.virginia.gov.

STATE BOARD FOR COMMUNITY COLLEGES

January 18, 2006 - 1:30 p.m. -- Open Meeting
James Monroe Building, 101 North 14th Street, 15th Floor, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

Meetings of the Academic Committee, Student Affairs and Workforce Development Committee, and Budget and Finance Committee begin at 1:30 p.m. The Facilities Committee and the Audit Committee will meet at 3 p.m. The Personnel Committee will meet at 3:30 p.m.

Contact: D. Susan Hayden, Director of Public Affairs, Virginia Community College System, 101 N. 14th St., Richmond, VA 23219, telephone (804) 819-4961, FAX (804) 819-4768, (804) 371-8504/TTY ☎

January 19, 2006 - 9 a.m. -- Open Meeting
James Monroe Building, 101 North 14th Street, 15th Floor, Godwin-Hamel Board Room, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A meeting of the full board. Public comment may be received at the beginning of the meeting upon notification at least five working days prior to the meeting.

Contact: D. Susan Hayden, Director of Public Affairs, Virginia Community College System, 101 N. 14th St., 15th Floor, Richmond, VA 23219, telephone (804) 819-4961, FAX (804) 819-4768, (804) 371-8504/TTY ☎

COMPENSATION BOARD

† **January 10, 2006 - 2 p.m.** -- Open Meeting
102 Governor Street, Richmond, Virginia. ♿

The Compensation Board will host the annual meeting with Constitutional Officer Association presidents to discuss issues/legislation for the upcoming General Assembly Session.

Contact: Cindy P. Waddell, Compensation Board, P.O. Box 710, Richmond, VA 23218, telephone (804) 225-3308, FAX (804) 371-0235, e-mail cindy.waddell@scb.virginia.gov.

Calendar of Events

COMMONWEALTH COMPETITION COUNCIL

† **January 4, 2006 - 10 a.m.** -- Open Meeting
General Assembly Building, 9th and Broad Streets, 4th Floor
East Conference Room, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular meeting.

Contact: Peggy R. Robertson, Acting Executive Director, Commonwealth Competition Council, 1111 E. Broad St., Richmond, VA 23219, telephone (804) 786-3812, FAX (804) 225-3291, e-mail peggy.robertson@dpb.virginia.gov.

BOARD FOR CONTRACTORS

† **January 10, 2006 - 9 a.m.** -- Open Meeting
January 12, 2006 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. 

Informal fact-finding conferences.

Contact: Eric L. Olson, Executive Director, Board for Contractors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail contractors@dpor.virginia.gov.

BOARD OF CORRECTIONS

January 17, 2006 - 10 a.m. -- Open Meeting
† **March 14, 2006 - 10 a.m.** -- Open Meeting
Department of Corrections, 6900 Atmore Drive, 3rd Floor
Board Room, Richmond, Virginia. 

A meeting of the Liaison Committee to discuss correctional matters of interest to the board.

Contact: Barbara Woodhouse, Administrative Staff Assistant, Department of Corrections, 6900 Atmore Dr., Richmond, VA 23225, telephone (804) 674-3124, FAX (804) 674-3236, e-mail barbara.woodhouse@vadoc.virginia.gov.

January 17, 2006 - 1 p.m. -- Open Meeting
† **March 14, 2006 - 1 p.m.** -- Open Meeting
Department of Corrections, 6900 Atmore Drive, 3rd Floor,
Richmond, Virginia. 

A meeting of the Correctional Services/Policy and Regulations Committee to discuss correctional services and policy/regulation matters to be considered by the board.

Contact: Barbara Woodhouse, Administrative Staff Assistant, Department of Corrections, 6900 Atmore Dr., Richmond, VA 23225, telephone (804) 674-3124, FAX (804) 674-3236, e-mail barbara.woodhouse@vadoc.virginia.gov.

January 18, 2006 - 9:30 a.m. -- Open Meeting
† **March 15, 2006 - 9:30 a.m.** -- Open Meeting
Department of Corrections, 6900 Atmore Drive, 3rd Floor,
Room 3054, Richmond, Virginia. 

A meeting of the Administration Committee to discuss administrative matters to be considered by the board.

Contact: Barbara Woodhouse, Administrative Staff Assistant, Department of Corrections, 6900 Atmore Dr., Richmond, VA 23225, telephone (804) 674-3124, FAX (804) 674-3236, e-mail barbara.woodhouse@vadoc.virginia.gov.

January 18, 2006 - 10 a.m. -- Open Meeting
† **March 15, 2006 - 10 a.m.** -- Open Meeting
Department of Corrections, 6900 Atmore Drive, 3rd Floor
Board Room, Richmond, Virginia. 

A regular meeting of the full board to review and discuss all matters considered by board committees that require action by the board.

Contact: Barbara Woodhouse, Administrative Staff Assistant, Department of Corrections, 6900 Atmore Dr., Richmond, VA 23225, telephone (804) 674-3124, FAX (804) 674-3236, e-mail barbara.woodhouse@vadoc.virginia.gov.

BOARD OF DENTISTRY

January 6, 2006 - 9 a.m. -- Open Meeting
February 3, 2006 - 9 a.m. -- Open Meeting
February 10, 2006 - 9 a.m. -- Open Meeting
† **March 17, 2006 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Richmond, Virginia. 

A meeting of the Special Conference Committee to hold informal conferences. There will not be a public comment period.

Contact: Cheri Emma-Leigh, Operations Manager, Department of Health Professions, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9906, FAX (804) 662-7246, (804) 662-7197/TTY , e-mail cheri.emma-leigh@dhp.virginia.gov.

March 2, 2006 - 9 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Richmond, Virginia. 

Formal hearings. There will not be a public comment period.

Contact: Cheri Emma-Leigh, Operations Manager, Department of Health Professions, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9906, FAX (804) 662-7246, (804) 662-7197/TTY , e-mail cheri.emma-leigh@dhp.virginia.gov.

March 3, 2006 - 9 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Richmond, Virginia. 

A general business meeting. There will be a public comment period during the first 15 minutes of the meeting.

Contact: Sandra Reen, Executive Director, Board of Dentistry, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9906, FAX (804) 662-7246, (804) 662-7197/TTY , e-mail sandra.reen@dhp.virginia.gov.

BOARD OF EDUCATION

January 11, 2006 - 9 a.m. -- Open Meeting

February 15, 2006 - 9 a.m. -- Open Meeting

† March 22, 2006 - 9 a.m. -- Open Meeting

James Monroe Building, 101 North 14th Street, Main Lobby Level, Conference Rooms C and D, Richmond, Virginia. 
(Interpreter for the deaf provided upon request)

A regular business meeting of the board. Public comment will be received. The public is urged to confirm arrangements prior to each meeting by viewing the Department of Education's public meeting calendar at <http://www.pen.k12.va.us/VDOE/meetings.html>. This site will contain the latest information on the meeting arrangements and will note any last minute changes in time or location. Persons who wish to speak or who require the services of an interpreter for the deaf should contact the agency at least 72 hours in advance.

Contact: Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, P.O. Box 2120, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, e-mail margaret.roberts@doe.virginia.gov.

January 17, 2006 - 7 p.m. -- Public Hearings

Loudoun County, Virginia.

Chesapeake City, Virginia.

Richmond, Virginia.

Waynesboro, Virginia.

Wytheville, Virginia.

Specific sites will be announced in advance of the hearing date.

January 31, 2006 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Education intends to amend regulations entitled **8 VAC 20-131, Regulations Establishing Standards for Accrediting Public Schools in Virginia**. The purpose of the proposed action is to update standards for accreditation. The regulations were last amended in 2000. Since that time, public schools in Virginia have implemented more rigorous requirements for accountability both at the school level and the student level. Now that most Virginia schools are fully accredited, and the first high school class required to earn verified units of credit has graduated from high school, the board undertook a comprehensive review of the regulations to determine if there are changes that might be needed. Substantive changes proposed are related to additional options for students to meet the requirements for graduation, the methodology for calculating accreditation ratings, greater flexibility for transfer students, more rigorous benchmarks for accreditation, and better defined sanctions for schools, superintendents, and school boards if a school loses its accreditation.

Statutory Authority: § 22.1-253.13:3 of the Code of Virginia.

Contact: Anne D. Wescott, Assistant Superintendent for Polity and Communications, Department of Education, P.O. Box 2121, Richmond, VA 23218, telephone (804) 225-2403, FAX (804) 225-2524 or e-mail anne.wescott@doe.virginia.gov.

Advisory Board on Teacher Education and Licensure

NOTE: CHANGE IN MEETING DATE

February 6, 2006 - 9 a.m. -- Open Meeting

† March 20, 2006 - 9 a.m. -- Open Meeting

Location to be announced.

A regular meeting. The public is urged to confirm arrangements prior to each meeting by viewing the Department of Education's public meeting calendar at <http://www.pen.k12.va.us/VDOE/meetings.html>. This site will contain the latest information on the meeting arrangements and will note any last-minute changes in time or location. Please note that persons requesting the services of an interpreter for the deaf are asked to do so at least 72 hours in advance so that the appropriate arrangements may be made.

Contact: Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, P.O. Box 2120, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, e-mail margaret.roberts@doe.virginia.gov.

LOCAL EMERGENCY PLANNING COMMITTEE - CITY OF WINCHESTER

January 4, 2006 - 3 p.m. -- Open Meeting

Timbrook Public Safety Center, 231 East Piccadilly Street, Winchester, Virginia.

A regular meeting.

Contact: L.A. Miller, Fire and Rescue Chief, Local Emergency Planning Committee, Winchester Fire and Rescue Department, 231 E. Piccadilly St., Winchester, VA 22601, telephone (540) 662-2298, FAX (540) 542-1318, (540) 662-4131/TTY .

DEPARTMENT OF ENVIRONMENTAL QUALITY

January 5, 2006 - 6:30 p.m. -- Open Meeting

Page Middle School, 5628 George Washington Memorial Highway, Gloucester, Virginia. 

The second and final meeting on the fecal coliform bacteria TMDL for 16 shellfish propagation waters located in Gloucester and Mathews counties. The public notice appears in the November 28, 2005, Virginia Register of Regulations. The public comment period begins on January 6, 2006, and ends on February 3, 2006.

Contact: Chester Bigelow, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4554, FAX (804) 698-4116, e-mail ccbigeLOW@deq.virginia.gov.

Calendar of Events

† **January 12, 2006 - 6 p.m.** -- Open Meeting
New River Community College, Edwards Hall, Room 206,
Dublin, Virginia. 

A public meeting on the development of an implementation plan for the fecal coliform and general standard (benthic) impairments in Back Creek in Pulaski. The public notice appears in the Virginia Register on December 26, 2005. The comment period begins on December 28, 2005, and ends on February 28, 2006.

Contact: Jason Hill, Department of Environmental Quality, 3019 Peters Creek Rd., Roanoke, VA 24019, telephone (540) 562-6724, FAX (540) 562-6860, e-mail jrhill@deq.virginia.gov.

† **March 21, 2006 - 9 a.m.** -- Open Meeting
Department of Environmental Quality, 629 East Main Street,
Richmond, Virginia. 

A meeting of the Ground Water Protection Steering Committee. The meeting will begin with a presentation by Scott Kudlas, DEQ Office of Water Supply Planning. Agency updates will follow the presentation; the meeting will adjourn by 11 a.m.

Contact: Mary Ann Massie, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4042, e-mail mamassie@deq.virginia.gov.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

† **January 17, 2006 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Conference Room 4, Richmond, Virginia. 

A meeting to discuss general business matters related to the practice of funeral service.

Contact: Elizabeth Young, Executive Director, Board of Funeral Directors and Embalmers, Alcoa Building, 6603 West Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9907, FAX (804) 662-9523, (804) 662-7197/TTY , e-mail elizabeth.young@dhp.virginia.gov.

† **January 17, 2006 - 1 p.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Conference Room 4, Richmond, Virginia. 

A formal hearing to hear possible violations of the laws and regulations governing the practice of funeral service.

Contact: Elizabeth Young, Executive Director, Board of Funeral Directors and Embalmers, 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9907, FAX (804) 662-9523, (804) 662-7197/TTY , e-mail elizabeth.young@dhp.virginia.gov.

† **January 25, 2006 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor Conference, Room 1 Richmond, Virginia.

A meeting of the Legislative/Regulatory Committee to discuss the rules and regulations that pertain to the practice of funeral service.

Contact: Elizabeth Young, Executive Director, Board of Funeral Directors and Embalmers, 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9907, FAX (804) 662-9523, (804) 662-7197/TTY , e-mail elizabeth.young@dhp.virginia.gov.

DEPARTMENT OF HEALTH

January 17, 2006 - 9 a.m. -- Open Meeting
Madison Building, 109 Governor Street, 5th Floor Conference Room, Richmond, Virginia.

A meeting of the Authorized Onsite Soil Evaluator Regulations Advisory Committee to make recommendations to the commissioner regarding AOSE/PE policies, procedures and programs.

Contact: Donna Tiller, Executive Secretary, Department of Health, 109 Governor St., Richmond, VA 23219, telephone (804) 864-7470, FAX (804) 864-7475, e-mail donna.tiller@vdh.virginia.gov.

BOARD FOR HEARING AID SPECIALISTS

† **March 15, 2006 - 9 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, 4th Floor, Richmond, Virginia. 

A general business meeting including consideration of regulatory issues as may be presented on the agenda. The meeting is open to the public; however, a portion of the board's business may be discussed in closed session. 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: William H. Ferguson, II, Executive Director, Board for Hearing Aid Specialists, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-6295, (804) 367-9753/TTY , e-mail hearingaidspec@dpor.virginia.gov.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

† **January 10, 2006 - 11:30 a.m.** -- Open Meeting
101 N 14th St., Richmond, Virginia.

Committee meetings begin at approximately 8 a.m. Agenda materials will be available on the website approximately one week prior to the meeting at www.schev.edu. A public comment period will be allocated on the meeting agenda. To be scheduled, those interested in making public comment should contact the person listed below no later than 5 p.m. three business days prior to the meeting date. At the time of the request, the speaker's name, address and topic must be provided. Each speaker will be given up to three minutes to address SCHEV. Speakers are asked to

submit a written copy of their remarks at the time of comment.

Contact: Lee Ann Rung, State Council of Higher Education for Virginia, 101 N 14th St., Richmond, VA 23219, telephone (804) 225-2602, FAX (804) 371-7911, e-mail LeeAnnRung@schev.edu.

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

January 17, 2006 - 10 a.m. -- Open Meeting
Department of Housing and Community Development, 501 North Second Street, Richmond, Virginia. 

A regular business meeting.

Contact: Stephen W. Calhoun, Regulatory Coordinator, Department of Housing and Community Development, The Jackson Center, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7000, FAX (804) 371-7090, (804) 371-7089/TTY , e-mail steve.calhoun@dhcd.virginia.gov.

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

† **February 27, 2006** - Public comments may be submitted until this date.

Notice is hereby given that the Department of Human Resource Management intends to amend regulations entitled **1 VAC 55-20, Commonwealth of Virginia Health Benefits Program**. The purpose of the proposed action is to bring the state regulations in line with the Working Families Tax Relief Act (WFTRA). The current definition of a dependent is based on IRS regulations that allowed an employee to cover certain dependents without incurring imputed income based on the state's contribution to the plan. WFTRA went into effect December 2004 and redefined who is considered a qualifying dependent for tax purposes under IRS § 152. WFTRA removes the requirement that a qualifying child be claimed by an employee as a dependent on his federal income tax return and sets up dependency criteria based on relationship, residency, age and self-support.

Statutory Authority: § 2.2-2818 of the Code of Virginia.

Contact: Charles Reed, Associate Director, Department of Human Resource Management, 101 N. 14th St., 13th Floor, Richmond, VA 23219, telephone (804) 786-3124, FAX (804) 371-0231 or e-mail charles.reed@dhrm.virginia.gov.

BOARD OF JUVENILE JUSTICE

January 11, 2006 - 9 a.m. -- Open Meeting
Cedar Lodge, 1601 Bon Air Road, Bon Air, Virginia.

Details will be provided closer to the meeting date.

Contact: Donald R. Carignan, Regulatory Coordinator, Department of Juvenile Justice, P.O. Box 1110, Richmond, VA 23219-1110, telephone (804) 371-0743, FAX (804) 371-0773 or e-mail don.carignan@djj.virginia.gov.

NOTE: CHANGE IN PUBLIC HEARING DATE

January 11, 2006 - 10 a.m. -- Public Hearing
Cedar Lodge, 1601 Bon Air Road, Bon Air, Virginia.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Juvenile Justice intends to amend regulations entitled **6 VAC 35-10, Public Participation Guidelines**. The purpose of the proposed action is to update the regulation to reflect technological and statutory changes since the original regulation was adopted in 1991.

Statutory Authority: §§ 2.2-4007 and 66-3 of the Code of Virginia.

Public comments may be submitted until January 11, 2006, to Patricia Rollston, P.O. Box 1110, Richmond, VA 23219-1110.

Contact: Donald R. Carignan, Regulatory Coordinator, Department of Juvenile Justice, P.O. Box 1110, Richmond, VA 23219-1110, telephone (804) 371-0743, FAX (804) 371-0773 or e-mail don.carignan@djj.virginia.gov.

STATE LIBRARY BOARD

January 27, 2006 - 8:15 a.m. -- Open Meeting

† **March 13, 2006 - 8:15 a.m.** -- Open Meeting

The Library of Virginia, 800 East Broad Street, Richmond, Virginia. 

Meetings of the board to discuss matters pertaining to the Library of Virginia and the board. Committees of the board will meet as follows:

8:15 a.m. - Public Library Development Committee, Orientation Room
Publications and Educational Services Committee, Conference Room B
Records Management Committee, Conference Room C

9:30 a.m. - Archival and Information Services Committee, Orientation Room
Collection Management Services Committee, Conference Room B
Legislative and Finance Committee, Conference Room C

10:30 a.m. - Library Board, Conference Room, 2M

Contact: Jean H. Taylor, Executive Secretary to the Librarian, The Library of Virginia, 800 E. Broad St., Richmond, VA 23219-8000, telephone (804) 692-3535, FAX (804) 692-3594, (804) 692-3976/TTY , e-mail jtaylor@lva.lib.va.us.

COMMISSION ON LOCAL GOVERNMENT

† **January 5, 2006 - 10 a.m.** -- Open Meeting

The Jackson Center, 501 North Second Street, First Floor Board Room, Richmond, Virginia. 

A regular meeting to consider such matters as may be presented.

Contact: Ted McCormack, Associate Director, Commission on Local Government, 501 N. Second St., Richmond, VA

Calendar of Events

23219, telephone (804) 786-6508, FAX (804) 371-7090, (804) 371-7089/TTY ☎, e-mail ted.mccormack@dhcd.virginia.gov.

BOARD OF LONG-TERM CARE ADMINISTRATORS

† **January 10, 2006 - 9:30 a.m.** -- Public Hearing
Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, Virginia. ♿

† **February 24, 2006** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Long-Term Care Administrators intends to amend regulations entitled **18 VAC 95-20, Regulations Governing the Practice of Nursing Home Administrators**. The purpose of the proposed action is to amend educational requirements for initial licensure that have been problematic or confusing for some applicants and to clarify the existing regulations.

Statutory Authority: § 54.1-2400 and Chapter 31 (§ 54.1-3100 et seq.) of the Code of Virginia.

Public comments may be submitted until February 24, 2006, to Sandra K. Reen, Executive Director, Board of Long-Term Care Administrators, 6603 West Broad Street, Richmond, VA 23230.

Contact: Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.virginia.gov.

January 10, 2006 - 9:30 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, Virginia. ♿

A meeting to discuss general business matters. There will be a 15-minute public comment period during the beginning of the meeting.

Contact: Sandra Reen, Executive Director, Board of Long-Term Care Administrators, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-7457, FAX (804) 662-9943, (804) 662-7197/TTY ☎, e-mail sandra.reen@dhp.virginia.gov.

VIRGINIA MANUFACTURED HOUSING BOARD

January 19, 2006 - 10 a.m. -- Open Meeting
Department of Housing and Community Development, The Jackson Center, 501 North Second Street, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A regular meeting to handle manufactured home claims and complaints and carry out administrative responsibilities of the Virginia Manufactured Housing Licensing and Transaction Recovery Fund Regulations.

Contact: Curtis L. McIver, State Building Code Administrator, Virginia Manufactured Housing Board, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7160, FAX (804) 371-7092, (804) 371-7089/TTY ☎, e-mail curtis.mciver@dhcd.virginia.gov.

MARINE RESOURCES COMMISSION

† **January 24, 2006 - 9:30 a.m.** -- Open Meeting
† **February 28, 2006 - 9:30 a.m.** -- Open Meeting
Marine Resources Commission, 2600 Washington Avenue, 4th Floor, Newport News, Virginia. ♿ (Interpreter for the deaf provided upon request)

A monthly commission meeting.

Contact: Jane McCroskey, Commission Secretary, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2215, FAX (757) 247-8101, toll-free (800) 541-4646, (757) 247-2292/TTY ☎, e-mail jane.mccroskey@mrc.virginia.gov.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

† **February 24, 2006** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to adopt regulations entitled:

12 VAC 30-70, Methods and Standards for Establishing Payments Rates; Inpatient Hospital Services.

12 VAC 30-80, Methods and Standards for Establishing Payments Rates; Other Types of Care.

12 VAC 30-90, Methods and Standards for Establishing Payments Rates; Long-Term Care.

The purpose of the proposed action is to sunset intergovernmental financial transfers that are not being phased out by the federal government.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Contact: William Lessard, Provider Reimbursement Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 225-4593, FAX (804) 786-1680 or e-mail william.lessard@dmas.virginia.gov.

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† **February 24, 2006** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to adopt regulations entitled **12 VAC 30-120, Waivered Services** and **12 VAC 30-141, Family Access to Medical Insurance Security Plan (FAMIS)**. The purpose of the proposed action is to exclude participants in the Virginia Birth-Related Neurological Injury Compensation Program from Medicaid and FAMIS managed care.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Contact: Daniel Plain, Managed Care Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300,

Richmond, VA 23219, telephone (804) 786-7958, FAX (804) 786-1680 or e-mail daniel.plain@dmas.virginia.gov.

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† **February 24, 2006** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to adopt regulations entitled **12 VAC 30-60, Standards Established and Methods Used to Assure High Quality Care**, and **12 VAC 30-90, Methods and Standards for Establishing Payments Rates; Long-Term Care**. The purpose of the proposed action is to provide additional reimbursement (\$10 per day) to nursing facilities (NF) for residents who require specialized treatment beds due to their having at least one treatable Stage IV pressure ulcer.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Contact: Teja Stokes, Project Manager, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-0527, FAX (804) 786-1680 or e-mail teja.stokes@dmas.virginia.gov.

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January 27, 2006 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to adopt regulations entitled **12 VAC 30-120, Waivered Services**. The purpose of the proposed action is to conform the agency's regulations to recent federally approved changes to the Home and Community Based Services Mental Retardation Waiver Program that have resulted from the federally required waiver renewal process.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Contact: Teja Stokes, Project Manager, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-0527, FAX (804) 786-1680 or e-mail teja.stokes@dmas.virginia.gov.

MOTOR VEHICLE DEALER BOARD

† **January 9, 2006 - 8:30 a.m.** -- Open Meeting
Department of Motor Vehicles, 2300 West Broad Street, Room 702, Richmond, Virginia. (Interpreter for the deaf provided upon request)

Committees will meet as follows:

Dealer Practices Committee - 8:30 a.m.
Licensing Committee - Immediately following Dealer Practices
Advertising Committee - 9:30 a.m. or immediately after Licensing, whichever is later

Transaction Recovery Fund Committee - Immediately following Advertising
Franchise Law Committee - To be scheduled as needed.
Full board meeting - 10 a.m. or five to 45 minutes following Transaction Recovery Fund

NOTE: Meetings may begin later, but not earlier than scheduled. Meeting end times are approximate. Any person who needs any accommodation in order to participate in the meeting should contact the board at least 10 days before the meeting so that suitable arrangements can be made.

Contact: Alice R. Weedon, Administrative Assistant, Motor Vehicle Dealer Board, 2201 W. Broad St., Suite 104, Richmond, VA 23220, telephone (804) 367-1100, FAX (804) 367-1053, toll-free (877) 270-0203, e-mail dboard@mvdv.virginia.gov.

VIRGINIA MUSEUM OF FINE ARTS

NOTE: CHANGE IN LOCATION

January 3, 2006 - 8 a.m. -- Open Meeting

February 7, 2006 - 8 a.m. -- Open Meeting

March 7, 2006 - 8 a.m. -- Open Meeting

Virginia Museum of Fine Arts, 200 North Boulevard, CEO 2nd Floor Meeting Room, Richmond, Virginia. (Interpreter for the deaf provided upon request)

An Executive Committee work session for staff to update the committee. Public comment will not be received.

Contact: Suzanne Broyles, Secretary of the Museum, Virginia Museum of Fine Arts, 200 N. Boulevard, Richmond, VA 23220, telephone (804) 340-1503, FAX (804) 340-1502, (804) 340-1401/TTY (Interpreter for the deaf provided upon request), e-mail sbroyles@vmfa.state.va.us.

BOARD OF NURSING

† **February 6, 2006 - 9 a.m.** -- Open Meeting

† **February 8, 2006 - 9 a.m.** -- Open Meeting

† **February 14, 2006 - 9 a.m.** -- Open Meeting

† **February 23, 2006 - 9 a.m.** -- Open Meeting

† **February 27, 2006 - 9 a.m.** -- Open Meeting

† **February 28, 2006 - 9 a.m.** -- Open Meeting

† **March 2, 2006 - 9 a.m.** -- Open Meeting

Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, Virginia. (Interpreter for the deaf provided upon request)

A Special Conference Committee comprised of two or three members of the Virginia Board of Nursing or agency subordinate will conduct informal conferences with licensees and certificate holders. Public comment will not be received.

Contact: Jay P. Douglas, R.N., M.S.M., C.S.A.C., Executive Director, Board of Nursing, 6603 West Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY (Interpreter for the deaf provided upon request), e-mail nursebd@dhp.virginia.gov.

January 23, 2006 - 9 a.m. -- Open Meeting

January 25, 2006 - 9 a.m. -- Open Meeting

January 26, 2006 - 9 a.m. -- Open Meeting

† **March 20, 2006 - 9 a.m.** -- Open Meeting

† **March 22, 2006 - 9 a.m.** -- Open Meeting

Calendar of Events

† **March 23, 2006 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Board Room 2, Richmond, Virginia. 

A panel of the board will conduct formal hearings with licensees and/or certificate holders. Public comment will not be received.

Contact: Jay P. Douglas, R.N., M.S.M., C.S.A.C., Executive Director, Board of Nursing, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY , e-mail nursebd@dhp.virginia.gov.

January 24, 2006 - 9 a.m. -- Open Meeting
† **March 21, 2006 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Board Room 2, Richmond, Virginia. 

A general business meeting including committee reports, consideration of regulatory action and discipline case decisions as presented on the agenda. Public comment will be received at 11 a.m.

Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY , e-mail jay.douglas@dhp.virginia.gov.

JOINT BOARDS OF NURSING AND MEDICINE

† **February 22, 2006 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor Richmond, Virginia. 

A regular meeting.

Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY , e-mail jay.douglas@dhp.virginia.gov.

OLD DOMINION UNIVERSITY

February 13, 2006 - 3 p.m. -- Open Meeting
† **March 20, 2006 - 3 p.m.** -- Open Meeting
Old Dominion University, Webb University Center, Norfolk,
Virginia. 

A regular meeting of the executive committee of the governing board of the institution to discuss business of the board and the institution as determined by the rector and the president. Public comment will not be received by the board.

Contact: Donna Meeks, Executive Secretary to the Board of Visitors, Old Dominion University, 204 Koch Hall, Norfolk, VA 23529, telephone (757) 683-3072, FAX (757) 683-5679, e-mail dmeeks@odu.edu.

BOARD OF PHYSICAL THERAPY

† **January 27, 2006 - 9 a.m.** -- Open Meeting
Department of Health Professions 6603 West Broad Street,
5th Floor, Conference Room 1, Richmond, Virginia. 

A general business meeting.

Contact: Elizabeth Young, Executive Director, Board of Physical Therapy, Alcoa Bldg., 6603 West Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9924, FAX (804) 662-9523, (804) 662-7197/TTY , e-mail elizabeth.young@dhp.virginia.gov.

BOARD OF PSYCHOLOGY

January 10, 2006 - 9:30 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Richmond, Virginia. 

A business meeting to include reports from standing committees and any regulatory and disciplinary matters as may be presented on the agenda. Comments will be received at the beginning of the meeting.

Contact: Evelyn B. Brown, Executive Director, Board of Psychology, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9913, FAX (804) 662-9943, (804) 662-7197/TTY , e-mail evelyn.brown@dhp.virginia.gov.

VIRGINIA PUBLIC GUARDIAN AND CONSERVATOR ADVISORY BOARD

† **March 23, 2006 - 10 a.m.** -- Open Meeting
Department for the Aging, 1610 Forest Avenue, Suite 100,
Richmond, Virginia. 

A quarterly meeting.

Contact: Janet Dingle Brown, Esq., Public Guardianship Coordinator and Legal Services Developer, Virginia Department for the Aging, 1610 Forest Ave., Suite 100, Richmond, VA 23229, telephone (804) 662-7049, FAX (804) 662-9354, toll-free (800) 552-3402, (804) 662-9333/TTY , e-mail janet.brown@vda.virginia.gov.

DEPARTMENT OF REHABILITATIVE SERVICES

Virginia Statewide Independent Living Council

† **January 19, 2006 - Noon** -- Open Meeting
Resources for Independent Living Center, 4009 Fitzhugh
Avenue, Richmond Virginia.

A business meeting. Public comment will be received at 12:30 pm. The Virginia Statewide Independent Living Council encourages a scent free environment. If interpreter services or other accommodations are required, please notify Ms. Grubb.

Contact: Lisa Grubb, Executive Director, Department of Rehabilitative Services, 8004 Franklin Farms Drive,

Richmond, VA 23288, telephone (804) 897-7228, FAX (804) 897-1080, e-mail VirginiaSILC@comcast.net.

VIRGINIA RESEARCH AND TECHNOLOGY ADVISORY COMMISSION

† **March 21, 2006 - 1 p.m.** -- Open Meeting
University of Virginia Research Park, Charlottesville, Virginia.

A quarterly meeting.

Contact: Nancy Vorona, Virginia Research and Technology Advisory Commission, 2214 Rock Hill Rd., Suite 600, Herndon, VA 20170, telephone (703) 689-3043, e-mail nvorona@cit.org.

VIRGINIA RESOURCES AUTHORITY

January 10, 2006 - 9 a.m. -- Open Meeting
Virginia Resources Authority, 707 East Main Street, 2nd Floor Conference Room, Richmond, Virginia.

A regular board meeting.

Contact: Trisha Henshaw, Office Manager, Virginia Resources Authority, 707 E. Main St., Suite 1350, Richmond, VA 23219, telephone (804) 644-3331, FAX (804) 644-3109, e-mail thenshaw@virginiareources.org.

SAFETY AND HEALTH CODES BOARD

February 13, 2006 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Safety and Health Codes Board intends to amend regulations entitled **16 VAC 25-60, Administrative Regulation for the Virginia Occupational Safety and Health Program**. The purpose of the proposed action is to amend the administrative regulations for the Virginia Occupational Safety and Health Program.

Statutory Authority: §§ 40.1-6 and 40.1-22 of the Code of Virginia.

Contact: Reba O'Connor, Regulatory Coordinator, Department of Labor and Industry, 13 S. 13th St., Richmond, VA 23219, telephone (804) 371-2631, FAX (804) 371-6524 or e-mail reba.oconnor@doli.virginia.gov.

† **February 25, 2006** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Safety and Health Codes Board intends to adopt regulations entitled **16 VAC 25-55, Financial Responsibility of Boiler and Pressure Vessel Contract Fee Inspectors**. The purpose of the proposed action is to set minimum aggregate limits for professional liability or errors of omission coverage or other methods of insuring financial responsibility for boiler and pressure

vessel contract fee inspectors operating in the Commonwealth.

Statutory Authority: § 40.1-51.9:2 of the Code of Virginia.

Contact: Fred P. Barton, Director, Boiler Safety Compliance, Department of Labor and Industry, 13 S. 13th St., Richmond, VA 23219, telephone (804) 371-2631, FAX (804) 371-6524 or e-mail fred.barton@doli.virginia.gov.

DEPARTMENT OF SOCIAL SERVICES

Family and Children's Trust Fund

† **January 1, 2006 - Noon** -- Open Meeting
Department of Social Services, 7 North 8th Street, Richmond, Virginia. 

The Marketing Committee will meet by telephone to discuss current marketing initiatives and future planning.

Contact: Fran Inge, Executive Director, Department of Social Services, 7 N. 8th St., Richmond, VA 23219, telephone (804) 726-7604, FAX (804) 726-7015, e-mail fran.inge@dss.virginia.gov.

BOARD FOR PROFESSIONAL SOIL SCIENTISTS AND WETLAND PROFESSIONALS

February 13, 2006 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A meeting to conduct board business. The meeting is open to the public; however, a portion of the board's business may be discussed in closed session. All meetings are subject to cancellation. Any person desiring to attend the meeting and requiring special accommodations or interpreter services should contact the board at least 10 days prior to the meeting so suitable arrangements can be made. The board fully complies with the Americans with Disabilities Act.

Contact: Mark N. Courtney, Executive Director, Board for Professional Soil Scientists and Wetland Professionals, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail soilscientist@dpor.virginia.gov.

TREASURY BOARD

† **January 18, 2006 - 9 a.m.** -- Open Meeting
James Monroe Building, 101 North 14th Street, 3rd Floor, Treasury Board Room, Richmond, Virginia. 

A regular meeting.

Contact: Melissa K. Mayes, Secretary, Department of the Treasury, 101 N. 14th St., 3rd Floor, Richmond, VA 23219, telephone (804) 371-6011, e-mail melissa.mayes@trs.virginia.gov.

Calendar of Events

DEPARTMENT OF VETERANS SERVICES

Board of Veterans Services

† **January 10, 2006 - 9:30 a.m.** -- Open Meeting
Virginia War Memorial, 621 South Belvidere Street,
Richmond, Virginia. 

A regular meeting.

Contact: Rhonda Earman, Administrative Supervisor,
Department of Veterans Services, 900 E. Main St., Richmond,
VA 23219, telephone (804) 786-0286, e-mail
rhonda.earman@dvs.virginia.gov.

Joint Leadership Council of Veterans Service Organizations

† **March 15, 2006 - 11 a.m.** -- Open Meeting
Richmond area (location to be determined). 

A regular meeting.

Contact: Steve Combs, Assistant to the Commissioner,
Department of Veterans Services, 900 E. Main St., Richmond,
VA 23219, telephone (804) 786-0294, e-mail
steven.combs@dvs.virginia.gov.

VIRGINIA WASTE MANAGEMENT BOARD

January 9, 2006 - 10 a.m. -- Public Hearing
Department of Environmental Quality, 629 East Main Street,
Richmond, Virginia.

January 27, 2006 - Public comments may be submitted until
this date.

Notice is hereby given in accordance with § 2.2-4007 of the
Code of Virginia that the Virginia Waste Management Board
intends to amend regulations entitled **9 VAC 20-85,
Regulations Governing Management of Coal
Combustion By-Products**. The purpose of the purpose of
the proposed action is include (i) provisions for fossil fuel
combustion products; (ii) discussion of possibly eliminating
the regulation and placing all provision of the regulation into
the Virginia Solid Waste Management Regulations or
removing the provisions addressing coal ash from the
VSWMR and consolidating the provisions of this regulation;
and (iii) additional issues that are identified during the
NOIRA comment period, the technical advisory committee
meetings, and during the public comment period.

Statutory Authority: § 10.1-1402 of the Code of Virginia.

Contact: Michael Dieter, Department of Environmental
Quality, P.O. Box 10009, Richmond, VA 23240, telephone
(804) 698-4146, FAX (804) 698-4327 or e-mail
mjdieter@deq.virginia.gov.

STATE WATER CONTROL BOARD

December 30, 2005 - Public comments may be submitted
until this date.

Notice is hereby given in accordance with § 2.2-4007 of the
Code of Virginia that the State Water Control Board intends
to amend regulations entitled **9 VAC 25-194, General
Virginia Pollutant Discharge Elimination System
(VPDES) Permit for Car Wash Facilities**. The purpose of
the proposed action is to reissue the existing general
VPDES permit for car wash facilities that expires on
October 15, 2007.

Statutory Authority: § 62.1-44.15 of the Code of Virginia; § 402
of the Clean Water Act; 40 CFR Parts 122, 123 and 124.

Contact: George Cosby, Department of Environmental
Quality, P.O. Box 10009, Richmond, VA 23240, telephone
(804) 698-4067, FAX (804) 698-4032 or e-mail
gecosby@deq.virginia.gov.

January 3, 2006 - 3 p.m. -- Open Meeting

January 3, 2006 - 7 p.m. -- Open Meeting
Department of Environmental Quality, Northern Regional
Office, 13901, Crown Court, Woodbridge, Virginia. 

January 4, 2006 - 7 p.m. -- Open Meeting

Department of Environmental Quality, Tidewater Regional
Office, 5636 Southern Boulevard, Virginia Beach, Virginia. 

January 5, 2006 - 3 p.m. -- Open Meeting

January 5, 2006 - 7 p.m. -- Open Meeting
Department of Environmental Quality, Piedmont Regional
Office, 4949-A Cox Road, Glen Allen, Virginia. 

An information meeting on the General VPDES Permit for
Total Nitrogen and Total Phosphorus Discharges and
Nutrient Trading in the Chesapeake Bay Watershed.

Contact: Kyle Winter, State Water Control Board, P.O. Box
10009, Richmond, VA 23240, telephone (804) 698-4182,
e-mail kiwinter@deq.virginia.gov.

January 10, 2006 - 9:30 a.m. -- Open Meeting

Department of Environmental Quality, Piedmont Regional
Office, 4949-A Cox Road, Glen Allen, Virginia. 

A meeting of the advisory committee assisting in the
development of a General VPDES Permit for Total Nitrogen
and Total Phosphorus Discharges and Nutrient Trading in
the Chesapeake Bay Watershed in Virginia (9 VAC 25-820)

Contact: Kyle Winter, State Water Control Board, P.O. Box
10009, Richmond, VA 23240, telephone (804) 698-4182,
e-mail kiwinter@deq.virginia.gov.

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January 13, 2006 - Public comments may be submitted until
this date.

Notice is hereby given in accordance with § 2.2-4007 of the
Code of Virginia that the State Water Control Board intends
to adopt regulations entitled **9 VAC 25-800, Virginia Water
Protection General Permit for Minor Water Withdrawals**.

The purpose of the proposed action is to establish a general Virginia Water Protection Permit for water withdrawals.

Statutory Authority: §§ 62.1-44.15 and 62.1-44.15:5 of the Code of Virginia.

Contact: Ellen Gilinsky, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4375, FAX (804) 698-4032 or e-mail egilinsky@deq.virginia.gov.

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

March 8, 2006 - 8:30 a.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. 

A meeting to conduct board business. The meeting is open to the public; however, a portion of the board's business may be discussed in closed session. All meetings are subject to cancellation. Any person desiring to attend the meeting and requiring special accommodations or interpreter services should contact the board at least 10 days prior to the meeting so suitable arrangements can be made. The board fully complies with the Americans with Disabilities Act.

Contact: David E. Dick, Executive Director, Board for Waterworks and Wastewater Works Operators, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail waterwasteoper@dpor.virginia.gov.

INDEPENDENT

STATE LOTTERY BOARD

January 11, 2006 - 9 a.m. -- Open Meeting
State Lottery Department, 900 East Main Street, 13th Floor,
Richmond, Virginia. 

A regular meeting. There will be an opportunity for public comment shortly after the meeting is convened.

Contact: Frank S. Ferguson, Director, Legislative and Regulatory Affairs, State Lottery Department, 900 E. Main St., Richmond, VA 23219, telephone (804) 692-7901, FAX (804) 692-7905, e-mail fferguson@valottery.state.va.us.

VIRGINIA OFFICE FOR PROTECTION AND ADVOCACY

Board for Protection and Advocacy

January 20, 2006 - 9 a.m. -- Open Meeting
Virginia Office for Protection and Advocacy, Byrd Building,
1910 Byrd Avenue, Suite 5, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular meeting. Public comment is welcomed by the board and will be received beginning at 9 a.m. Public comment will also be accepted by telephone. If you wish to provide public comment via telephone, call Lisa Shehi, Administrative Assistant at 1-800-552-3962 (Voice/TTY) or e-mail at lisa.shehi@vopa.virginia.gov no later than January 6, 2006. Ms. Shehi will take your name and phone number and you will be telephoned during the public comment period. If interpreter services or other accommodations are required, please contact Ms. Shehi no later than January 6, 2006.

Contact: Lisa Shehi, Administrative Assistant, Virginia Office for Protection and Advocacy, 1910 Byrd Avenue, Suite 5, Richmond, VA 23230, telephone (804) 225-2042, FAX (804) 662-7431, toll-free (800) 552-3962, (804) 225-2042/TTY , e-mail lisa.shehi@vopa.virginia.gov.

Disabilities Advisory Council

January 11, 2006 - 10 a.m. -- Open Meeting
Virginia Office for Protection and Advocacy, Byrd Building,
1910 Byrd Avenue, Suite 5, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular meeting. This meeting is open to the public. Public comment is welcomed by the council and will be received beginning at 10 a.m.. Public comment will also be accepted by telephone. For more information on participating in this conference call or to provide public comment via telephone, or arrange for interpreter services or accommodations call or e-mail Lisa Shehi.

Contact: Lisa Shehi, Administrative Assistant, Virginia Office for Protection and Advocacy, 1910 Byrd Ave., Suite 5, Richmond, Virginia 23230, telephone (804) 225-2042, FAX (804) 662-7413, toll-free (800) 552-3962, (804) 225-2042/TTY , e-mail lisa.shehi@vopa.virginia.gov.

PAIMI Advisory Council

February 16, 2006 - 10 a.m. -- Open Meeting
Virginia Office for Protection and Advocacy, Byrd Building,
1910 Byrd Avenue, Suite 5, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular meeting. Public comment is welcome and will be received at the beginning of the meeting. For those needing interpreter services or other accommodations, please contact Ms. Lisa Shehi no later than February 2, 2006.

Contact: Lisa Shehi, Administrative Assistant, Virginia Office for Protection and Advocacy, 1910 Byrd Ave., Suite 5, Richmond, VA 23230, telephone (804) 225-2042, FAX (804) 662-7431, toll-free (800) 552-3962, (804) 225-2042/TTY , e-mail lisa.shehi@vopa.virginia.gov.

Calendar of Events

LEGISLATIVE

JOINT COMMISSION ON ADMINISTRATIVE RULES

January 10, 2006 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room B, Richmond, Virginia. 

A regular meeting. For questions regarding the meeting agenda, contact Elizabeth Palen, Division of Legislative Services, (804) 786-3591. Individuals requiring interpreter services or other accommodations should telephone Senate Committee Operations at (804) 698-7450, (804) 698-7419/TTY, or write to Senate Committee Operations, P.O. Box 396, Richmond, VA 23218, at least seven days prior to the meeting.

Contact: Nathan Hatfield, Senate Committee Operations, General Assembly Bldg., 910 Capitol St., Richmond, VA 23219, telephone (804) 698-7410.

JOINT SUBCOMMITTEE STUDYING CONFLICTS OF INTEREST AND LOBBYIST DISCLOSURE FILINGS

† December 28, 2005 - 1 p.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia. 

A regular meeting. For questions regarding the meeting agenda, contact Amigo Wade, Division of Legislative Services, (804) 786-3591.

Contact: Barbara L. Teague, House Committee Operations, 910 Capitol St., Richmond, VA 23219, telephone (804) 698-1540.

DISABILITY COMMISSION

† January 9, 2006 - 1 p.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room A, Richmond, Virginia. 

A regular meeting. For questions regarding the meeting agenda, contact Pat Davis, Division of Legislative Services, (804) 786-3591.

Contact: Patty Lung, Senate Committee Operations, General Assembly Bldg., 910 Capitol St., Richmond, VA 23219, telephone (804) 698-7410.

VIRGINIA FREEDOM OF INFORMATION ADVISORY COUNCIL

† December 29, 2005 - 1 p.m. -- Open Meeting
General Assembly Building, House Room D, 910 Capitol Street, Richmond, Virginia. 

This meeting will be the fifth and final meeting of the Freedom of Information Advisory Council for 2005.

Contact: Maria J.K. Everett, Executive Director, Virginia Freedom of Information Advisory Council, General Assembly

Bldg., 910 Capitol St., Second Floor, Richmond, Virginia 23219, telephone (804) 225-3056, FAX (804) 371-8705, toll-free (866) 448-4100, e-mail foiaacouncil@leg.state.va.us.

JOINT SUBCOMMITTEE ON MANUFACTURING NEEDS AND THE FUTURE OF MANUFACTURING IN VIRGINIA

† January 10, 2006 - 1 p.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room A, Richmond, Virginia. 

A regular meeting. For questions regarding the meeting agenda, contact Frank Munyan, Division of Legislative Services, (804) 786-3591.

Contact: Patty Lung, Senate Committee Operations, General Assembly Bldg., 910 Capitol St., Richmond, VA 23219, telephone (804) 698-7410.

JOINT SUBCOMMITTEE STUDYING THE COMMONWEALTH'S PROGRAM FOR PRISONER REENTRY TO SOCIETY

January 10, 2006 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, 3rd Floor East Conference Room, Richmond, Virginia. 

A regular meeting. For questions regarding the meeting agenda, contact Pat Davis, Division of Legislative Services, (804) 786-3591.

Contact: Nathan Hatfield, Senate Committee Operations, General Assembly Bldg., 910 Capitol St., Richmond, VA 23219, telephone (804) 698-7410, e-mail nhatfield@sov.state.va.us.

JOINT SUBCOMMITTEE STUDYING THE VOTING EQUIPMENT AND CERTIFICATION PROCESS

† January 5, 2006 - 10 a.m. -- Open Meeting
General Assembly Building, 9th and Broad Streets, House Room C, Richmond, Virginia. 

A regular meeting. For questions regarding the meeting agenda, contact Mary Spain, Division of Legislative Services, (804) 786-3591.

Contact: Pam Burnham, House Committee Operations, 910 Capitol St., Richmond, VA 23219, telephone (804) 698-1540.

CHRONOLOGICAL LIST

OPEN MEETINGS

December 28

† Conflicts of Interest and Lobbyist Disclosure Filings, Joint Subcommittee Studying

December 29

† Freedom of Information Advisory Council, Virginia

January 1, 2006

† Social Services, Department of
- Family and Children's Trust Fund

January 3, 2006

† Alcoholic Beverage Council Board
Museum of Fine Arts, Virginia
Water Control Board, State

January 4

† Competition Council, Commonwealth
Emergency Planning Committee, Local
- City of Winchester
Water Control Board, State

January 5

Air Pollution Control Board, State
Environmental Quality, Department of
† Local Government, Commission on
† Voting Equipment and Certification Process, Joint
Subcommittee Studying
Water Control Board, State

January 6

† Agriculture and Consumer Services, Department of
- Virginia Sheep Industry Board
† Art and Architectural Review Board
† Child Fatality Review Team, State
Dentistry, Board of

January 9

† Disability Commission
† Motor Vehicle Dealer Board

January 10

Administrative Rules, Joint Commission on
Blind and Vision Impaired, Board for the
† Compensation Board
† Contractors, Board for
† Higher Education for Virginia, State Council of
Long-Term Care Administrators, Board of
† Manufacturing Needs and the Future of Manufacturing in
Virginia, Joint Subcommittee on
Prisoner Reentry to Society, Joint Subcommittee Studying
the Commonwealth's Program for
Psychology, Board of
Resources Authority, Virginia
† Veterans Services, Department of
- Board of Veterans Services
Water Control Board, State

January 11

Education, Board of
Juvenile Justice, Board of
Lottery Board, State
Protection and Advocacy, Virginia Office for
- Disabilities Advisory Council

January 12

† Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects,
Board for
Auctioneers Board
Barbers and Cosmetology, Board for
† Child Day-Care Council
Contractors, Board for
† Environmental Quality, Department of

January 17

† Alcoholic Beverage Control Board
Corrections, Board of

† Funeral Directors and Embalmers, Board of
Health, Department of
Housing and Community Development, Board of

January 18

† Agriculture and Consumer Services, Department of
- Virginia Irish Potato Board
† Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects,
Board for
Community Colleges, State Board for
Corrections, Board of
† Treasury Board

January 19

Community Colleges, State Board for
Manufactured Housing Board, Virginia
† Rehabilitative Services, Department of
- Statewide Independent Living Council

January 20

Protection and Advocacy, Virginia Office for
- Board for Protection and Advocacy

January 23

Nursing, Board of

January 24

† Marine Resources Commission
Nursing, Board of

January 25

† Funeral Directors and Embalmers, Board of
Nursing, Board of

January 26

Nursing, Board of

January 27

Library Board, State
† Physical Therapy, Board of

January 30

† Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects,
Board for

January 31

Agriculture and Consumer Services, Department of
- Virginia Horse Industry Board
Asbestos, Lead, and Home Inspectors, Virginia Board for

February 1

Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects,
Board for
Branch Pilots, Board for

February 2

Branch Pilots, Board for

February 3

Dentistry, Board of

February 6

† Alcoholic Beverage Control Board
† Barbers and Cosmetology, Board for
Education, Board of
- Advisory Board on Teacher Education and Licensure
† Nursing, Board of

February 7

Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects,
Board for
Museum of Fine Arts, Virginia

Calendar of Events

February 8

Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects,
Board for
† Nursing, Board of

February 9

Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects,
Board for

February 10

Dentistry, Board of

February 13

Old Dominion University
Soil Scientists and Wetland Professionals, Board for
Professional

February 14

† Nursing, Board of

February 15

Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects,
Board for
Education, Board of

February 16

Protection and Advocacy, Virginia Office for
- PAIMI Advisory Council

February 21

† Alcoholic Beverage Control Board

February 22

† Nursing and Medicine, Joint Boards of

February 23

† Nursing, Board of

February 27

† Nursing, Board of

February 28

† Marine Resources Commission
† Nursing, Board of

March 2

Dentistry, Board of
† Nursing, Board of

March 3

Dentistry, Board of

March 6

† Alcoholic Beverage Control Board

March 7

Museum of Fine Arts, Virginia

March 8

Waterworks and Wastewater Works Operators, Board for

March 10

† Child Fatality Review Team, State

March 13

† Asbestos, Lead, and Home Inspectors, Virginia Board for

† Library Board, State

March 14

† Alzheimer's Disease and Related Disorders Commission
† Corrections, Board of

March 15

† Corrections, Board of
† Hearing Aid Specialists, Board for
† Veterans Services, Department of
- Joint Leadership Council of Veterans Service
Organizations

March 16

† Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects,
Board for

March 17

† Dentistry, Board of

March 20

† Alcoholic Beverage Control Board
† Education, Board of
- Advisory Board on Teacher Education and Licensure
† Nursing, Board of
† Old Dominion University

March 21

† Environmental Quality, Department of
- Ground Water Protection Steering Committee
† Nursing, Board of
Research and Technology Advisory Commission, Virginia

March 22

† Education, Board of
† Nursing, Board of

March 23

† Nursing, Board of
† Public Guardian and Conservator Advisory Board, Virginia

PUBLIC HEARINGS

January 9, 2006

Waste Management Board, Virginia

January 10

† Long Term Care Administrators, Board of

January 11

Juvenile Justice, Board of

January 12

Air Pollution Control Board, State

January 17

Education, Board of

March 16

† Architects, Professional Engineers, Land Surveyors,
Certified Interior Designers and Landscape Architects