



Virginia Register of Regulations

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THE VIRGINIA REGISTER INFORMATION PAGE

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

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

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

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

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

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

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

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

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

provide for additional public comment, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the period for which the Governor has provided for additional public comment; (iii) the Governor and the General Assembly exercise their authority to suspend the effective date of a regulation until the end of the next regular legislative session; or (iv) the agency suspends the regulatory process, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 30-day public comment period and no earlier than 15 days from publication of the readopted action.

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

FAST-TRACK RULEMAKING PROCESS

Section 2.2-4012.1 of the Code of Virginia provides an exemption from certain provisions of the Administrative Process Act for agency regulations deemed by the Governor to be noncontroversial. To use this process, Governor's concurrence is required and advance notice must be provided to certain legislative committees. Fast-track regulations will become effective on the date noted in the regulatory action if no objections to using the process are filed in accordance with § 2.2-4012.1.

EMERGENCY REGULATIONS

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

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

STATEMENT

The foregoing constitutes a generalized statement of the procedures to be followed. For specific statutory language, it is suggested that Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2 of the Code of Virginia be examined carefully.

CITATION TO THE VIRGINIA REGISTER

The *Virginia Register* is cited by volume, issue, page number, and date. **23:7 VA.R. 1023-1140 December 11, 2006**, refers to Volume 23, Issue 7, pages 1023 through 1140 of the *Virginia Register* issued on December 11, 2006.

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

Members of the Virginia Code Commission: **R. Steven Landes**, Chairman; **John S. Edwards**, Vice Chairman; **Ryan T. McDougle**; **Robert Hurt**; **Robert L. Calhoun**; **Frank S. Ferguson**; **E.M. Miller, Jr.**; **Thomas M. Moncure, Jr.**; **James F. Almand**; **Cleo Elaine Powell**.

Staff of the Virginia Register: **Jane D. Chaffin**, Registrar of Regulations; **June T. Chandler**, Assistant Registrar.

PUBLICATION SCHEDULE AND DEADLINES

This schedule is available on the *Register's* Internet home page (<http://register.state.va.us>).

March 2008 through December 2008

<u>Volume: Issue</u>	<u>Material Submitted By Noon*</u>	<u>Will Be Published On</u>
24:13	February 13, 2008	March 3, 2008
24:14	February 27, 2008	March 17, 2008
INDEX 2 Volume 24		April 2008
24:15	March 12, 2008	March 31, 2008
24:16	March 26, 2008	April 14, 2008
24:17	April 9, 2008	April 28, 2008
24:18	April 23, 2008	May 12, 2008
24:19	May 7, 2008	May 26, 2008
24:20	May 21, 2008	June 9, 2008
INDEX 3 Volume 24		July 2008
24:21	June 4, 2008	June 23, 2008
24:22	June 18, 2008	July 7, 2008
24:23	July 2, 2008	July 21, 2008
24:24	July 16, 2008	August 4, 2008
24:25	July 30, 2008	August 18, 2008
24:26	August 13, 2008	September 1, 2008
FINAL INDEX Volume 24		October 2008
25:1	August 27, 2008	September 15, 2008
25:2	September 10, 2008	September 29, 2008
25:3	September 24, 2008	October 13, 2008
25:4	October 8, 2008	October 27, 2008
25:5	October 22, 2008	November 10, 2008
25:6	November 5, 2008	November 24, 2008
25:7	November 18, 2008 (Tuesday)	December 8, 2008

*Filing deadlines are Wednesdays unless otherwise specified.

CUMULATIVE TABLE OF VIRGINIA ADMINISTRATIVE CODE SECTIONS ADOPTED, AMENDED, OR REPEALED

The table printed below lists regulation sections, by Virginia Administrative Code (VAC) title, that have been amended, added or repealed in the *Virginia Register* since the regulations were originally published or last supplemented in VAC (the Fall 2007 VAC Supplement includes final regulations published through *Virginia Register* Volume 23, Issue 21, dated June 25, 2007). Emergency regulations, if any, are listed, followed by the designation "emer," and errata pertaining to final regulations are listed. Proposed regulations are not listed here. The table lists the sections in numerical order and shows action taken, the volume, issue and page number where the section appeared, and the effective date of the section.

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
Title 1. Administration			
1 VAC 55-30-10 through 1 VAC 55-30-90	Added	23:26 VA.R. 4413-4416	10/3/07
1 VAC 55-30-10 through 1 VAC 55-30-90	Erratum	24:7 VA.R. 940	--
Title 2. Agriculture			
2 VAC 5-110 (Forms)	Amended	23:26 VA.R. 4452	--
2 VAC 5-210-30	Amended	24:9 VA.R. 1096	12/11/07
2 VAC 5-210-41	Amended	24:9 VA.R. 1097	12/11/07
2 VAC 5-580-10 through 2 VAC 5-580-310	Repealed	24:2 VA.R. 72	10/16/07
2 VAC 5-585-10 through 2 VAC 5-585-4070	Added	24:2 VA.R. 72-133	10/16/07
Title 3. Alcoholic Beverages			
3 VAC 5-50-40	Amended	23:25 VA.R. 4107	*
3 VAC 5-50-50	Amended	23:25 VA.R. 4108	*
3 VAC 5-50-80	Amended	23:25 VA.R. 4108	*
3 VAC 5-50-100	Amended	23:25 VA.R. 4108	*
3 VAC 5-50-130	Amended	23:25 VA.R. 4109	*
3 VAC 5-50-140	Amended	23:25 VA.R. 4110	*
3 VAC 5-50-140 emer	Amended	24:11 VA.R. 1344	1/9/08-1/8/09
3 VAC 5-50-145 emer	Added	24:11 VA.R. 1345	1/9/08-1/8/09
3 VAC 5-70-225 emer	Added	24:10 VA.R. 1257	1/2/08-1/1/09
Title 4. Conservation and Natural Resources			
4 VAC 5-36-50	Amended	24:6 VA.R. 638	1/1/08
4 VAC 5-36-60	Amended	24:6 VA.R. 644	1/1/08
4 VAC 5-36-70	Amended	24:6 VA.R. 645	1/1/08
4 VAC 5-36-90	Amended	24:6 VA.R. 647	1/1/08
4 VAC 5-36-100	Amended	24:6 VA.R. 649	1/1/08
4 VAC 5-36-110	Amended	24:6 VA.R. 654	1/1/08
4 VAC 5-36-120	Amended	24:6 VA.R. 655	1/1/08
4 VAC 5-36-130	Amended	24:6 VA.R. 656	1/1/08
4 VAC 5-36-140	Amended	24:6 VA.R. 657	1/1/08
4 VAC 5-36-150	Amended	24:6 VA.R. 659	1/1/08
4 VAC 5-36-200	Amended	24:6 VA.R. 662	1/1/08
4 VAC 5-36-210	Amended	24:6 VA.R. 670	1/1/08
4 VAC 5-36-220	Amended	24:6 VA.R. 675	1/1/08
4 VAC 15-20-50	Amended	24:10 VA.R. 1258	1/1/08
4 VAC 15-20-130	Amended	24:10 VA.R. 1259	1/1/08
4 VAC 15-20-200	Amended	24:10 VA.R. 1261	1/1/08
4 VAC 15-20-210	Amended	24:10 VA.R. 1261	1/1/08
4 VAC 15-30-5	Amended	24:10 VA.R. 1262	1/1/08

* Objection to Fast-Track Rulemaking 24:1

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
4 VAC 15-30-40	Amended	24:10 VA.R. 1262	1/1/08
4 VAC 15-200-10	Amended	24:6 VA.R. 676	10/26/07
4 VAC 15-270-40	Amended	24:6 VA.R. 676	7/1/08
4 VAC 15-270-80	Added	24:6 VA.R. 676	10/26/07
4 VAC 15-270-90	Added	24:6 VA.R. 677	1/1/08
4 VAC 15-320-25	Amended	24:10 VA.R. 1265	1/1/08
4 VAC 15-330-30	Amended	24:10 VA.R. 1272	1/1/08
4 VAC 15-330-100	Amended	24:10 VA.R. 1272	1/1/08
4 VAC 15-330-120	Amended	24:10 VA.R. 1272	1/1/08
4 VAC 15-330-160	Amended	24:10 VA.R. 1272	1/1/08
4 VAC 15-330-171	Amended	24:10 VA.R. 1273	1/1/08
4 VAC 15-330-200	Amended	24:10 VA.R. 1273	1/1/08
4 VAC 15-340-10	Amended	24:10 VA.R. 1273	1/1/08
4 VAC 15-340-30	Amended	24:10 VA.R. 1274	1/1/08
4 VAC 15-350-20	Amended	24:10 VA.R. 1275	1/1/08
4 VAC 15-350-30	Amended	24:10 VA.R. 1275	1/1/08
4 VAC 15-350-60	Amended	24:10 VA.R. 1275	1/1/08
4 VAC 15-350-70	Amended	24:10 VA.R. 1275	1/1/08
4 VAC 15-360-10	Amended	24:10 VA.R. 1276	1/1/08
4 VAC 20-20-50	Amended	24:5 VA.R. 555	11/1/07
4 VAC 20-150-30	Amended	24:10 VA.R. 1277	1/1/08
4 VAC 20-252-55	Amended	24:10 VA.R. 1278	1/1/08
4 VAC 20-252-90	Amended	24:4 VA.R. 471	10/1/07
4 VAC 20-252-100	Amended	24:4 VA.R. 471	10/1/07
4 VAC 20-252-120	Amended	24:10 VA.R. 1278	1/1/08
4 VAC 20-252-150	Amended	24:10 VA.R. 1279	1/1/08
4 VAC 20-252-160	Amended	24:10 VA.R. 1279	1/1/08
4 VAC 20-252-230	Amended	24:10 VA.R. 1281	1/1/08
4 VAC 20-260-10	Amended	24:4 VA.R. 472	10/1/07
4 VAC 20-260-20	Amended	24:4 VA.R. 472	10/1/07
4 VAC 20-260-30	Amended	24:4 VA.R. 473	10/1/07
4 VAC 20-260-35	Added	24:4 VA.R. 474	10/1/07
4 VAC 20-260-40	Amended	24:4 VA.R. 474	10/1/07
4 VAC 20-260-60	Amended	24:4 VA.R. 474	10/1/07
4 VAC 20-320-50	Amended	24:12 VA.R. 1456	2/1/08
4 VAC 20-530-20	Amended	24:12 VA.R. 1456	2/1/08
4 VAC 20-530-32	Repealed	24:12 VA.R. 1457	2/1/08
4 VAC 20-610-20	Amended	24:8 VA.R. 959	12/1/07
4 VAC 20-610-25	Added	24:8 VA.R. 959	12/1/07
4 VAC 20-610-30	Amended	24:8 VA.R. 960	12/1/07
4 VAC 20-610-50	Amended	24:8 VA.R. 961	12/1/07
4 VAC 20-610-60	Amended	24:8 VA.R. 961	12/1/07
4 VAC 20-620-30	Amended	24:10 VA.R. 1281	12/27/07
4 VAC 20-620-40 emer	Amended	24:8 VA.R. 962	11/28/07-12/27/07
4 VAC 20-620-40	Amended	24:10 VA.R. 1282	12/27/07
4 VAC 20-650-20	Amended	24:4 VA.R. 474	10/1/07
4 VAC 20-650-30	Amended	24:4 VA.R. 475	10/1/07
4 VAC 20-650-40	Amended	24:4 VA.R. 475	10/1/07
4 VAC 20-720-20	Amended	24:4 VA.R. 475	10/1/07
4 VAC 20-720-20	Erratum	24:5 VA.R. 621	--
4 VAC 20-720-40 through 4 VAC 20-720-80	Amended	24:4 VA.R. 478-480	10/1/07

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
4 VAC 20-720-40	Amended	24:12 VA.R. 1457	2/1/08
4 VAC 20-720-50	Amended	24:12 VA.R. 1458	2/1/08
4 VAC 20-720-60	Amended	24:12 VA.R. 1458	2/1/08
4 VAC 20-720-80	Amended	24:12 VA.R. 1458	2/1/08
4 VAC 20-720-95	Added	24:4 VA.R. 480	10/1/07
4 VAC 20-720-110	Amended	24:4 VA.R. 480	10/1/07
4 VAC 20-755-10	Amended	24:2 VA.R. 133	9/1/07
4 VAC 20-755-20	Amended	24:2 VA.R. 133	9/1/07
4 VAC 20-755-30	Amended	24:2 VA.R. 136	9/1/07
4 VAC 20-910-45	Amended	24:5 VA.R. 556	11/1/07
4 VAC 20-960-45	Amended	24:8 VA.R. 964	1/1/08
4 VAC 20-960-47	Amended	24:8 VA.R. 964	1/1/08
4 VAC 20-1040-20	Amended	24:8 VA.R. 964	1/1/08
4 VAC 20-1040-35	Added	24:12 VA.R. 1459	2/1/08
4 VAC 20-1090-30	Amended	24:8 VA.R. 965	12/1/07
4 VAC 20-1120-20	Amended	23:23 VA.R. 3871	6/28/07
4 VAC 20-1130-10 through 4 VAC 20-1130-70	Added	24:8 VA.R. 968-970	12/1/07
4 VAC 25-20 (Forms)	Amended	23:24 VA.R. 3968	--
4 VAC 25-50-10 through 4 VAC 25-50-110	Repealed	23:22 VA.R. 3696	8/8/07
4 VAC 25-130 (Forms)	Amended	24:11 VA.R. 1424	--
4 VAC 25-130-777.17	Amended	23:22 VA.R. 3696	8/8/07
Title 5. Corporations			
5 VAC 5-20-20	Amended	24:11 VA.R. 1347	2/15/08
5 VAC 5-20-140	Amended	24:11 VA.R. 1347	2/15/08
5 VAC 5-20-150	Amended	24:11 VA.R. 1348	2/15/08
5 VAC 5-20-170	Amended	24:11 VA.R. 1348	2/15/08
5 VAC 5-20-240	Amended	24:11 VA.R. 1349	2/15/08
5 VAC 5-30-10	Amended	23:23 VA.R. 3872	7/1/07
5 VAC 5-30-20	Amended	23:23 VA.R. 3872	7/1/07
5 VAC 5-30-30	Amended	23:23 VA.R. 3873	7/1/07
5 VAC 5-30-40	Amended	23:23 VA.R. 3873	7/1/07
5 VAC 5-30-50	Amended	23:23 VA.R. 3874	7/1/07
5 VAC 5-30-60	Amended	23:23 VA.R. 3874	7/1/07
5 VAC 5-30-70	Amended	23:23 VA.R. 3875	7/1/07
Title 6. Criminal Justice and Corrections			
6 VAC 15-20-10 through 6 VAC 15-20-230	Amended	23:22 VA.R. 3697-3703	8/9/07
6 VAC 15-61-10 through 6 VAC 15-61-300	Repealed	24:8 VA.R. 970	1/24/08
6 VAC 15-62-10 through 6 VAC 15-62-120	Added	24:8 VA.R. 970-979	1/24/08
6 VAC 15-62 (Forms)	Amended	24:12 VA.R. 1523	--
6 VAC 20-120-40	Amended	23:25 VA.R. 4177	9/19/07
6 VAC 35-20-37 emer	Amended	23:25 VA.R. 4178	8/1/07-7/31/08
6 VAC 35-180-10 through 6 VAC 35-180-170	Added	24:5 VA.R. 557-561	1/1/08
6 VAC 35-190-10 through 6 VAC 35-190-110	Added	24:2 VA.R. 137-139	10/31/07
6 VAC 40-50-10 through 6 VAC 40-50-80 emer	Added	23:23 VA.R. 3876	7/1/06-12/29/07
6 VAC 40-50-10 through 6 VAC 40-50-80	Added	24:9 VA.R. 1103-1104	2/6/08
Title 8. Education			
8 VAC 20-21-10 through 8 VAC 20-21-730	Repealed	23:25 VA.R. 4179	9/21/07
8 VAC 20-22-10 through 8 VAC 20-22-760	Added	23:25 VA.R. 4179-4214	9/21/07
8 VAC 20-160-10	Amended	23:23 VA.R. 3876	8/27/07
8 VAC 20-160-20	Amended	23:23 VA.R. 3878	8/27/07

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
8 VAC 20-160-30	Amended	23:23 VA.R. 3878	8/27/07
8 VAC 20-160-40	Amended	23:23 VA.R. 3879	8/27/07
8 VAC 20-160-50	Amended	23:23 VA.R. 3879	8/27/07
8 VAC 20-160-60	Amended	23:23 VA.R. 3879	8/27/07
8 VAC 20-190-10	Repealed	24:5 VA.R. 562	1/1/08
8 VAC 20-500-10	Repealed	24:5 VA.R. 563	1/1/08
8 VAC 20-541-10 through 8 VAC 20-541-60	Repealed	23:25 VA.R. 4214	9/21/07
8 VAC 20-542-10 through 8 VAC 20-542-600	Added	23:25 VA.R. 4214-4270	9/21/07
8 VAC 35-60-10	Added	24:1 VA.R. 25	8/28/07
8 VAC 35-60-20	Added	24:1 VA.R. 25	8/28/07
8 VAC 35-60-30	Added	24:1 VA.R. 25	8/28/07
8 VAC 40-140-10 through 8 VAC 40-140-90	Added	23:22 VA.R. 3704-3706	7/1/07
Title 9. Environment			
9 VAC 5-20-203	Amended	24:5 VA.R. 564	12/12/07
9 VAC 5-20-204	Amended	24:5 VA.R. 565	12/12/07
9 VAC 5-40-20	Amended	24:5 VA.R. 566	12/12/07
9 VAC 5-50-20	Amended	24:5 VA.R. 570	12/12/07
9 VAC 5-50-400	Amended	24:5 VA.R. 573	12/12/07
9 VAC 5-50-410	Amended	24:5 VA.R. 573	12/12/07
9 VAC 5-60-60	Amended	24:5 VA.R. 579	12/12/07
9 VAC 5-60-90	Amended	24:5 VA.R. 579	12/12/07
9 VAC 5-60-92	Added	24:5 VA.R. 579	12/12/07
9 VAC 5-60-95	Amended	24:5 VA.R. 579	12/12/07
9 VAC 5-60-100	Amended	24:5 VA.R. 580	12/12/07
9 VAC 5-91-20	Amended	24:5 VA.R. 587	12/12/07
9 VAC 5-140-1061	Added	24:6 VA.R. 679	12/26/07
9 VAC 5-140-1062	Added	24:6 VA.R. 680	12/26/07
9 VAC 5-140-2061	Added	24:6 VA.R. 681	12/26/07
9 VAC 5-140-2062	Added	24:6 VA.R. 682	12/26/07
9 VAC 5-140-3061	Added	24:6 VA.R. 683	12/26/07
9 VAC 5-140-3062	Added	24:6 VA.R. 683	12/26/07
9 VAC 5-140-3400	Amended	24:5 VA.R. 594	12/12/07
9 VAC 20-60-18	Amended	24:9 VA.R. 1106	2/6/08
9 VAC 20-130-10	Amended	24:4 VA.R. 480	11/28/07
9 VAC 20-130-40	Amended	24:4 VA.R. 484	11/28/07
9 VAC 20-130-60	Amended	24:4 VA.R. 484	11/28/07
9 VAC 20-130-70	Amended	24:4 VA.R. 484	11/28/07
9 VAC 20-130-90	Amended	24:4 VA.R. 485	11/28/07
9 VAC 20-130-110	Amended	24:4 VA.R. 485	11/28/07
9 VAC 20-130-120	Amended	24:4 VA.R. 486	11/28/07
9 VAC 20-130-120	Erratum	24:6 VA.R. 889	--
9 VAC 20-130-125	Added	24:4 VA.R. 488	11/28/07
9 VAC 20-130-125	Erratum	24:6 VA.R. 889	--
9 VAC 20-130-130	Amended	24:4 VA.R. 489	11/28/07
9 VAC 20-130-140	Repealed	24:4 VA.R. 489	11/28/07
9 VAC 20-130-150	Repealed	24:4 VA.R. 489	11/28/07
9 VAC 20-130-165	Amended	24:4 VA.R. 489	11/28/07
9 VAC 20-130-175 through 9 VAC 20-130-230	Amended	24:4 VA.R. 490-493	11/28/07
9 VAC 20-130-200	Erratum	24:6 VA.R. 889	--
9 VAC 25-20-10	Amended	24:6 VA.R. 701	1/1/08
9 VAC 25-20-20	Amended	24:6 VA.R. 702	1/1/08

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
9 VAC 25-20-30	Repealed	24:6 VA.R. 702	1/1/08
9 VAC 25-20-40	Amended	24:6 VA.R. 702	1/1/08
9 VAC 25-20-50	Amended	24:6 VA.R. 703	1/1/08
9 VAC 25-20-60	Amended	24:6 VA.R. 703	1/1/08
9 VAC 25-20-90	Amended	24:6 VA.R. 704	1/1/08
9 VAC 25-20-100	Amended	24:6 VA.R. 704	1/1/08
9 VAC 25-20-110	Amended	24:6 VA.R. 705	1/1/08
9 VAC 25-20-120	Amended	24:6 VA.R. 706	1/1/08
9 VAC 25-20-130	Amended	24:6 VA.R. 708	1/1/08
9 VAC 25-20-146	Added	24:6 VA.R. 708	1/1/08
9 VAC 25-20-147	Added	24:6 VA.R. 709	1/1/08
9 VAC 25-20-148	Added	24:6 VA.R. 709	1/1/08
9 VAC 25-20-149	Added	24:6 VA.R. 709	1/1/08
9 VAC 25-31-100	Amended	24:3 VA.R. 313	11/14/07
9 VAC 25-31-100	Amended	24:6 VA.R. 711	1/1/08
9 VAC 25-31-120	Amended	24:3 VA.R. 309	11/14/07
9 VAC 25-31-165	Amended	24:3 VA.R. 333	11/14/07
9 VAC 25-31-220	Amended	24:6 VA.R. 731	1/1/08
9 VAC 25-31-290	Amended	24:6 VA.R. 735	1/1/08
9 VAC 25-31-460	Amended	24:6 VA.R. 738	1/1/08
9 VAC 25-31-475	Added	24:6 VA.R. 738	1/1/08
9 VAC 25-31-485	Added	24:6 VA.R. 738	1/1/08
9 VAC 25-31-505	Added	24:6 VA.R. 739	1/1/08
9 VAC 25-32 (Forms)	Amended	24:11 VA.R. 1316	--
9 VAC 25-32-40	Amended	24:6 VA.R. 739	1/1/08
9 VAC 25-32-60	Amended	24:6 VA.R. 739	1/1/08
9 VAC 25-32-80	Amended	24:6 VA.R. 740	1/1/08
9 VAC 25-32-100	Amended	24:6 VA.R. 743	1/1/08
9 VAC 25-32-140	Amended	24:6 VA.R. 743	1/1/08
9 VAC 25-32-210	Amended	24:6 VA.R. 744	1/1/08
9 VAC 25-32-220	Amended	24:6 VA.R. 745	1/1/08
9 VAC 25-32-240	Amended	24:6 VA.R. 745	1/1/08
9 VAC 25-32-300	Amended	24:6 VA.R. 745	1/1/08
9 VAC 25-32-310 through 9 VAC 25-32-760	Added	24:6 VA.R. 746-781	1/1/08
9 VAC 25-120-10	Amended	24:9 VA.R. 1107	2/6/08
9 VAC 25-120-20	Amended	24:9 VA.R. 1107	2/6/08
9 VAC 25-120-50	Amended	24:9 VA.R. 1108	2/6/08
9 VAC 25-120-60	Amended	24:9 VA.R. 1108	2/6/08
9 VAC 25-120-70	Amended	24:9 VA.R. 1108	2/6/08
9 VAC 25-120-80	Amended	24:9 VA.R. 1109	2/6/08
9 VAC 25-196-20	Amended	24:9 VA.R. 1124	2/6/08
9 VAC 25-196-40	Amended	24:9 VA.R. 1124	2/6/08
9 VAC 25-196-60	Amended	24:9 VA.R. 1124	2/6/08
9 VAC 25-196-70	Amended	24:9 VA.R. 1125	2/6/08
9 VAC 25-210-10	Amended	24:9 VA.R. 1132	2/6/08
9 VAC 25-210-60	Amended	24:9 VA.R. 1136	2/6/08
9 VAC 25-210-116	Amended	24:9 VA.R. 1140	2/6/08
9 VAC 25-210-130	Amended	24:9 VA.R. 1142	2/6/08
9 VAC 25-260-5	Amended	24:4 VA.R. 536	8/14/07
9 VAC 25-260-30	Amended	24:2 VA.R. 139	9/11/07

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SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
9 VAC 25-260-30	Amended	24:2 VA.R. 140	9/11/07
9 VAC 25-260-30	Amended	24:7 VA.R. 908	**
9 VAC 25-260-50	Amended	24:4 VA.R. 536	8/14/07
9 VAC 25-260-187	Added	24:4 VA.R. 536	8/14/07
9 VAC 25-260-310	Amended	24:4 VA.R. 536	8/14/07
9 VAC 25-260-480	Amended	24:4 VA.R. 536	8/14/07
9 VAC 25-660-10	Amended	24:9 VA.R. 1144	2/6/08
9 VAC 25-660-60	Amended	24:9 VA.R. 1145	2/6/08
9 VAC 25-660-70	Amended	24:9 VA.R. 1147	2/6/08
9 VAC 25-660-80	Amended	24:9 VA.R. 1148	2/6/08
9 VAC 25-660-100	Amended	24:9 VA.R. 1148	2/6/08
9 VAC 25-670-10	Amended	24:9 VA.R. 1156	2/6/08
9 VAC 25-670-70	Amended	24:9 VA.R. 1157	2/6/08
9 VAC 25-670-80	Amended	24:9 VA.R. 1158	2/6/08
9 VAC 25-670-100	Amended	24:9 VA.R. 1159	2/6/08
9 VAC 25-680-10	Amended	24:9 VA.R. 1170	2/6/08
9 VAC 25-680-60	Amended	24:9 VA.R. 1172	2/6/08
9 VAC 25-680-70	Amended	24:9 VA.R. 1174	2/6/08
9 VAC 25-680-80	Amended	24:9 VA.R. 1175	2/6/08
9 VAC 25-680-100	Amended	24:9 VA.R. 1176	2/6/08
9 VAC 25-690-10	Amended	24:9 VA.R. 1188	2/6/08
9 VAC 25-690-70	Amended	24:9 VA.R. 1190	2/6/08
9 VAC 25-690-80	Amended	24:9 VA.R. 1191	2/6/08
9 VAC 25-690-100	Amended	24:9 VA.R. 1191	2/6/08
9 VAC 25-720-50	Amended	23:23 VA.R. 3881	10/22/07
9 VAC 25-720-50	Amended	23:23 VA.R. 3888	10/22/07
9 VAC 25-720-50	Amended	23:23 VA.R. 3895	10/22/07
9 VAC 25-720-50	Amended	24:2 VA.R. 140	11/15/07
9 VAC 25-720-80	Amended	23:23 VA.R. 3901	10/22/07
9 VAC 25-720-90	Amended	24:2 VA.R. 147	11/15/07
9 VAC 25-790-10	Amended	24:6 VA.R. 784	1/1/08
9 VAC 25-790-50	Amended	24:6 VA.R. 787	1/1/08
9 VAC 25-790-60	Amended	24:6 VA.R. 787	1/1/08
9 VAC 25-790-120	Amended	24:6 VA.R. 788	1/1/08
9 VAC 25-790-130	Amended	24:6 VA.R. 790	1/1/08
9 VAC 25-790-150	Amended	24:6 VA.R. 790	1/1/08
9 VAC 25-790-180	Amended	24:6 VA.R. 791	1/1/08
9 VAC 25-790-200	Amended	24:6 VA.R. 791	1/1/08
9 VAC 25-790-240	Amended	24:6 VA.R. 791	1/1/08
9 VAC 25-790-540	Amended	24:6 VA.R. 792	1/1/08
9 VAC 25-790-550	Amended	24:6 VA.R. 792	1/1/08
9 VAC 25-790-570	Amended	24:6 VA.R. 795	1/1/08
9 VAC 25-790-580	Amended	24:6 VA.R. 797	1/1/08
9 VAC 25-790-590	Amended	24:6 VA.R. 797	1/1/08
9 VAC 25-790-600	Amended	24:6 VA.R. 798	1/1/08
9 VAC 25-790-660	Amended	24:6 VA.R. 799	1/1/08
9 VAC 25-790-880	Amended	24:6 VA.R. 799	1/1/08
Title 11. Gaming			
11 VAC 10-45-10	Amended	24:5 VA.R. 595	12/12/07

** Effective upon filing notice of U.S. EPA approval with Registrar.

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
11 VAC 10-45-25	Added	24:5 VA.R. 596	12/12/07
Title 12. Health			
12 VAC 5-31-2300 through 12 VAC 5-31-2970	Added	24:6 VA.R. 806-818	1/1/08
12 VAC 5-40-10 through 12 VAC 5-40-190	Repealed	24:6 VA.R. 806	1/1/08
12 VAC 5-90-80 emer	Amended	24:5 VA.R. 597	10/24/07-10/23/08
12 VAC 5-125-10 through 12 VAC 5-125-180	Added	23:23 VA.R. 3904-3919	9/1/07
12 VAC 5-220-10	Amended	24:11 VA.R. 1350	3/5/08
12 VAC 5-220-110	Amended	24:11 VA.R. 1353	3/5/08
12 VAC 5-220-130	Amended	24:11 VA.R. 1354	3/5/08
12 VAC 5-220-200	Amended	24:11 VA.R. 1354	3/5/08
12 VAC 5-371-150	Amended	24:11 VA.R. 1357	3/5/08
12 VAC 5-381-10 through 12VAC5-381-40	Amended	24:11 VA.R. 1358-1361	3/5/08
12 VAC 5-381-60 through 12VAC5-381-100	Amended	24:11 VA.R. 1361-1362	3/5/08
12 VAC 5-381-120	Amended	24:11 VA.R. 1362	3/5/08
12 VAC 5-381-140	Amended	24:11 VA.R. 1362	3/5/08
12 VAC 5-381-150	Amended	24:11 VA.R. 1362	3/5/08
12 VAC 5-381-240	Amended	24:11 VA.R. 1363	3/5/08
12 VAC 5-381-280	Amended	24:11 VA.R. 1363	3/5/08
12 VAC 5-391-10	Amended	24:11 VA.R. 1364	3/5/08
12 VAC 5-391-30 through 12 VAC 5-391-100	Amended	24:11 VA.R. 1366-1368	3/5/08
12 VAC 5-391-120	Amended	24:11 VA.R. 1368	3/5/08
12 VAC 5-391-130	Amended	24:11 VA.R. 1368	3/5/08
12 VAC 5-391-150	Amended	24:11 VA.R. 1369	3/5/08
12 VAC 5-391-160	Amended	24:11 VA.R. 1369	3/5/08
12 VAC 5-391-250	Amended	24:11 VA.R. 1370	3/5/08
12 VAC 5-391-280	Amended	24:11 VA.R. 1370	3/5/08
12 VAC 5-410-230	Amended	24:11 VA.R. 1371	3/5/08
12 VAC 5-421-10	Amended	24:2 VA.R. 149	10/16/07
12 VAC 5-421-90	Amended	24:2 VA.R. 157	10/16/07
12 VAC 5-421-100	Amended	24:2 VA.R. 157	10/16/07
12 VAC 5-421-120	Amended	24:2 VA.R. 158	10/16/07
12 VAC 5-421-140	Amended	24:2 VA.R. 158	10/16/07
12 VAC 5-421-160	Amended	24:2 VA.R. 159	10/16/07
12 VAC 5-421-170	Amended	24:2 VA.R. 159	10/16/07
12 VAC 5-421-180	Amended	24:2 VA.R. 159	10/16/07
12 VAC 5-421-190	Amended	24:2 VA.R. 159	10/16/07
12 VAC 5-421-200	Amended	24:2 VA.R. 160	10/16/07
12 VAC 5-421-230	Amended	24:2 VA.R. 160	10/16/07
12 VAC 5-421-250	Amended	24:2 VA.R. 160	10/16/07
12 VAC 5-421-270	Amended	24:2 VA.R. 160	10/16/07
12 VAC 5-421-295	Added	24:2 VA.R. 160	10/16/07
12 VAC 5-421-300	Amended	24:2 VA.R. 160	10/16/07
12 VAC 5-421-330	Amended	24:2 VA.R. 161	10/16/07
12 VAC 5-421-340	Amended	24:2 VA.R. 161	10/16/07
12 VAC 5-421-350	Amended	24:2 VA.R. 161	10/16/07
12 VAC 5-421-360	Amended	24:2 VA.R. 161	10/16/07
12 VAC 5-421-430	Amended	24:2 VA.R. 162	10/16/07
12 VAC 5-421-440	Amended	24:2 VA.R. 162	10/16/07
12 VAC 5-421-450	Amended	24:2 VA.R. 162	10/16/07
12 VAC 5-421-460	Added	24:2 VA.R. 162	10/16/07

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SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
12 VAC 5-421-500	Amended	24:2 VA.R. 162	10/16/07
12 VAC 5-421-520	Amended	24:2 VA.R. 163	10/16/07
12 VAC 5-421-530	Amended	24:2 VA.R. 163	10/16/07
12 VAC 5-421-550	Amended	24:2 VA.R. 163	10/16/07
12 VAC 5-421-560	Amended	24:2 VA.R. 163	10/16/07
12 VAC 5-421-570	Amended	24:2 VA.R. 163	10/16/07
12 VAC 5-421-580	Amended	24:2 VA.R. 163	10/16/07
12 VAC 5-421-590	Amended	24:2 VA.R. 164	10/16/07
12 VAC 5-421-600	Amended	24:2 VA.R. 164	10/16/07
12 VAC 5-421-620	Amended	24:2 VA.R. 164	10/16/07
12 VAC 5-421-670	Amended	24:2 VA.R. 164	10/16/07
12 VAC 5-421-680	Amended	24:2 VA.R. 164	10/16/07
12 VAC 5-421-700	Amended	24:2 VA.R. 164	10/16/07
12 VAC 5-421-720	Amended	24:2 VA.R. 166	10/16/07
12 VAC 5-421-760	Amended	24:2 VA.R. 166	10/16/07
12 VAC 5-421-765	Added	24:2 VA.R. 166	10/16/07
12 VAC 5-421-780	Amended	24:2 VA.R. 166	10/16/07
12 VAC 5-421-790	Amended	24:2 VA.R. 166	10/16/07
12 VAC 5-421-800	Amended	24:2 VA.R. 167	10/16/07
12 VAC 5-421-820	Amended	24:2 VA.R. 167	10/16/07
12 VAC 5-421-830	Amended	24:2 VA.R. 167	10/16/07
12 VAC 5-421-840	Amended	24:2 VA.R. 169	10/16/07
12 VAC 5-421-850	Amended	24:2 VA.R. 169	10/16/07
12 VAC 5-421-860	Amended	24:2 VA.R. 170	10/16/07
12 VAC 5-421-870	Amended	24:2 VA.R. 170	10/16/07
12 VAC 5-421-880	Added	24:2 VA.R. 171	10/16/07
12 VAC 5-421-890	Added	24:2 VA.R. 171	10/16/07
12 VAC 5-421-900	Added	24:2 VA.R. 171	10/16/07
12 VAC 5-421-910	Added	24:2 VA.R. 171	10/16/07
12 VAC 5-421-920	Added	24:2 VA.R. 171	10/16/07
12 VAC 5-421-930	Added	24:2 VA.R. 171	10/16/07
12 VAC 5-421-940	Amended	24:2 VA.R. 172	10/16/07
12 VAC 5-421-950	Amended	24:2 VA.R. 172	10/16/07
12 VAC 5-421-960	Amended	24:2 VA.R. 173	10/16/07
12 VAC 5-421-970	Amended	24:2 VA.R. 173	10/16/07
12 VAC 5-421-990	Amended	24:2 VA.R. 173	10/16/07
12 VAC 5-421-1000	Amended	24:2 VA.R. 173	10/16/07
12 VAC 5-421-1010	Amended	24:2 VA.R. 173	10/16/07
12 VAC 5-421-1020	Amended	24:2 VA.R. 173	10/16/07
12 VAC 5-421-1030	Amended	24:2 VA.R. 173	10/16/07
12 VAC 5-421-1040	Amended	24:2 VA.R. 173	10/16/07
12 VAC 5-421-1070	Amended	24:2 VA.R. 174	10/16/07
12 VAC 5-421-1090	Amended	24:2 VA.R. 174	10/16/07
12 VAC 5-421-1120	Amended	24:2 VA.R. 174	10/16/07
12 VAC 5-421-1200	Amended	24:2 VA.R. 174	10/16/07
12 VAC 5-421-1260	Amended	24:2 VA.R. 174	10/16/07
12 VAC 5-421-1270	Amended	24:2 VA.R. 174	10/16/07
12 VAC 5-421-1300	Amended	24:2 VA.R. 174	10/16/07
12 VAC 5-421-1310	Amended	24:2 VA.R. 174	10/16/07
12 VAC 5-421-1320	Amended	24:2 VA.R. 175	10/16/07
12 VAC 5-421-1330	Amended	24:2 VA.R. 175	10/16/07

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SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
12 VAC 5-421-1340	Amended	24:2 VA.R. 175	10/16/07
12 VAC 5-421-1350	Amended	24:2 VA.R. 175	10/16/07
12 VAC 5-421-1360	Amended	24:2 VA.R. 175	10/16/07
12 VAC 5-421-1370	Amended	24:2 VA.R. 176	10/16/07
12 VAC 5-421-1460	Amended	24:2 VA.R. 176	10/16/07
12 VAC 5-421-1510	Amended	24:2 VA.R. 176	10/16/07
12 VAC 5-421-1520	Amended	24:2 VA.R. 176	10/16/07
12 VAC 5-421-1530	Amended	24:2 VA.R. 177	10/16/07
12 VAC 5-421-1540	Amended	24:2 VA.R. 177	10/16/07
12 VAC 5-421-1620	Amended	24:2 VA.R. 177	10/16/07
12 VAC 5-421-1640	Amended	24:2 VA.R. 177	10/16/07
12 VAC 5-421-1660	Amended	24:2 VA.R. 177	10/16/07
12 VAC 5-421-1670	Amended	24:2 VA.R. 178	10/16/07
12 VAC 5-421-1680	Amended	24:2 VA.R. 178	10/16/07
12 VAC 5-421-1690	Amended	24:2 VA.R. 178	10/16/07
12 VAC 5-421-1700	Amended	24:2 VA.R. 178	10/16/07
12 VAC 5-421-1710	Amended	24:2 VA.R. 179	10/16/07
12 VAC 5-421-1720	Amended	24:2 VA.R. 179	10/16/07
12 VAC 5-421-1730	Amended	24:2 VA.R. 179	10/16/07
12 VAC 5-421-1750	Amended	24:2 VA.R. 179	10/16/07
12 VAC 5-421-1760	Amended	24:2 VA.R. 179	10/16/07
12 VAC 5-421-1780	Amended	24:2 VA.R. 179	10/16/07
12 VAC 5-421-1810	Amended	24:2 VA.R. 180	10/16/07
12 VAC 5-421-1820	Amended	24:2 VA.R. 180	10/16/07
12 VAC 5-421-1880	Amended	24:2 VA.R. 180	10/16/07
12 VAC 5-421-1890	Amended	24:2 VA.R. 180	10/16/07
12 VAC 5-421-1900	Amended	24:2 VA.R. 180	10/16/07
12 VAC 5-421-1960	Amended	24:2 VA.R. 181	10/16/07
12 VAC 5-421-2010	Amended	24:2 VA.R. 181	10/16/07
12 VAC 5-421-2080	Amended	24:2 VA.R. 181	10/16/07
12 VAC 5-421-2190	Amended	24:2 VA.R. 181	10/16/07
12 VAC 5-421-2200	Amended	24:2 VA.R. 181	10/16/07
12 VAC 5-421-2210	Amended	24:2 VA.R. 181	10/16/07
12 VAC 5-421-2270	Amended	24:2 VA.R. 181	10/16/07
12 VAC 5-421-2310	Amended	24:2 VA.R. 182	10/16/07
12 VAC 5-421-2320	Amended	24:2 VA.R. 182	10/16/07
12 VAC 5-421-2520	Amended	24:2 VA.R. 182	10/16/07
12 VAC 5-421-2630	Amended	24:2 VA.R. 182	10/16/07
12 VAC 5-421-2680	Amended	24:2 VA.R. 182	10/16/07
12 VAC 5-421-2710	Amended	24:2 VA.R. 182	10/16/07
12 VAC 5-421-2790	Amended	24:2 VA.R. 182	10/16/07
12 VAC 5-421-2810	Amended	24:2 VA.R. 182	10/16/07
12 VAC 5-421-2820	Amended	24:2 VA.R. 183	10/16/07
12 VAC 5-421-2840	Amended	24:2 VA.R. 183	10/16/07
12 VAC 5-421-2850	Amended	24:2 VA.R. 183	10/16/07
12 VAC 5-421-2870	Amended	24:2 VA.R. 183	10/16/07
12 VAC 5-421-2880	Amended	24:2 VA.R. 183	10/16/07
12 VAC 5-421-2930	Amended	24:2 VA.R. 183	10/16/07
12 VAC 5-421-2990	Amended	24:2 VA.R. 184	10/16/07
12 VAC 5-421-3040	Amended	24:2 VA.R. 184	10/16/07

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SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
12 VAC 5-421-3120	Amended	24:2 VA.R. 184	10/16/07
12 VAC 5-421-3200	Amended	24:2 VA.R. 184	10/16/07
12 VAC 5-421-3210	Amended	24:2 VA.R. 184	10/16/07
12 VAC 5-421-3230	Amended	24:2 VA.R. 184	10/16/07
12 VAC 5-421-3310	Amended	24:2 VA.R. 184	10/16/07
12 VAC 5-421-3370	Amended	24:2 VA.R. 185	10/16/07
12 VAC 5-421-3380	Amended	24:2 VA.R. 185	10/16/07
12 VAC 5-421-3450	Amended	24:2 VA.R. 185	10/16/07
12 VAC 5-421-3510	Amended	24:2 VA.R. 185	10/16/07
12 VAC 5-421-3560	Amended	24:2 VA.R. 185	10/16/07
12 VAC 5-421-3580	Amended	24:2 VA.R. 185	10/16/07
12 VAC 5-421-3590	Amended	24:2 VA.R. 186	10/16/07
12 VAC 5-421-3620	Amended	24:2 VA.R. 186	10/16/07
12 VAC 5-421-3660	Amended	24:2 VA.R. 186	10/16/07
12 VAC 5-421-3700	Amended	24:2 VA.R. 186	10/16/07
12 VAC 5-421-3750	Amended	24:2 VA.R. 187	10/16/07
12 VAC 5-421-3760	Amended	24:2 VA.R. 188	10/16/07
12 VAC 5-421-3800	Amended	24:2 VA.R. 188	10/16/07
12 VAC 5-421-3815	Added	24:2 VA.R. 188	10/16/07
12 VAC 5-421-3860	Amended	24:2 VA.R. 188	10/16/07
12 VAC 5-421-3900	Amended	24:2 VA.R. 188	10/16/07
12 VAC 5-421-3960	Amended	24:2 VA.R. 189	10/16/07
12 VAC 5-421-3970	Amended	24:2 VA.R. 189	10/16/07
12 VAC 5-421-4000	Amended	24:2 VA.R. 189	10/16/07
12 VAC 5-421-4035	Added	24:2 VA.R. 190	10/16/07
12 VAC 5-421-4050	Amended	24:2 VA.R. 191	10/16/07
12 VAC 5-421-4070	Amended	24:2 VA.R. 191	10/16/07
12 VAC 5-585-70	Amended	24:5 VA.R. 602	12/17/07
12 VAC 5-585-510	Amended	24:5 VA.R. 602	12/17/07
12 VAC 5-585-600	Amended	24:5 VA.R. 607	12/17/07
12 VAC 5-585-610	Amended	24:5 VA.R. 607	12/17/07
12 VAC 5-585-620	Amended	24:5 VA.R. 612	12/17/07
12 VAC 5-585-630	Amended	24:5 VA.R. 614	12/17/07
12 VAC 5-585-760 through 12 VAC 5-585-830	Added	23:25 VA.R. 4298-4301	10/1/07
12 VAC 30-10-820	Added	24:2 VA.R. 191	10/31/07
12 VAC 30-60-500 emer	Added	23:26 VA.R. 4427	8/8/07-8/7/08
12 VAC 30-80-40 emer	Amended	24:3 VA.R. 377	10/1/07-9/30/08
12 VAC 30-120	Erratum	23:24 VA.R. 4080	--
12 VAC 30-120-370 emer	Amended	23:24 VA.R. 4029	9/1/07-8/31/08
12 VAC 30-120-380 emer	Amended	23:24 VA.R. 4032	9/1/07-8/31/08
12 VAC 30-120-1500 through 12 VAC 30-120-1550	Added	24:6 VA.R. 819-829	12/26/07
12 VAC 30-135-100 through 12 VAC 30-135-360	Added	24:2 VA.R. 196-218	12/1/07
12 VAC 35-105-115	Added	24:11 VA.R. 1372	3/5/08
12 VAC 35-115-10 through 12 VAC 35-115-250	Amended	23:25 VA.R. 4301-4340	9/19/07
12 VAC 35-115-90	Erratum	24:6 VA.R. 889	--
12 VAC 35-115-145	Added	23:25 VA.R. 4329	9/19/07
12 VAC 35-115-146	Added	23:25 VA.R. 4330	9/19/07
12 VAC 35-115-160	Repealed	23:25 VA.R. 4332	9/19/07
Title 13. Housing			
13 VAC 5-31	Erratum	23:24 VA.R. 4079	--
13 VAC 5-91	Erratum	23:24 VA.R. 4080	--

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SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
13 VAC 5-112-340	Amended	24:8 VA.R. 979	1/23/08
13 VAC 10-40-20	Amended	24:7 VA.R. 911	11/13/07
13 VAC 10-40-60	Amended	24:7 VA.R. 914	11/13/07
13 VAC 10-40-80	Amended	24:7 VA.R. 915	11/13/07
13 VAC 10-40-100	Amended	24:7 VA.R. 916	11/13/07
13 VAC 10-40-110	Amended	24:7 VA.R. 917	11/13/07
13 VAC 10-40-120	Amended	24:7 VA.R. 917	11/13/07
13 VAC 10-40-130	Amended	24:7 VA.R. 917	11/13/07
13 VAC 10-40-170	Amended	24:7 VA.R. 920	11/13/07
13 VAC 10-40-190	Amended	24:7 VA.R. 920	11/13/07
13 VAC 10-40-210	Amended	24:7 VA.R. 921	11/13/07
13 VAC 10-40-230	Amended	24:7 VA.R. 921	11/13/07
13 VAC 10-180-10	Amended	24:11 VA.R. 1373	2/4/08
13 VAC 10-180-50	Amended	24:11 VA.R. 1374	2/4/08
13 VAC 10-180-60	Amended	24:11 VA.R. 1376	2/4/08
13 VAC 10-180-60	Amended	24:11 VA.R. 1387	2/4/08
13 VAC 10-180-100	Amended	24:11 VA.R. 1397	2/4/08
Title 14. Insurance			
14 VAC 5-215-20	Amended	23:22 VA.R. 3768	7/1/07
14 VAC 5-215-30	Amended	23:22 VA.R. 3768	7/1/07
14 VAC 5-215-50	Amended	23:22 VA.R. 3769	7/1/07
14 VAC 5-215-60	Amended	23:22 VA.R. 3770	7/1/07
14 VAC 5-215-80	Amended	23:22 VA.R. 3770	7/1/07
14 VAC 5-270-10 through 14 VAC 5-270-150	Amended	24:12 VA.R. 1460-1470	1/1/10
14 VAC 5-270-144	Added	24:12 VA.R. 1467	1/1/10
14 VAC 5-270-146	Added	24:12 VA.R. 1468	1/1/10
14 VAC 5-270-148	Added	24:12 VA.R. 1469	1/1/10
14 VAC 5-270-170	Amended	24:12 VA.R. 1470	1/1/10
14 VAC 5-270-174	Added	24:12 VA.R. 1470	1/1/10
14 VAC 5-270-180	Amended	24:12 VA.R. 1470	1/1/10
14 VAC 5-420-10 through 14 VAC 5-420-60	Added	24:7 VA.R. 926-931	2/15/08
Title 16. Labor and Employment			
16 VAC 15-21-30	Amended	23:23 VA.R. 3933	8/23/07
16 VAC 25-90-1910.6	Amended	24:1 VA.R. 26	12/15/07
16 VAC 25-90-1910.66 Appendix D	Amended	24:1 VA.R. 26	12/15/07
16 VAC 25-90-1910.302 through 16 VAC 25-90-1910.308	Amended	24:1 VA.R. 26	12/15/07
16 VAC 25-90-1910.399 Subpart S Appendix A	Amended	24:1 VA.R. 26	12/15/07
Title 18. Professional and Occupational Licensing			
18 VAC 30-20-80	Amended	24:10 VA.R. 1284	2/20/08
18 VAC 30-20-170	Amended	24:10 VA.R. 1284	2/20/08
18 VAC 30-20-171	Amended	24:10 VA.R. 1285	2/20/08
18 VAC 41-70-10 through 18 VAC 41-70-280	Added	23:25 VA.R. 4349-4359	9/20/07
18 VAC 50-30-10	Amended	24:3 VA.R. 416	11/15/07
18 VAC 50-30-40	Amended	24:3 VA.R. 418	11/15/07
18 VAC 50-30-90	Amended	24:3 VA.R. 419	11/15/07
18 VAC 50-30-100	Amended	24:3 VA.R. 419	11/15/07
18 VAC 50-30-120	Amended	24:3 VA.R. 419	11/15/07
18 VAC 50-30-130	Amended	24:3 VA.R. 420	11/15/07
18 VAC 50-30-190	Amended	24:3 VA.R. 421	11/15/07
18 VAC 50-30-200	Amended	24:3 VA.R. 422	11/15/07

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18 VAC 50-30-220	Amended	24:3 VA.R. 422	11/15/07
18 VAC 60-20-17	Amended	24:3 VA.R. 424	11/29/07
18 VAC 60-20-71	Amended	23:23 VA.R. 3934	8/22/07
18 VAC 60-20-220	Amended	24:10 VA.R. 1287	3/10/08
18 VAC 65-10-10 through 18 VAC 65-10-80	Amended	24:2 VA.R. 226-228	11/15/07
18 VAC 65-10-100	Amended	24:2 VA.R. 228	11/15/07
18 VAC 65-10-110	Amended	24:2 VA.R. 228	11/15/07
18 VAC 65-10-120	Amended	24:2 VA.R. 228	11/15/07
18 VAC 85-20-22	Amended	24:11 VA.R. 1404	3/5/08
18 VAC 85-20-140	Amended	24:1 VA.R. 27	10/17/07
18 VAC 85-20-226	Added	24:11 VA.R. 1404	3/5/08
18 VAC 85-20-235	Amended	23:25 VA.R. 4360	9/20/07
18 VAC 85-20-235	Amended	23:25 VA.R. 4361	9/20/07
18 VAC 85-20-290	Amended	23:23 VA.R. 3934	8/22/07
18 VAC 85-20-400 through 18 VAC 85-20-420	Adding	23:25 VA.R. 4362-4363	9/20/07
18 VAC 85-40-35	Amended	24:11 VA.R. 1404	3/5/08
18 VAC 85-40-61	Amended	24:1 VA.R. 28	10/17/07
18 VAC 85-40-61	Amended	24:1 VA.R. 29	10/18/07
18 VAC 85-40-65	Amended	24:1 VA.R. 28	10/17/07
18 VAC 85-40-67	Added	24:11 VA.R. 1405	3/5/08
18 VAC 85-50-35	Amended	24:11 VA.R. 1405	3/5/08
18 VAC 85-50-58	Amended	24:1 VA.R. 29	10/18/07
18 VAC 85-50-61	Added	24:11 VA.R. 1405	3/5/08
18 VAC 85-80-26	Amended	24:11 VA.R. 1406	3/5/08
18 VAC 85-80-72	Amended	24:1 VA.R. 29	10/18/07
18 VAC 85-80-73	Added	24:11 VA.R. 1406	3/5/08
18 VAC 85-101-25	Amended	24:11 VA.R. 1406	3/5/08
18 VAC 85-101-152	Amended	24:1 VA.R. 30	10/18/07
18 VAC 85-101-153	Added	24:11 VA.R. 1407	3/5/08
18 VAC 85-110-35	Amended	24:11 VA.R. 1407	3/5/08
18 VAC 85-110-155	Amended	24:1 VA.R. 30	10/18/07
18 VAC 85-110-161	Added	24:11 VA.R. 1407	3/5/08
18 VAC 85-120-130	Amended	24:2 VA.R. 229	10/31/07
18 VAC 90-20-30	Amended	23:25 VA.R. 4363	10/1/07
18 VAC 90-20-225	Added	23:25 VA.R. 4364	10/1/07
18 VAC 90-30-10	Amended	24:10 VA.R. 1288	2/20/08
18 VAC 90-30-120	Amended	24:10 VA.R. 1288	2/20/08
18 VAC 90-30-121	Added	24:10 VA.R. 1289	2/20/08
18 VAC 90-30-240	Added	24:3 VA.R. 427	11/29/07
18 VAC 90-40-100	Amended	24:6 VA.R. 831	1/11/08
18 VAC 90-60-100	Amended	24:3 VA.R. 429	11/29/07
18 VAC 95-10-10 through 18 VAC 95-10-80	Amended	24:2 VA.R. 231-232	11/15/07
18 VAC 95-10-100	Amended	24:2 VA.R. 232	11/15/07
18 VAC 95-10-110	Amended	24:2 VA.R. 232	11/15/07
18 VAC 95-10-120	Amended	24:2 VA.R. 232	11/15/07
18 VAC 95-30-10 through 18 VAC 95-30-210	Added	24:6 VA.R. 832-837	1/2/08
18 VAC 105-20-10	Amended	23:22 VA.R. 3791	9/24/07
18 VAC 110-20-10	Amended	24:8 VA.R. 983	1/23/08
18 VAC 110-20-180	Erratum	24:3 VA.R. 444	--
18 VAC 110-20-321	Added	24:8 VA.R. 986	1/23/08
18 VAC 110-20-411 through 18 VAC 110-20-416	Repealed	24:8 VA.R. 986-987	1/23/08

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18 VAC 110-30-15	Amended	24:10 VA.R. 1290	2/20/08
18 VAC 110-40-10 through 18 VAC 110-40-50	Amended	24:3 VA.R. 430-431	11/14/07
18 VAC 110-50-10	Amended	24:10 VA.R. 1290	2/20/08
18 VAC 110-50-160	Added	24:10 VA.R. 1291	2/20/08
18 VAC 110-50-170	Added	24:10 VA.R. 1291	2/20/08
18 VAC 110-50-180	Added	24:10 VA.R. 1292	2/20/08
18 VAC 110-50-190	Added	24:10 VA.R. 1292	2/20/08
18 VAC 112-20-81 emer	Added	24:4 VA.R. 497	11/1/07-10/31/08
18 VAC 112-20-90 emer	Amended	24:4 VA.R. 497	11/1/07-10/31/08
18 VAC 112-20-130 emer	Amended	24:4 VA.R. 498	11/1/07-10/31/08
18 VAC 112-20-131 emer	Amended	24:4 VA.R. 498	11/1/07-10/31/08
18 VAC 112-20-150 emer	Amended	24:4 VA.R. 499	11/1/07-10/31/08
18 VAC 120-40-10	Amended	23:24 VA.R. 4038	9/5/07
18 VAC 120-40-15	Added	23:24 VA.R. 4039	9/5/07
18 VAC 120-40-20	Amended	23:24 VA.R. 4039	9/5/07
18 VAC 120-40-60	Repealed	24:3 VA.R. 433	12/29/07
18 VAC 120-40-80 through 18 VAC 120-40-360	Amended	23:24 VA.R. 4040-4052	9/5/07
18 VAC 120-40-221	Added	23:24 VA.R. 4043	9/5/07
18 VAC 120-40-222	Added	23:24 VA.R. 4043	9/5/07
18 VAC 120-40-295	Added	23:24 VA.R. 4048	9/5/07
18 VAC 120-40-342	Added	23:24 VA.R. 4050	9/5/07
18 VAC 120-40-370	Repealed	23:24 VA.R. 4052	9/5/07
18 VAC 120-40-380	Repealed	23:24 VA.R. 4052	9/5/07
18 VAC 120-40-385	Added	23:24 VA.R. 4052	9/5/07
18 VAC 120-40-390	Amended	23:24 VA.R. 4053	9/5/07
18 VAC 120-40-400	Repealed	23:24 VA.R. 4053	9/5/07
18 VAC 120-40-410	Amended	23:24 VA.R. 4053	9/5/07
18 VAC 120-40-411	Added	23:24 VA.R. 4053	9/5/07
18 VAC 120-40-411.1 through 18 VAC 120-40-411.21	Added	23:24 VA.R. 4054-4064	9/5/07
18 VAC 120-40-415	Added	23:24 VA.R. 4064	9/5/07
18 VAC 120-40-415.1	Added	23:24 VA.R. 4065	9/5/07
18 VAC 120-40-415.2	Added	23:24 VA.R. 4065	9/5/07
18 VAC 120-40-415.3	Added	23:24 VA.R. 4065	9/5/07
18 VAC 120-40-420	Amended	23:24 VA.R. 4066	9/5/07
18 VAC 120-40-430	Amended	23:24 VA.R. 4066	9/5/07
18 VAC 125-20-170	Amended	24:12 VA.R. 1471	3/19/08
18 VAC 125-30-120	Amended	24:12 VA.R. 1471	3/19/08
18 VAC 130-20-10	Amended	24:6 VA.R. 838	1/1/08
18 VAC 130-20-30	Amended	24:6 VA.R. 842	1/1/08
18 VAC 130-20-60	Amended	24:6 VA.R. 843	1/1/08
18 VAC 130-20-110	Amended	24:6 VA.R. 844	1/1/08
18 VAC 130-20-170	Amended	24:6 VA.R. 844	1/1/08
18 VAC 130-20-180	Amended	24:6 VA.R. 844	1/1/08
18 VAC 130-20-210	Amended	24:6 VA.R. 846	1/1/08
18 VAC 130-20-220	Amended	24:6 VA.R. 847	1/1/08
18 VAC 130-20-230	Amended	24:6 VA.R. 847	1/1/08
18 VAC 135-20-10	Amended	24:11 VA.R. 1408	4/1/08
18 VAC 135-20-30	Amended	24:11 VA.R. 1409	4/1/08
18 VAC 135-20-60	Amended	24:11 VA.R. 1410	4/1/08
18 VAC 135-20-100	Amended	24:11 VA.R. 1410	4/1/08

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18 VAC 135-20-101	Added	24:11 VA.R. 1412	4/1/08
18 VAC 135-20-105	Amended	24:11 VA.R. 1413	4/1/08
18 VAC 135-20-160	Amended	24:11 VA.R. 1413	4/1/08
18 VAC 135-20-170	Amended	24:11 VA.R. 1414	4/1/08
18 VAC 135-20-180	Amended	24:11 VA.R. 1414	4/1/08
18 VAC 135-20-190	Amended	24:11 VA.R. 1416	4/1/08
18 VAC 135-20-210	Amended	24:11 VA.R. 1417	4/1/08
18 VAC 135-20-220	Amended	24:11 VA.R. 1417	4/1/08
18 VAC 135-20-280	Amended	24:11 VA.R. 1417	4/1/08
18 VAC 135-20-300	Amended	24:11 VA.R. 1418	4/1/08
18 VAC 135-20-345	Added	24:11 VA.R. 1418	4/1/08
18 VAC 135-20-360	Amended	24:11 VA.R. 1419	4/1/08
18 VAC 135-20-370	Amended	24:11 VA.R. 1419	4/1/08
18 VAC 135-20-390	Amended	24:11 VA.R. 1420	4/1/08
18 VAC 135-30 (Forms)	Amended	24:1 VA.R. 41	--
18 VAC 135-40 (Forms)	Amended	24:1 VA.R. 43	--
18 VAC 135-50-10	Amended	23:22 VA.R. 3794	9/22/07
18 VAC 135-50-20	Amended	23:22 VA.R. 3795	9/22/07
18 VAC 135-50-220	Amended	23:22 VA.R. 3795	9/22/07
18 VAC 135-50-400	Amended	23:22 VA.R. 3795	9/22/07
18 VAC 135-60-60	Amended	24:9 VA.R. 1230	3/1/08
18 VAC 150-10-10	Amended	23:23 VA.R. 3937	10/7/07
18 VAC 150-10-20	Amended	23:23 VA.R. 3937	10/7/07
18 VAC 150-10-30	Amended	23:23 VA.R. 3937	10/7/07
18 VAC 150-10-40	Amended	23:23 VA.R. 3938	10/7/07
18 VAC 150-10-50	Amended	23:23 VA.R. 3938	10/7/07
18 VAC 150-10-60	Amended	23:23 VA.R. 3938	10/7/07
18 VAC 150-10-70	Amended	23:23 VA.R. 3938	10/7/07
18 VAC 150-10-80	Amended	23:23 VA.R. 3938	10/7/07
18 VAC 150-10-100	Amended	23:23 VA.R. 3939	10/7/07
18 VAC 150-10-110	Amended	23:23 VA.R. 3939	10/7/07
18 VAC 150-10-120	Amended	23:23 VA.R. 3939	10/7/07
18 VAC 150-20-30	Amended	24:3 VA.R. 436	11/29/07
18 VAC 150-20-100	Amended	24:3 VA.R. 436	11/29/07
18 VAC 150-20-140	Amended	24:3 VA.R. 437	11/29/07
18 VAC 150-20-220	Added	24:3 VA.R. 438	11/29/07
18 VAC 150-20-230	Added	24:3 VA.R. 438	11/29/07
18 VAC 150-20-240	Added	24:3 VA.R. 438	11/29/07
Title 19. Public Safety			
19 VAC 30-20-115	Added	24:11 VA.R. 1421	3/6/08
19 VAC 30-70-6	Amended	24:8 VA.R. 988	3/1/08
19 VAC 30-70-7	Amended	24:8 VA.R. 988	3/1/08
19 VAC 30-70-9	Amended	24:8 VA.R. 989	3/1/08
19 VAC 30-70-10	Amended	24:8 VA.R. 991	3/1/08
19 VAC 30-70-40	Amended	24:8 VA.R. 994	3/1/08
19 VAC 30-70-50	Amended	24:8 VA.R. 995	3/1/08
19 VAC 30-70-60	Amended	24:8 VA.R. 997	3/1/08
19 VAC 30-70-80	Amended	24:8 VA.R. 998	3/1/08
19 VAC 30-70-90	Amended	24:8 VA.R. 1001	3/1/08
19 VAC 30-70-110 through 19 VAC 30-70-660	Amended	24:8 VA.R. 1001-1070	3/1/08
19 VAC 30-170-15	Amended	24:2 VA.R. 233	10/1/07

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SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
19 VAC 30-170-50	Amended	24:2 VA.R. 233	10/1/07
19 VAC 30-190-10 through 19 VAC 30-190-140	Added	24:11 VA.R. 1421-1423	3/6/08
Title 20. Public Utilities and Telecommunications			
20 VAC 5-417-10	Amended	24:4 VA.R. 513	10/9/07
20 VAC 5-417-50	Amended	24:4 VA.R. 513	10/9/07
Title 21. Securities and Retail Franchising			
21 VAC 5-10-40	Amended	23:23 VA.R. 3940	7/1/07
21 VAC 5-20-65	Added	23:23 VA.R. 3942	7/1/07
21 VAC 5-20-95	Added	23:23 VA.R. 3942	7/1/07
21 VAC 5-20-280	Amended	23:23 VA.R. 3943	7/1/07
21 VAC 5-20-330	Amended	23:23 VA.R. 3947	7/1/07
21 VAC 5-80-65	Added	23:23 VA.R. 3949	7/1/07
21 VAC 5-80-160	Amended	23:23 VA.R. 3950	7/1/07
21 VAC 5-80-200	Amended	23:23 VA.R. 3954	7/1/07
21 VAC 5-110	Erratum	23:24 VA.R. 4079	--
21 VAC 5-110-65	Added	23:23 VA.R. 3959	7/1/07
21 VAC 5-110-75	Added	23:23 VA.R. 3960	7/1/07
Title 22. Social Services			
22 VAC 15-30-310	Amended	24:10 VA.R. 1295	3/6/08
22 VAC 40-35-10	Amended	23:23 VA.R. 3962	9/1/07
22 VAC 40-35-80	Amended	23:23 VA.R. 3965	9/1/07
22 VAC 40-35-90	Amended	23:23 VA.R. 3965	9/1/07
22 VAC 40-35-100	Amended	23:23 VA.R. 3966	9/1/07
22 VAC 40-41-10 through 22 VAC 40-41-50	Amended	23:22 VA.R. 3796-3799	9/1/07
22 VAC 40-41-55	Amended	23:22 VA.R. 3799	9/1/07
22 VAC 40-41-60	Amended	23:22 VA.R. 3799	9/1/07
22 VAC 40-72-55	Added	24:5 VA.R. 616	12/12/07
22 VAC 40-72-367	Added	24:5 VA.R. 616	12/12/07
22 VAC 40-72-930	Amended	24:1 VA.R. 38	11/1/07
22 VAC 40-72-960	Amended	24:1 VA.R. 39	11/1/07
22 VAC 40-375-10 through 22 VAC 40-375-60	Repealed	24:5 VA.R. 616	12/12/07
22 VAC 40-470-10	Amended	24:9 VA.R. 1231	2/6/08
22 VAC 40-685-30	Amended	24:9 VA.R. 1231	2/6/08
22 VAC 40-770-10 through 22 VAC 40-770-160	Repealed	24:2 VA.R. 234	11/1/07
22 VAC 40-771-10 through 22 VAC 40-771-160	Added	24:2 VA.R. 234-242	11/1/07
22 VAC 42-10-10 through 22 VAC 42-10-1000	Repealed	24:6 VA.R. 849	12/28/07
22 VAC 42-11-10 through 22 VAC 42-11-1090	Added	24:6 VA.R. 850-885	12/28/07
Title 23. Taxation			
23 VAC 10-10-10 through 23 VAC 10-10-80	Amended	24:12 VA.R. 1520-1521	4/19/08
23 VAC 10-10-80	Amended	24:12 VA.R. 1521	4/19/08
23 VAC 10-10-90	Repealed	24:12 VA.R. 1522	4/19/08
23 VAC 10-210-485	Amended	23:24 VA.R. 4069	9/6/07
23 VAC 10-210-693 emer	Amended	23:25 VA.R. 4364	7/26/07-07/25/08
23 VAC 10-210-6041	Amended	23:24 VA.R. 4068	9/6/07
23 VAC 10-210-6042	Amended	23:24 VA.R. 4069	9/6/07
23 VAC 10-210-6043	Amended	23:24 VA.R. 4069	9/6/07
23 VAC 10-240-20 through 23 VAC 10-240-60	Repealed	23:25 VA.R. 4372-4373	10/04/07
23 VAC 10-240-100	Repealed	23:25 VA.R. 4373	10/04/07
23 VAC 10-240-130	Repealed	23:25 VA.R. 4373	10/04/07
23 VAC 10-240-140	Repealed	23:25 VA.R. 4373	10/04/07

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
23 VAC 10-240-150	Repealed	23:25 VA.R. 4373	10/04/07
23 VAC 10-240-200	Repealed	23:25 VA.R. 4373	10/04/07
23 VAC 10-240-210	Repealed	23:25 VA.R. 4373	10/04/07
23 VAC 10-240-240	Repealed	23:25 VA.R. 4373	10/04/07
23 VAC 10-240-270	Repealed	23:25 VA.R. 4373	10/04/07
23 VAC 10-240-280	Repealed	23:25 VA.R. 4373	10/04/07
23 VAC 10-240-300	Repealed	23:25 VA.R. 4374	10/04/07
23 VAC 10-240-310	Repealed	23:25 VA.R. 4374	10/04/07
23 VAC 10-240-330	Repealed	23:25 VA.R. 4374	10/04/07
23 VAC 10-240-340	Repealed	23:25 VA.R. 4374	10/04/07
23 VAC 10-240-360	Repealed	23:25 VA.R. 4374	10/04/07
23 VAC 10-240-380	Repealed	23:25 VA.R. 4374	10/04/07
23 VAC 10-240-400	Repealed	23:25 VA.R. 4375	10/04/07
23 VAC 10-240-420	Repealed	23:25 VA.R. 4375	10/04/07
23 VAC 10-240-430	Repealed	23:25 VA.R. 4375	10/04/07
23 VAC 10-240-450	Repealed	23:25 VA.R. 4375	10/04/07
23 VAC 10-240-460	Repealed	23:25 VA.R. 4375	10/04/07
Title 24. Transportation and Motor Vehicles			
24 VAC 20-120-10 through 24 VAC 20-120-180	Repealed	24:4 VA.R. 516	1/1/08
24 VAC 20-121-10 through 24 VAC 20-121-220	Adding	24:4 VA.R. 516-529	1/1/08
24 VAC 22-20-10	Amended	24:3 VA.R. 439	12/1/07
24 VAC 22-20-20	Amended	24:3 VA.R. 440	12/1/07
24 VAC 27-10-10 through 24 VAC 27-10-120	Added	23:24 VA.R. 4071-4075	9/20/07
24 VAC 30-45-10	Added	24:2 VA.R. 243	10/1/07
24 VAC 30-45-20	Added	24:2 VA.R. 243	10/1/07
24 VAC 30-45-30	Added	24:2 VA.R. 244	10/1/07
24 VAC 30-200-10	Amended	24:4 VA.R. 529	11/28/07
24 VAC 30-200-20	Amended	24:4 VA.R. 530	11/28/07
24 VAC 30-200-30	Amended	24:4 VA.R. 531	11/28/07
24 VAC 30-200-35	Added	24:4 VA.R. 532	11/28/07
24 VAC 30-200-40	Amended	24:4 VA.R. 533	11/28/07

PETITIONS FOR RULEMAKING

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF MEDICINE

Initial Agency Notice

Title of Regulation: **18VAC85-20. Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic.**

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

Name of Petitioner: Dr. Sarwat Siddiqui.

Nature of Petitioner's Request: Amend 18VAC85-20-140 of the regulations, which requires an applicant to pass Parts 1, 2 and 3 of the USMLE within 10 years or to hold board certification.

Agency's Plan for Disposition of Request: The board will receive public comment on the petition for rulemaking and will consider any public comment and the petition at a meeting of the Executive Committee on April 4, 2008.

Comments may be submitted until March 24, 2008.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4621, FAX (804) 527-4426, or email william.harp@dhp.virginia.gov.

VA.R. Doc. No. R08-08; Filed February 4, 2008, 3:50 p.m.

NOTICES OF INTENDED REGULATORY ACTION

TITLE 11. GAMING

CHARITABLE GAMING BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with §2.2-4007.01 of the Code of Virginia that the Charitable Gaming Board intends to consider amending the following regulations: **11VAC15-22, Charitable Gaming Rules and Regulations.** Chapter 264 of the 2007 Acts of Assembly requires changes to the agency's gaming regulations. The agency has contracted with a vendor to provide guidance in developing these changes. The contract/purchase order was finalized November 9, 2007. Timelines are being developed with the vendor and staff. The agency will be working with the vendor to identify issues in the current rules and regulations that may be impacted by the implementation of these electronic games of chance systems.

In addition, the agency is seeking information on (i) the continued need for the regulation; (ii) the complexity of the regulation; (iii) the extent to which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (iv) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation.

The agency will be conducting focus group meetings with various charitable gaming organizations and suppliers/manufacturers prior to the development of the proposed rules and regulations changes.

The agency is seeking comments on the intended regulatory action, including but not limited to (i) ideas to assist in the development of a proposal, (ii) the costs and benefits of the alternatives stated in this background document or other alternatives, and (iii) potential impacts of the regulation. The agency is also seeking information on impacts on small businesses as defined in §2.2-4007.1 of the Code of Virginia. Information may include (i) projected reporting, recordkeeping and other administrative costs, (ii) probable effect of the regulation on affected small businesses, and (iii) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments may do so by mail, email or fax to Michael Menefee, Inspection and Training Manager, Department of Charitable Gaming, 101 N. 14th Street, Richmond, VA 23219, or mike.menefee@dcg.virginia.gov or by FAX to 804-786-1079. Written comments must include the name and address of the commenter.

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

Statutory Authority: §18.2-340.34 of the Code of Virginia.

Public Comments: Public comments may be submitted until April 2, 2008.

Agency Contact: Betty Bowman, Assistant Director-Administration, Department of Charitable Gaming, James Monroe Building, 101 North 14th Street, Richmond, VA 23219, telephone 804-786-3015, FAX 804-786-1079, or email betty.bowman@dcg.virginia.gov.

VA.R. Doc. No. R08-1183; Filed February 12, 2008, 8:37 a.m.

TITLE 13. HOUSING

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

Withdrawal of Notice of Intended Regulatory Action

Notice is hereby given that Board of Housing and Community Development has WITHDRAWN the Notice of Intended Regulatory Action for 13VAC5-21, Virginia Certification Standards. The notice relating to incorporating the latest editions of nationally recognized model building codes and standards produced by the International Code Council was published in 23:11 VA.R. 1653 February 5, 2007. Following discussions with the Department of Planning and Budget, it was determined that, since the amendments to the regulation are editorial in nature or for correlation with other current regulations, that they should be promulgated as fast-track regulations.

Agency Contact: Steve Calhoun, Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7015, FAX (804) 371-7090 or email steve.calhoun@dhcd.virginia.gov.

VA.R. Doc. No. R07-122; Filed February 5, 2008, 11:44 a.m.

Withdrawal of Notice of Intended Regulatory Action

Notice is hereby given that Board of Housing and Community Development has WITHDRAWN the Notice of Intended Regulatory Action for 13VAC5-95, Virginia Manufactured Home Safety Regulations, which was published in 23:11 VA.R. 1654 February 5, 2007. Following discussions with the Department of Planning and Budget, it was determined that, since the amendments to the regulation are editorial in nature or for correlation with other current regulations, that they should be promulgated as fast-track regulations.

Agency Contact: Steve Calhoun, Regulatory Coordinator, Department of Housing and Community Development, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7015, FAX (804) 371-7090 or email steve.calhoun@dhcd.virginia.gov.

VA.R. Doc. No. R07-127; Filed February 5, 2008, 11:44 a.m.

REGULATIONS

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

Symbol Key

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

TITLE 2. AGRICULTURE

STATE MILK COMMISSION

Proposed Regulation

REGISTRAR'S NOTICE: The Milk Commission is exempt from the Administrative Process Act in accordance with §2.2-4002 A 7 of the Code of Virginia, which exempts the Milk Commission in promulgating regulations regarding (i) producers' license and base; (ii) classification and allocation of milk, computation sales and shrinkage; and (iii) class prices for producers' milk, time and method of payment, butterfat testing and differential.

Title of Regulation: **2VAC15-20. Regulations for the Control and Supervision of Virginia's Milk Industry (amending 2VAC15-20-81).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comments: Public comments may be submitted until March 10, 2008.

Agency Contact: Rodney L. Phillips, Administrator, State Milk Commission, Oliver Hill Building, 102 Governor Street, Room 205, Richmond, VA 23219, telephone (804) 786-2013, FAX (804) 786-3779, or email rodney.phillips@vdacs.virginia.gov.

Summary:

The proposed amendment allows for an additional premium to be charged on Virginia Class I pounds for organic milk.

2VAC15-20-81. Class prices for producer's milk, time and method of payment, and butterfat testing.

A. CWT Class prices.

1. Class I

	July through February	March through June
Eastern Virginia Market	\$8.46/cwt.	\$8.26/cwt.
Southwest Virginia Market	\$7.96/cwt.	\$7.76/cwt.
Western Virginia Market	\$8.16/cwt.	\$7.96/cwt.

The above established Class I prices shall be adjusted automatically in accordance with the following procedure, provided:

(1) a. The Eastern Market Class I price shall not exceed the average prevailing Class I price of Metropolitan Washington, D.C., and Raleigh, North Carolina, by more than \$0.80 per hundredweight nor be less than \$0.30 per hundredweight above the average prevailing Class I price of Metropolitan Washington, D.C., and Raleigh, North Carolina;

b. The Southwest Market Class I price shall not exceed the average prevailing Class I price of Bristol, Virginia, and Charleston, West Virginia, by more than \$0.60 per hundredweight nor be less than \$0.30 per hundredweight above the average prevailing Class I price of Bristol, Virginia, and Charleston, West Virginia; and

c. The Western Market Class I price shall not exceed the average prevailing Class I price of Metropolitan Washington, D.C., and Winston Salem, North Carolina, by more than \$0.60 per hundredweight nor be less than \$0.30 per hundredweight above the average prevailing Class I price of Metropolitan Washington, D.C., and Winston Salem, North Carolina.

(2) Class I prices shall be increased by an amount determined by multiplying the number of two-point brackets that the average bi-monthly composite index exceeds 101.0 by \$0.20; and

(3) Class I prices shall be decreased by an amount determined by multiplying the number of two-point brackets that the average bi-monthly composite index descends below 99.0 by \$0.20.

(4) The average bi-monthly composite index brackets shall be in accordance with the following schedule:

Average Bi-monthly Composite Index Brackets (Nos. through Nos.) Continued	Amount of Adjustment (Cents) Continued
96.9 - 98.9	- 20
99.0 - 101.0	- 0
101.1 - 103.1	+ 20
103.2 - 105.2	+ 40
105.3 - 107.3	+ 60

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107.4 - 109.4	+ 80	183.0 - 185.0	+800
109.5 - 111.5	+100	185.1 - 187.1	+820
111.6 - 113.6	+120	187.2 - 189.2	+840
113.7 - 115.7	+140	189.3 - 191.3	+860
115.8 - 117.8	+160	191.4 - 193.4	+880
117.9 - 119.9	+180	193.5 - 195.5	+900
120.0 - 122.0	+200	195.6 - 197.6	+920
122.1 - 124.1	+220	197.7 - 199.7	+940
124.2 - 126.2	+240	199.8 - 201.8	+960
126.3 - 128.3	+260	201.9 - 203.9	+980
128.4 - 130.4	+280	204.0 - 206.0	+1000
130.5 - 132.5	+300	206.1 - 208.1	+1020
132.6 - 134.6	+320	208.2 - 210.2	+1040
134.7 - 136.7	+340	210.3 - 212.3	+1060
136.8 - 138.8	+360	212.4 - 214.4	+1080
138.9 - 140.9	+380	214.5 - 216.5	+1100
141.0 - 143.0	+400	216.6 - 218.6	+1120
143.1 - 145.1	+420	Continued	Continued
145.2 - 147.2	+440	<p>(5) A monthly composite index shall be determined by dividing the sum of the index numbers of the six factors shown in subsections (a x 1), (b x 1), (c x 1), (d x 1), (e x 1), (f x 2) of this subparagraph by seven. The latest available published monthly data for any of the above six factors shall be used in determining the monthly index number.</p> <p>a. The U.S. Index of prices paid, taxes, and farm wage rates, as published in "Agricultural Prices" by the U.S.D.A.</p> <p>b. The U.S. Index of prices received as published in "Agricultural Prices" by the U.S.D.A.</p> <p>c. The average price per ton paid by Virginia farmers for 16% dairy feed, as published in "Agricultural Prices" by the U.S.D.A.</p> <p>d. The average cost of the market basket for Richmond-Norfolk-Virginia Beach-Portsmouth, as published in "The Market Basket and Retail Food Prices" by the Virginia Department of Labor and Industry.</p> <p>e. The average weekly earnings of workers in Virginia manufacturing industries, as published in "Trends in Employment Hours and Earnings Virginia and Statistical Metropolitan Areas" by the Virginia Department of Labor and Industry.</p>	
147.3 - 149.3	+460		
149.4 - 151.4	+480		
151.5 - 153.5	+500		
153.6 - 155.6	+520		
155.7 - 157.7	+540		
157.8 - 159.8	+560		
159.9 - 161.9	+580		
162.0 - 164.0	+600		
164.1 - 166.1	+620		
166.2 - 168.2	+640		
168.3 - 170.3	+660		
170.4 - 172.4	+680		
172.5 - 174.5	+700		
174.6 - 176.6	+720		
176.7 - 178.7	+740		
178.8 - 180.8	+760		
180.9 - 182.9	+780		

f. An average of the prevailing Class I prices in Raleigh, North Carolina; Metropolitan Washington, D.C.; Winston Salem, North Carolina; Bristol, Virginia; and Charleston, West Virginia.

(6) The six-month average, November 1973 through April 1974, shall equal 100 for each of the above factors for the purpose of determining the monthly index number for each factor.

(7) The current month's Class I price adjustment, if any, shall be determined by a bi-monthly composite index which shall be a simple average of the monthly composite indices of the second and third preceding months.

(8) On or before the 23rd day of each month, the agency shall determine the Class I butterfat, skim and net prices for the following month and announce same to all licensed processing general distributors and on the same date the agency will announce the Class II skim, butterfat and net prices.

Effective May 1, 1995, the following modifications to the indexes will be utilized in determining the monthly composite index used in calculating the Class I price for Virginia State Milk Commission marketing areas pursuant to subdivisions A 1 (1) through (7) of this section:

The U.S. Index of prices paid, taxes, and farm wage rates as published in "Agricultural Prices" by the U.S.D.A. will be determined by using the monthly movement of the reweighted and reconstructed prices paid index (PPITW) as published by the U.S.D.A. The monthly movement of the new prices paid index (PPITW) will be applied each month to the preceding month's revised index of prices paid, taxes, and farm wage rates using December 1994 as the base month.

The U.S. Index of prices received as published in "Agricultural Prices" by the U.S.D.A. will be determined by using the monthly movement of the reweighted and reconstructed prices received index as published by the U.S.D.A. The monthly movement of the new prices received index will be applied each month to the preceding month's revised index of prices received using December 1994 as the base month.

The average price per ton paid by all Virginia farmers for 16% dairy feed as published in "Agricultural Prices" by the U.S.D.A. will be determined by using the monthly movement of the index of prices paid, production items, complete feeds as published by the U.S.D.A. The monthly movement of this index will be applied each month to the preceding month's index of 16% dairy feed, Appalachian using April 1995 as the base month.

The authoritative publisher of the Market Basket for Richmond-Norfolk-Virginia Beach-Portsmouth will be

the Virginia Department of Agriculture and Consumer Services. The resultant index numbers derived from the above calculations will be utilized as specified in the cited regulation.

2. Class I-A. The price used in computing each distributor's obligation for producer milk (of 3.5% butterfat) allocated to Class I-A shall be the Class II skim, butterfat, and net prices.

3. Class II. The price per cwt. for all markets shall be the monthly Class II price announced by the market administrator of appropriate marketing area.

4. The total value of base deliveries made in accordance with 2VAC15-20-50 B 2 shall be discounted in accordance with the following procedure to reflect the cost savings of transporting, storing and handling of producer milk on a uniform daily basis:

a. Subtract from each cooperative association's total pounds of base deliveries allocated to Class I sales for each delivery period an amount equal to twice the sum of the differences between the pounds of assigned daily base and the pounds of daily base deliveries which are less than the pounds of assigned daily base for each day during the delivery period.

b. The net hundredweight (not less than zero) resulting from the above procedure multiplied by \$0.11 will be the amount of discount for base deliveries during the delivery period.

~~5. Producers or their agents shall not sell milk or offer milk for sale at prices other than those established. No milk shall be sold or offered for sale by producers or their agents at prices other than those established except milk that is certified by USDA as organic. Milk certified as organic by USDA may have premiums negotiated at a higher price than that announced by the commission.~~

B. Butterfat testing. Butterfat testing shall be conducted in accordance with the following procedure:

1. General distributors shall determine the average butterfat content of all assigned producer milk delivered by each producer who is not a member of a cooperative association, as defined in 2VAC15-20-10, by four or more tests made at approximately equal intervals during each delivery period.

2. All assigned producer milk accompanied by a bill of lading that is delivered by a cooperative association to a licensed distributor and is accepted by the distributor shall be paid for by the distributor at a rate that is determined by the butterfat test specified on the bill of lading accompanying the load of milk.

3. The butterfat content of all assigned cooperative association milk delivered by methods other than specified

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in subdivision 2 of this subsection, shall be determined in accordance with procedures specified by the agency if mutual agreement between the cooperative association and the distributor cannot be reached as to the butterfat content of such deliveries.

4. All sampling and testing shall be conducted by persons licensed by the Virginia Department of Agriculture and Consumer Services. These tests shall be made by the Babcock Test, or other tests approved by that department, and shall, as directed by the approving authority, be subject to check tests made by a licensed tester.

C. Time of payment.

1. On or before the 23rd day of a delivery period, general distributors shall make a partial payment to producers or cooperative associations of producers for base deliveries received during the first 15 days of the delivery period. The partial payment shall be not less than an amount determined by multiplying the previous month's Class II skim, butterfat or net price for 3.5% milk by the hundredweight of base deliveries for the first 15 days of the delivery period; provided full and final payment for the preceding delivery period was made in accordance with subdivision 2 of this subsection, otherwise the partial payment shall be not less than an amount determined by multiplying the current Class I skim, butterfat and net prices for 3.5% milk by the hundredweight of base deliveries for the first 15 days of the delivery period.

2. On or before the 16th day following the close of a delivery period, state regulated general distributors shall make full and final payment to producers or cooperative associations of producers for deliveries received during such delivery period pursuant to this chapter. Fully federally regulated general distributors shall make full and final payment to producers or cooperative associations of producers for deliveries received during such delivery period pursuant to the applicable provisions of the order in which they are pooled. Payment shall be made so that it is received by the dates applicable to state order and federal order plants.

3. Certified or registered mail may be required for all U.S. Postal Service deliveries of producer payments made by general distributors pursuant to subdivisions 1 and 2 of this subsection when directed in writing by the agency.

4. The approving authority may, after a hearing, require individual general distributors to make settlement with producers or cooperative associations of producers for deliveries at intervals other than provided in subdivisions 1 and 2 of this subsection.

5. All licensed producers or association of producers supplying base deliveries to processing general distributors located in Norfolk, Portsmouth, Hampton, Newport News or Chesapeake shall be allocated \$0.10 per hundredweight

from the total monthly Eastern Market Class I producer payments. This allocation shall be made prorata in accordance with the monthly base deliveries to the processing general distributors located in the aforementioned cities.

6. Before the 15th day of each month, the agency shall determine the required monthly equalization payments and give written notice to all affected parties of the amounts payable. The monthly equalization payments shall be made to the Milk Commission Equalization Fund no later than the 25th day of the month subsequent to the end of each delivery period. On or before the last day of each month, the agency shall disburse all funds (less a balance necessary to pay all bank charges) paid in during the current month in accordance with subdivision 5 of this subsection.

D. Redistribution of producer losses. When the approving authority is satisfied that when one or more licensed distributors is unable, due to bankruptcy or receivership, to fulfill the financial obligation to producers and/or cooperative associations of producers for base deliveries, the approving authority may authorize the establishment of a temporary producer redistribution fund to reallocate a distributor's deficient financial obligation.

1. When it is determined that an obligation for base milk deliveries cannot be satisfied, the distributor(s), producer(s) or cooperative associations of producers involved shall notify the approving authority within five working days of a voluntary filing or adjudication of bankruptcy or receivership, or within five working days of August 1, 1991, for licensed distributors currently in bankruptcy or receivership. This notification shall be in writing accompanied by copies of pertinent court documents.

2. The producer funded redistribution of losses of an unfulfilled obligation of base deliveries shall be limited to an amount not to exceed the unsecured value of base deliveries calculated in accordance with this chapter.

3. A producer funded redistribution rate shall be established which will be the lesser of the actual dollar loss under subdivision 2 of this subsection or the dollars generated by a rate not in excess of 0.10/cwt., levied on producer's and/or cooperative associations of producers' monthly Class I allocated base deliveries for a period not to exceed 12 months for each bankruptcy. Each distributor shall remit to the agency no later than the 15th of each month the amount collected in accordance with this subdivision applicable to the prior month's delivery period at the rate established by the approving authority.

4. The agency shall disburse all redistribution funds, net of applicable bank charges, collected each month for the redistribution fund by the last day of the month. Funds will

be disbursed prorata in relationship to the loss incurred by producers and/or cooperative associations of producers, less applicable bank charges.

5. Producers or cooperative associations of producers shall assign to the agency that portion of their loss claim which pertains to the value of redistributed funds paid on Virginia base deliveries by the agency in order to participate in the producer redistribution fund.

6. Any overpayment or recovery of loss claims assigned to the agency by producers or cooperative associations of producers to the producer redistribution fund shall be disbursed to producers or cooperative associations of producers on a prorata basis of payments made to the fund.

VA.R. Doc. No. R08-1175; Filed February 6, 2008, 8:02 a.m.

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TITLE 4. CONSERVATION AND NATURAL RESOURCES

BOARD OF GAME AND INLAND FISHERIES

Proposed Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is exempt from the Administrative Process Act pursuant to subdivision A 3 of §2.2-4002 of the Code of Virginia when promulgating regulations regarding the management of wildlife. The board is required by §2.2-4031 of the Code of Virginia to publish all proposed and final wildlife management regulations, including length of seasons and bag limits allowed on the wildlife resources within the Commonwealth of Virginia.

Title of Regulation: **4VAC15-270. Game: Firearms (repealing 4VAC15-270-50).**

Statutory Authority: §§29.1-501 and 29.1-502 of the Code of Virginia.

Public Hearing Information:

April 1, 2008 - 9 a.m. - 4000 West Broad Street, Richmond, VA

Public Comments: Public comments may be submitted until 5 p.m. on March 13, 2008.

Agency Contact: Phil Smith, Regulatory Coordinator, 4016 W. Broad Street, Richmond, VA 23230, telephone (804) 367-8341 or email phil.smith@dgif.virginia.gov.

Summary:

The proposal rescinds the prohibition on the use of high velocity, long-range rifles, shotguns loaded with slugs and pistols or revolvers of a larger caliber than 22 rim-

fire for hunting in Northumberland County. The section proposed to be rescinded is inconsistent with a local ordinance on firearms adopted by the Northumberland County government.

4VAC15-270-50. Use of certain firearms prohibited in Northumberland County. (Repealed.)

~~It shall be unlawful to use high velocity, long range rifles, shotguns loaded with slugs and pistols or revolvers of a larger calibre than 22 rim fire for hunting in Northumberland County.~~

VA.R. Doc. No. R08-1189; Filed February 13, 2008, 11:35 a.m.

Proposed Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to §29.1-701 E of the Code of Virginia, which provides that the board shall promulgate regulations to implement Chapter 7 (§29.1-700 et seq.) of Title 29.1 (Boating Laws) as prescribed in Article 1 (§29.1-500 et seq.) of Chapter 5 of Title 29.1 of the Code of Virginia. Regulations promulgated pursuant to Article 1 of Chapter 5 of Title 29.1 (Wildlife Management Regulations) are exempt from the Administrative Process Act pursuant to subdivision A 3 of §2.2-4002 of the Code of Virginia.

Title of Regulation: **4VAC15-410. Watercraft: Boating Safety Education (adding 4VAC15-410-10 through 4VAC15-410-170).**

Statutory Authority: §§29.1-701, 29.1-735, and 29.1-735.2 of the Code of Virginia.

Public Hearing Information:

April 1, 2008 - 9 a.m. - 4000 West Broad Street, Richmond, VA

Public Comments: Public comments may be submitted until 5 p.m. on March 16, 2008.

Agency Contact: Phil Smith, Regulatory Coordinator, Board of Game and Inland Fisheries, 4016 West Broad Street, Richmond, VA 23230, telephone (804) 367-8341 or email phil.smith@dgif.virginia.gov.

Summary:

The proposed regulation complies with §29.1-735.2 of the Code of Virginia, which mandates that the Board of Game and Inland Fisheries promulgate regulations by July 1, 2008, to implement a boating safety education program for all motorboat and personal watercraft operators to meet boating safety education requirements.

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CHAPTER 410

WATERCRAFT: BOATING SAFETY EDUCATION

4VAC15-410-10. Application.

This chapter applies to all operators of a motorboat with a motor of 10 horsepower or greater or personal watercraft on the public waters of the Commonwealth. However, the provisions of this chapter shall not apply to law-enforcement officers while they are engaged in the performance of their official duties.

4VAC15-410-20. Definitions.

As used in this chapter, unless the context clearly requires a different meaning, the following words and terms shall have the following meanings:

"Approved course provider" is any individual, business, or organization that instructs or provides a boating safety education course approved by the National Association of State Boating Law Administrators and accepted by the department. An approved course provider shall have executed and have on file a valid cooperative agreement with the department.

"Board" means the Board of Game and Inland Fisheries.

"Boating safety education course" means a course offered in the classroom, through the Internet, or through an electronic format such as CD-ROM that provides a course content and test questions that have been reviewed and approved by the National Association of State Boating Law Administrators in accordance with the National Boating Education Standards, updated January 1, 2008, and accepted by the department. A boating safety education course shall include no less than 50 test questions, which shall include at least 10 test questions specific about Virginia boating laws.

"Department" means the Department of Game and Inland Fisheries.

"Dockside safety checklist" means a document provided by the department that consists of selected facts about Virginia boating laws and safe boat operation that a rental or livery agent or motorboat leasing business is required to present to those who rent or lease a motorboat. The dockside safety checklist must be reviewed and initialed by the person operating the motorboat before the boat can be rented/leased and operated.

"Equivalency exam" means a written examination that is developed by the department to test the knowledge of information included in the curriculum of a boating safety education course (may also be referred to as a challenge exam). The equivalency exam is intended to provide experienced and knowledgeable boaters with the opportunity to meet the boating safety education compliance requirement set forth in §29.1-735.2 of the Code of Virginia without having to take and successfully complete a boating safety

education course. The equivalency exam shall be comprised of no less than 75 or more than 100 test questions, shall include no less than 25 questions specific about Virginia boating laws, and shall be proctored by an individual(s) specifically designated by the department. A minimum score of at least 70% shall be considered passing.

"Motorboat" means any vessel propelled by machinery whether or not the machinery is the principal source of propulsion and for this chapter shall mean with a motor of 10 horsepower or greater.

"NASBLA" means the National Association of State Boating Law Administrators.

"NASBLA approved course" means a boating safety education course that has been reviewed and approved by NASBLA.

"Onboard direct supervision" as referenced in §29.1-735.2 B 6 and 9 of the Code of Virginia occurs when a person maintains close visual and verbal contact with, provides adequate direction to, and can immediately assume control of a motorboat from the operator of a motorboat. A person who is water skiing, or is in the cabin of a motorboat and not at the helm/wheel is not considered to be in direct supervision.

"Operate" means to navigate or otherwise control the movement of a motorboat or vessel.

"Optional Virginia Boater Education Card" means a card authorized for issuance by the department to persons who (i) can show they have met the minimum standard of boating safety education course competency, (ii) possess a valid license to operate a vessel issued to maritime personnel by the United States Coast Guard or a marine certificate issued by the Canadian government, (iii) possess a Canadian Pleasure Craft Operator's Card, or (iv) possess a commercial fisherman registration pursuant to §28.2-241 of the Code of Virginia.

"Personal watercraft" means a motorboat less than 16 feet in length that uses an inboard motor powering a jet pump as its primary motive power and that is designed to be operated by a person sitting, standing, or kneeling on, rather than in the conventional manner of sitting or standing inside the vessel.

"Proctored" means that the written equivalency exam has been administered under the direct supervision of (i) a designated member of the United States Coast Guard Auxiliary or the United States Power Squadrons®, (ii) a designated department employee, or (iii) an individual who has been approved for such purpose by the department.

"Temporary operator's certificate" means a nonrenewable document issued with the certificate of number for the motorboat, if the boat is new or was sold with a transfer of ownership. A temporary operator's certificate shall be issued only by the department, by any person authorized by the director to act as an agent to issue a certificate of number pursuant to §29.1-706 of the Code of Virginia, or by a license

agent of the department authorized to issue a temporary registration certificate for a motorboat. A temporary operator's certificate shall allow the owner(s) to operate a motorboat with a motor of 10 horsepower or greater or personal watercraft in Virginia for 90 days.

"Vessel" means every description of watercraft, other than a seaplane on the water, used or capable of being used as a means of transportation on water.

"Waters of the Commonwealth" means any public waters within the territorial limits of the Commonwealth.

4VAC15-410-30. Compliance schedule and phase-in provisions.

The requirements for boating safety education shall be phased in according to the following provisions:

1. Personal watercraft operators 20 years of age or younger shall meet the requirements by July 1, 2009;
2. Personal watercraft operators 35 years of age or younger shall meet the requirements by July 1, 2010;
3. Personal watercraft operators 50 years of age or younger and motorboat operators 20 years of age or younger shall meet the requirements by July 1, 2011;
4. All personal watercraft operators, regardless of age, and motorboat operators 30 years of age or younger shall meet the requirements by July 1, 2012;
5. Motorboat operators 40 years of age or younger shall meet the requirements by July 1, 2013;
6. Motorboat operators 45 years of age or younger shall meet the requirements by July 1, 2014;
7. Motorboat operators 50 years of age or younger shall meet the requirements by July 1, 2015;
8. All motorboat operators, regardless of age, shall meet the requirements by July 1, 2016.

4VAC15-410-40. Provisions for compliance and minimum standards for boating safety education course competency.

A. A person shall be considered in compliance with the requirements for boating safety education if he meets one or more of the following provisions pursuant to §29.1-735.2 B 1 through 9 of the Code of Virginia:

1. Completes and passes a boating safety education course;
2. Passes an equivalency exam;
3. Possesses a valid license to operate a vessel issued to maritime personnel by the United States Coast Guard or a marine certificate issued by the Canadian government or possesses a Canadian Pleasure Craft Operator's Card;

4. Possesses a temporary operator's certificate;

5. Possesses a rental or lease agreement from a motorboat rental or leasing business that lists the person as the authorized operator of the motorboat;

6. Operates the motorboat under onboard direct supervision of a person who meets the requirements of this section;

7. Is a nonresident, is temporarily using the waters of Virginia for a period not to exceed 90 days, and meets any applicable boating safety education requirements of the state of residency, or possesses a Canadian Pleasure Craft Operator's Card;

8. Has assumed operation of the motorboat due to the illness or physical impairment of the initial operator, and is returning the motorboat to shore in order to provide assistance or care for the operator; or

9. Is registered as a commercial fisherman pursuant to §28.2-241 of the Code of Virginia or is under the onboard direct supervision of the commercial fisherman while operating the commercial fisherman's boat.

B. The minimum standards for boating safety education course competency required by the department are:

1. Successful completion of a classroom boating safety education course in person and a passing score of at least 70% on a written test administered closed-book at the conclusion of the course by the designated course instructor(s) or other designated course assistant;

2. Successful completion of a classroom boating safety education course in person and a passing score of at least 90% on a written test administered open-book at the conclusion of the course by the designated course instructor(s) or other designated course assistant;

3. Successful completion of a boating safety education course offered through the Internet or through an electronic format such as CD-ROM and a passing score of at least 90% on a self-test administered in conjunction with the course material; or

4. A score of at least 70% on a proctored equivalency exam.

4VAC15-410-50. Boating safety education course provider requirements.

A. To be an approved course provider, any individual, business, or organization that instructs or provides a boating safety education course shall execute and have on file a cooperative agreement with the department. It shall be the responsibility of the state boating law administrator to develop and execute such agreements. A list of approved course providers and boating safety education courses shall be kept by the department and made available to the public.

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Such list does not constitute any endorsement of any course or course provider by the department or the board.

B. As of January 1, 2009, boating safety education courses offered through the Internet and accepted by the department shall:

1. Be approved by NASBLA in accordance with the National Boating Education Standards, updated January 1, 2008, for course content/testing;

2. Be provided only by an approved course provider who has executed a valid cooperative agreement with the department. Such agreements may be amended at any time by the department and may be cancelled with 30 days notice upon failure of the course provider to comply with the terms and conditions of the agreement or its amendments;

3. Be formatted and made available to the student only in instructional/training modules;

4. Consist of no less than six instructional/training modules with each module having no less than 10 test questions, randomly selected from a pool of questions that contains at least three times the number of questions presented in the module test in 2009 and four times the number of questions presented in the module test in 2010 and each following year;

5. Allow for the student to advance through the modules only in a sequential, chronological order and only upon successful completion of the test questions for the module. Successful completion shall be by a score of at least 90% correct on the test questions;

6. Be designed so that the student should spend at least six hours of active involvement in completing the course. Completing the course shall include familiarization with the course material, completion of any review questions, and completion of the test questions. The course design shall also include the provision of at least 50 separate web pages of course content and material for presentation to the student. Active involvement shall require the student to click on a "Next" or "Forward" button to progress through the course material;

7. Be designed so that the student is directed to repeat the entire module if the student has not scored at least 90% correct on the test questions for that module. The student shall also be provided with a reference to the applicable course text material for any missed questions on the module test; and

8. Be designed to promote the presentation, understanding and comprehension of boating safety information and safe practices and not the simple completion of an end-of-course test.

C. Any material and/or products to be used by an approved course provider that make reference to the department must be approved by the department, through the state boating law administrator, before publishing and/or distribution to the public.

D. Any fees charged by a course provider are set by the course provider, but must be clearly communicated to the student prior to taking the course.

4VAC15-410-60. Boating safety education course availability.

A. The department shall coordinate with the United States Coast Guard Auxiliary, the United States Power Squadrons, and any other approved course provider so that classroom-based boating safety education courses are available across the Commonwealth throughout the year.

B. The department shall coordinate with approved course providers of Internet-based courses so that courses developed and offered in accordance with 4VAC15-410-50 B are available.

C. The department shall make testing opportunities for the proctored equivalency exam available on a statewide basis throughout the year.

4VAC15-410-70. Boating safety education course certificates.

A. Upon successful completion of a boating safety education course, the approved course provider shall provide the student with a course certificate and/or pocket-size card. At a minimum, such certificate/card shall include the student's name and date of birth, the issuance date, the name of the course, and indication of NASBLA course approval and acceptance by the department. On a schedule and in a manner mutually agreed to through a cooperative agreement, each approved course provider shall provide a record to the department of those students issued a course certificate and/or pocket-size card. Upon request by the student and subject to verification of successful course completion, it shall be the responsibility of each approved course provider to issue duplicate certificates/cards.

B. Upon successful completion of the proctored equivalency exam, the department shall issue a completion certificate and/or card, which shall include the person's name, date of birth, and the issuance date. Upon request by the person to whom the certificate/card was originally issued and subject to verification of successful completion, the department shall issue a duplicate certificate/card.

4VAC15-410-80. Recordkeeping and student records.

A. The department shall maintain a database of all students successfully completing the department's classroom-based boating safety education course and all persons successfully completing the equivalency exam. Such database shall

include, but not be limited to, student name, address, date of birth, course/equivalency exam completion date, and the specific name of the course. On a schedule and in a manner mutually agreed to through a cooperative agreement, each approved course provider for other classroom-based boating safety education courses shall provide a record to the department of those students successfully completing such course and the department may add this information to the student database. A change in student address will be made only upon receipt of a written request from the affected student.

B. Each approved course provider for boating safety education courses offered over the Internet or through an electronic format such as CD-ROM shall maintain a database of all students successfully completing such course. The database shall include, but not be limited to, student name, address, date of birth, course completion date, and the specific name of the course. On a schedule and in a manner mutually agreed to through a cooperative agreement, each approved course provider shall provide a record to the department of those students successfully completing their course. Such record shall include the database information referenced in this section. It shall be the responsibility of each approved course provider to ensure that reasonable measures, such as the Payment Card Industry (PCI) data security measures, are taken to protect any acquired student data. Further, such data shall not be sold or otherwise used in any way except for the student's own completion of a boating safety education course and issuance of course completion documents.

4VAC15-410-90. Instructor certification.

A. To be certified as a boating safety education course instructor for the department's classroom-based boating safety education course, a person shall have successfully completed a classroom-based boating safety education course and be certified as an instructor by the United States Coast Guard Auxiliary, or the United States Power Squadrons, or the National Safe Boating Council, or another certification program accepted by the department.

B. Applicants for certified instructor shall submit an application to the department on a form and in a manner determined by the state boating law administrator. At a minimum, the application shall include:

1. The applicant's name;
2. The applicant's street address;
3. The applicant's telephone number;
4. The applicant's email address, if any;
5. Information describing the applicant's experience and training in boating safety and seamanship and proof of

completion of a NASBLA approved boating safety education course; and

6. Any other information deemed necessary after review of the initial application.

C. Applicants may be required to submit a written consent for a criminal history background check in a manner determined by the Law Enforcement Division of the department.

4VAC15-410-100. Provisions for open-book tests for classroom courses.

A. A boating safety education course offered in a classroom setting by either the department or an approved course provider shall offer the student the option of taking the end-of-course exam either closed-book or open-book. The minimum standards for boating safety education course competency shall be as provided for in 4VAC15-410-40 B 1 and 2.

B. In taking the exam open-book, the student may use the course text, instructor handouts, any related course material, and any personal notes taken during the class instruction to assist in the completion of the exam. The exam must be completed in a single session with a time limit not to exceed two hours.

4VAC15-410-110. Equivalency exam criteria.

A. The department shall develop and make available a written equivalency exam to test the knowledge of information included in the curriculum of a boating safety education course. Such exam shall provide experienced and knowledgeable boaters with the opportunity to meet the boating safety education compliance requirement set forth in §29.1-735.2 of the Code of Virginia without having to take and successfully complete a boating safety education course.

B. The equivalency exam shall be proctored by an individual(s) specifically designated by the department. The use of reference materials shall not be allowed while the exam is being administered and the exam shall be completed in a single session with a time limit not to exceed three hours.

C. The equivalency exam shall be comprised of no less than 75 nor more than 100 exam questions and a minimum score of at least 70% shall be considered passing. Upon successful completion, an exam certificate and/or card shall be issued to the person completing the exam.

4VAC15-410-120. Requirements for motorboat rental and leasing businesses and the dockside safety checklist program.

A. Any person, business, or organization that provides a motorboat with a motor of 10 horsepower or greater or personal watercraft for rent or lease shall provide the rental/lease boat operator with a dockside safety checklist

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provided by the department. Other persons authorized to operate such boat shall also be provided with the dockside safety checklist.

B. A dockside safety checklist shall consist of selected facts about Virginia boating laws and safe boat operation.

C. The authorized operator(s) of the rental/leased boat shall review and initial each item in the dockside safety checklist before they may operate the boat being rented or leased.

D. The dockside safety checklist for the authorized operator(s) shall be retained on board the boat being rented or leased, along with the rental or lease agreement from the motorboat rental or leasing business, when the boat is being operated.

E. Any person who presents documentation that he has met the minimum standards for boating safety education course competency in accordance with 4VAC15-410-40 B or possesses a valid license to operate a vessel issued to maritime personnel by the United States Coast Guard or a marine certificate issued by the Canadian government or possesses a Canadian Pleasure Craft Operator's Card or possesses a commercial fisherman registration pursuant to §28.2-241 of the Code of Virginia shall be exempt from the dockside safety checklist requirements.

F. Pursuant to §29.1-735.2 B 6 of the Code of Virginia, a person may be allowed to operate the rented/leased boat without completing the dockside safety checklist as long as he is operating under the onboard direct supervision of a person (i) who has completed the dockside safety checklist or (ii) who is otherwise exempt from the dockside safety checklist requirement.

4VAC15-410-130. Temporary operator's certificate.

A. The registered owner(s) of a motorboat or personal watercraft, if the boat is new or was sold with a transfer of ownership, shall be issued with the certificate of number for the motorboat or personal watercraft a temporary operator's certificate that shall allow the owner(s) to operate such boat in Virginia for 90 days.

B. A temporary operator's certificate shall be issued by the department, by any person authorized by the director to act as an agent to issue a certificate of number pursuant to §29.1-706 of the Code of Virginia, or by a license agent of the department authorized to issue a temporary registration certificate for a motorboat. A temporary operator's certificate shall not be renewable.

4VAC15-410-140. Optional Virginia Boater Education Card.

A. The department may establish an optional Virginia Boater Education Card for issuance to persons who can show that they have met the minimum standard of boating safety education course competency or who possesses a valid

license to operate a vessel issued to maritime personnel by the United States Coast Guard or a marine certificate issued by the Canadian government or possesses a Canadian Pleasure Craft Operator's Card or possesses a commercial fisherman registration pursuant to §28.2-241 of the Code of Virginia.

B. To obtain an optional Virginia Boater Education Card, a person must provide to the department:

1. A completed application on a form provided by the department. The application shall require the applicant's name, current mailing address, and date of birth. The applicant must also sign a statement declaring that statements made on the form are true and correct and that all documents submitted with the form are true and correct copies of documents issued to the applicant. Incomplete applications will be returned to the applicant;

2. A copy of the documentation (such as the boating safety education course completion certificate/wallet card or equivalency exam completion certificate/card) that indicates that the minimum standards for boating safety education course competency have been met. Such documents must contain the name of the individual applying for the Virginia Boater Education Card. The department may require the applicant to provide the original document in the event that the copy submitted with the application is illegible or if the authenticity of the copy is not certain.

C. Upon receipt by the applicant, the optional Virginia Boater Education Card will serve in lieu of any other certificates or cards that have been issued to the bearer as a result of meeting the minimum standards for boating safety education course competency. As such, the Virginia Boater Education Card will not be transferable or revocable and will have no expiration date.

D. A person may apply, on a form provided by the Department, for a replacement Virginia Boater Education Card. A replacement card may be issued if the original card is lost, stolen or destroyed, if misinformation is printed on the card, or if the bearer has legally changed their name. The application shall include an affidavit stating the circumstances that led to the need for replacement of the original card.

4VAC15-410-150. Fees.

A. Pursuant to §29.1-735.2 E of the Code of Virginia, the board may establish fees for boating safety courses and certificates provided by the department. Such fees shall not exceed the cost of giving such instruction for each person participating in and receiving the instruction.

B. The department shall not charge a fee for the provision of its state course for basic boating education delivered in a conventional classroom setting.

C. Fees charged by an approved course provider for boating safety education courses are set by the course provider, but

must be clearly communicated to the student prior to taking the course.

D. The fee for issuance of an optional Virginia Boater Education Card, which will serve in lieu of a previously-obtained boating safety education course certificate/card, shall be \$10. The fee for a replacement card shall be \$8.00.

4VAC15-410-160. Penalties.

As provided for in §§29.1-735.2 H and 29.1-748 B of the Code of Virginia, any person who violates any provision of this chapter shall be subject to a civil penalty of \$100. All civil penalties assessed under this chapter shall be deposited in the Motorboat and Water Safety Fund of the Game Protection Fund and used as provided for in §29.1-701 of the Code of Virginia.

NOTICE: The forms used in administering the above regulation are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS

Optional Virginia Boater Education Card Application Form (eff. (insert effective date)).

DOCUMENTS INCORPORATED BY REFERENCE

National Boating Education Standards, updated January 1, 2008, National Association of State Boating Law Administrators.

VA.R. Doc. No. R08-1187; Filed February 13, 2008, 11:34 a.m.

MARINE RESOURCES COMMISSION

Final Regulation

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: 4VAC20-530. Pertaining to American Shad (amending 4VAC20-530-31).

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

Effective Date: February 5, 2008.

Agency Contact: Brandy L. Battle, Agency Regulatory Coordinator, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, FAX (757) 247-2002, or email brandy.battle@mrc.virginia.gov.

Summary:

This amendment continues the participation requirements for the American shad bycatch fishery into 2008.

4VAC20-530-31. Bycatch fishery.

A. Any registered commercial fisherman meeting the conditions described in this subsection shall be eligible to participate in the American shad bycatch fishery in ~~2007~~ 2008:

1. The registered commercial fisherman shall apply for a VMRC American Shad Bycatch Permit and possess that permit while fishing, landing, or selling his catch of American shad.
2. The registered commercial fisherman shall complete the VMRC American Shad Bycatch Survey form to describe his pending fishing activity.

B. It shall be unlawful for any person to possess aboard a vessel more than 10 American shad. When more than one registered and permitted fisherman is fishing on the same vessel, it shall be unlawful to possess more than 10 American shad aboard that vessel.

C. It shall be unlawful for any person to possess aboard a vessel or land any American shad, unless that person possesses at least an equal number of fish of only the

following food-grade species: spot, croaker, bluefish, catfish, striped bass or white perch.

D. Possession of American shad by any person permitted in accordance with this section shall be lawful only when those American shad were harvested from the bycatch area. Possession of any American shad harvested in Virginia waters that are outside of the bycatch area shall constitute a violation of this regulation, except as described in 4VAC20-530-32.

E. American shad harvested only as bycatch by anchored gill nets and staked gill nets may be possessed or retained for sale in accordance with the provisions of this regulation. It shall be unlawful for any person to harvest, land or possess any American shad taken by any commercial gear, except anchored gill net or staked gill net, or any recreational gear.

F. Every fisherman permitted for the American shad bycatch fishery shall contact the commission's interactive voice response system once weekly to report the following for the preceding weekly period: name, registration number, number of fishing trips taken, water body fished, number of nets set, number of American shad caught and number retained.

VA.R. Doc. No. R08-1174; Filed February 5, 2008, 11:21 a.m.

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TITLE 6. CRIMINAL JUSTICE AND CORRECTIONS

STATE BOARD OF CORRECTIONS

Final Regulation

REGISTRAR'S NOTICE: The Board of Corrections is claiming an exemption from the Administrative Process Act pursuant to (i) §2.2-4002 B 9 of the Code of Virginia, which exempts agency action relating to inmates of prisons or other such facilities or parolees therefrom, (ii) §2.2-4002 B 10 of the Code of Virginia, which exempts agency action relating to the custody of persons in, or sought to be placed in, mental, penal or other state institutions as well as the treatment, supervision, or discharge of such persons, and (iii) §2.2-4006 A 3, which excludes regulations that consist only of changes in style or form or corrections of technical errors. The Board of Corrections will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 6VAC15-62. Standards for State Community Corrections Units (amending 6VAC15-62-110).

Statutory Authority: §53.1-5 of the Code of Virginia.

Effective Date: March 3, 2008.

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Agency Contact: Janice Dow, Agency Regulatory Coordinator, Department of Corrections, P.O. Box 23963, Richmond, VA 23261-6963, telephone (804) 674-3303 x1128, FAX (804) 674-3017, or email janice.dow@vadoc.virginia.gov.

Summary:

The amendments (i) make grammatical corrections, (ii) change the time line for a released offender to meet with field staff from five working days to 10 working days, and (iii) incorporate by reference Interstate Commission for Adult Offender Supervisor Rules effective January 1, 2008.

6VAC15-62-110. Supervision.

A. Where statute authorizes arrest authority for probation and parole officers, written policy, procedure and practice define the scope of these powers.

B. Written policy, procedure and practice provide that a pre-arrest briefing shall be conducted prior to a planned arrest with all staff and other law-enforcement agencies participating in the action.

C. Written policy, procedure and practice provide procedures for probation and parole officers to transport offenders.

D. Written policy, procedure and practice govern critical incident protocol.

E. Written policy, procedure and practice govern classification and supervision of offenders in order to safeguard the community and meet the program needs of the offender. Offenders should be placed in the appropriate supervision level after the initial interview as required; such level to be determined by an approved risk assessment tool and process. Reclassification should occur at six-month evaluation periods or where warranted and be recorded and justified in the chronological record.

F. Written policy, procedure and practice provide for the field officer and offender to jointly develop and follow up on a written supervision plan that includes:

1. Specific supervision objectives (including the safeguarding of the community and meeting the program needs of the offender and methods to achieve the objectives.
2. An initial assessment of each offender (and all subsequent reassessments) using a standardized and validated assessment tool.
3. Specific criteria for determining and changing an offenders supervision plan.
4. Regular reviews of the ~~offenders~~ offender's progress with an individual supervision plan.

5. Appropriate programs and services and proportionate incentives and sanctions.

6. Adjustments to the individual plan made based on the reassessment and in accordance with the offenders performance in the community.

Any review results are recorded in the case file and communicated with the offender.

A review and update of the ~~offenders~~ offender's plan, as needed, is performed at least annually.

G. The probation/parole district staff may request the court or the paroling authority to add, remove or modify any of the special conditions, including early termination of supervision, where indicated.

H. The conditions of probation/parole are furnished in writing to the offender. When a problem prevents an offender from understanding conditions of supervision, a field officer or other person should assist the offender in understanding them. The offender acknowledges in writing that he has received and understands the conditions or there is certification to that effect.

I. Written policy procedure and practice provide that access to supervision staff is available 24 hours a day. Offenders should be made aware that 24-hour access is available and informed of methods for obtaining access.

J. Written policy, procedure and practice provide that the security of the ~~offenders~~ offender's file and file material is maintained.

K. Written policy, procedure and practice preclude offenders from being confronted with possible probation/parole violations for failure to meet financial obligations other than those that are conditions of probation/parole.

L. Written policy, procedure and practice provide for reviews of offender progress with recommendation of early termination of supervision where indicated. The results of such reviews are recorded in the case file.

M. Male and female offenders under supervision have equal access to all agency programs and activities.

N. Written policy, procedure and practice define, in accordance with the courts or parole authority, the types of minor violation that can be resolved by field staff.

O. Written policy, procedure and practice require that all alleged probation/parole violations be reviewed by the probation and parole officer with the supervisor prior to formal violation proceedings.

P. Written policy, procedure and practice provide that all arrests and alleged probation/parole violations are investigated immediately; all serious arrests and major probation/parole violations are reported promptly in writing to the proper authority. A serious incident report will be sent

to the regional director and the deputy director as required by directives and procedures.

Q. Written policy, procedure and practice require that a probable cause hearing be held within 14 calendar days upon notification of the arrest and detention of the parolee or the lodging of the detention warrant. However, when there has been a conviction or a finding of probable cause on new criminal charges, the preliminary hearing is not required.

R. The probable cause hearing is held in or near the community where the violation is alleged to have occurred or where the offender has been taken into custody whenever possible.

S. Written policy, procedure and practice provide that the probable cause hearing may be delayed or postponed for good cause and the parolee may waive the hearing if first informed of his rights pertaining to the hearing and the consequences of waiving the hearing.

T. When requested by the revoking authority, a member of the administrative staff conducts a probable cause hearing and makes findings as to probable cause for revocation.

U. Written policy, procedure and practice require that the probable cause hearing is conducted by an administrative staff member who has no knowledge of the alleged violations.

V. Written policy, procedure and practice require that at least three days prior to the probable cause hearing, the parolee is notified in writing of the time and place of the hearing and of the specific violation or violations charged. The parolee is also advised in writing of the right to:

1. Present evidence and favorable witnesses.
2. Disclosure of evidence.
3. Confront adverse witnesses, unless the witnesses would be subjected to a risk of harm.
4. Have counsel of choice present or, in the case of indigent persons who request assistance to adequately present their case, may have counsel appointed.
5. Request postponement of the hearing for good cause.

W. Written policy, procedure and practice specify that the person who conducts the probable cause hearing determines whether there is probable cause to revoke parole and hold the offender for a revocation hearing before the revoking authority. The revoking authority may empower the hearing officer to defer the revocation recommendation, restore the offender to supervision, and employ available sanctions or report the findings and recommendation to the authority for a decision as to revocation. The hearing officer issues a verbal decision or recommendation immediately after the hearing and provides a written decision to the offender within 21 calendar days of the hearing.

X. Written policy, procedure and practice specify that the parolee is recommended for incarceration only when probable cause is found at the probable cause hearing and when it is determined, after considering the appropriateness of less severe sanctions, that the clear interest of the public requires incarceration.

Y. When violations occur, alternatives to revocation and incarceration are considered to the extent that public safety is not endangered and the possibility of successful community adjustment exists.

Z. Written policy, procedure and practice govern, in conformance with prevailing law, cooperation with law-enforcement agencies in efforts to apprehend offenders known to be or suspected of being involved in criminal activities.

AA. Written policy, procedure and practice specify the types of actions required to locate and recover absconders.

BB. Written policy, procedure and practice govern the exercise of authority for the arrest and detention of offenders pending a determination by the revoking authority as to whether probation/parole should be revoked.

CC. The authority for the arrest and detention of offenders is exercised only upon adequate evidence of a probable serious violation or repeated pattern of violation of conditions and a compelling need for detention pending the revoking authority's initial revocation decision.

DD. Written policy, procedure and practice provide for the use of physical force only in instances of justifiable self-defense and protection of others and in accordance with appropriate statutory authority. Only the minimum force necessary is employed.

EE. All incidents involving use of physical force are reported full, promptly and in writing to administrative staff for their information and review. All injuries are reported in writing and treated promptly.

FF. Special supervision reports are prepared whenever an unusual situation involving the offender occurs.

GG. Written policy, procedure and practice require that all offenders are informed of the grievance process available to them at the time of the initial interview.

HH. Written policy, procedure and practice govern the transfer, acceptance, rejection, or termination of interest in cases to and from other jurisdictions in accordance with the Rules effective January 1, ~~2007~~ 2008, adopted by the Interstate Compact for Adult Offender Supervision pursuant to Articles V and VIII of the Interstate Compact for Adult Offender Supervision.

II. Written policy, procedure and practice provide that probationers and parolees will sign all current Interstate

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Compact forms found on the interstate website (www.interstatecompact.org) that are necessary for movement and acceptance in the receiving state. The receiving district has 30 days from receipt of the request to conduct the investigation and provide a response.

JJ. Written policy, procedure and practice provide that the receiving state shall assume supervision standards and services that prevail for its own probationers and parolees, as well as for the sending states. The duration of supervision will be determined by the sending state and by court order. The degree of supervision shall be determined by the receiving state.

KK. Written policy, procedure and practice provide that required reports be submitted annually, upon case closure or upon request per the Rules effective January 1, ~~2007~~ 2008, adopted by the Interstate Compact for Adult Offender Supervision pursuant to Articles V and VIII of the Interstate Compact for Adult Offender Supervision.

LL. Written policy, procedure and practice provide that the receiving state shall be notified of any significant violations of parole and probation within 30 days per the Rules effective January 1, ~~2007~~ 2008, adopted by the Interstate Compact for Adult Offender Supervision pursuant to Articles V and VIII of the Interstate Compact for Adult Offender Supervision.

MM. Written policy, procedure and practice provide that preliminary on-site hearings will be conducted under the rules of the receiving state following due process as required by law.

NN. Written policy, procedure and practice provide that the initial personal contact between the newly released offender and the field staff takes place as soon as possible, but not more than ~~five~~ 10 working days after the ~~offenders~~ offender's release to supervision unless otherwise agreed upon prior to release.

OO. Parole violation reports are submitted within five working days after the hearing.

PP. The probation and parole staff provides assistance and services to ex-offenders who request such help consistent with the provisions of subdivision 3 of §53.1-145 of the Code of Virginia and applicable procedures.

QQ. The district cooperates in providing information on the legitimacy of transition visits.

DOCUMENTS INCORPORATED BY REFERENCE

Interstate Compact for Adult Offender Supervision Rules, effective January 1, ~~2007~~ 2008, adopted by the Interstate Compact for Adult Offender Supervision pursuant to Articles V and VIII of the Interstate Compact for Adult Offender Supervision.

VA.R. Doc. No. R08-1184; Filed February 12, 2008, 10:49 a.m.

TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Forms

NOTICE: The following forms have been filed by the State Water Control Board. The forms are available for public inspection at the State Water Control Board, 629 East Main Street, Richmond, Virginia 23218, or the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219. Copies of the forms may be obtained from Cindy M. Berndt, Director, Regulatory Affairs, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone 804-698-4378, FAX 804-698-4346 or email cmberndt@deq.virginia.gov.

Title of Regulation: **9VAC25-32. Virginia Pollution Abatement (VPA) Permit Regulation.**

FORMS

Virginia Pollution Abatement Permit Application, General Instructions, revised ~~10/95~~ 2008.

Virginia Pollution Abatement Permit Application, Form A, All Applicants, revised ~~10/95~~ 1/08.

Virginia Pollution Abatement Permit Application, Form B, Animal Waste, revised 10/95.

Virginia Pollution Abatement Permit Application, Form C, Industrial Waste, revised 10/95.

Virginia Pollution Abatement Permit Application, Form D, Municipal ~~Waste~~ Effluent and Biosolids, revised ~~10/95~~ 2/08.

Application for a Biosolids Use Permit, 2007.

Application for Land Application Supervisor Certification, revised 2007.

VA.R. Doc. No. R07-1185; Filed February 12, 2008, 1:41 p.m.

Fast-Track Regulation

Title of Regulation: **9VAC25-260. Water Quality Standards (amending 9VAC25-260-30).**

Statutory Authority: §62.1-44.15 of the Code of Virginia; Clean Water Act (33 USC §1251 et seq.); 40 CFR Part 131.

Public Hearing Information: No public hearings are scheduled.

Public Comments: Public comments may be submitted until April 2, 2008.

Effective Date: Effective upon filing notice of U.S. EPA approval with Registrar of Regulations.

Agency Contact: David C. Whitehurst, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4121, FAX (804) 698-4116, or email dcwhitehurst@deq.virginia.gov.

Basis: Section 62.1-44.15(3a) of the Code of Virginia, mandates and authorizes the State Water Control Board to establish water quality standards and policies for any state waters consistent with the purpose and general policy of the State Water Control Law, and to modify, amend or cancel any such standards or policies established. The federal Clean Water Act at 303(c) mandates the State Water Control Board to review and, as appropriate, modify and adopt water quality standards. The corresponding federal water quality standards regulation at 40 CFR 131.6 describes the minimum requirements for water quality standards. The minimum requirements are use designations, water quality criteria to protect the designated uses and an antidegradation policy. All of the citations mentioned describe mandates for water quality standards.

The Environmental Protection Agency (EPA) Water Quality Standards regulation (40 CFR 131.12) is the regulatory basis for the EPA requiring the states to establish within the antidegradation policy the Exceptional State Waters category and the eligibility decision criteria for these waters. EPA retains approval/disapproval oversight, but delegates to the states the election and designation of specific water bodies as Exceptional State Waters.

Purpose: The department has concluded that the proposed amendments to the regulation are essential to protecting the health, safety and welfare of the citizens of the Commonwealth by protecting the water quality and living resources of these particular water bodies for human consumption of fish, recreational uses and conservation. The board took action on this agency generated nomination for proposed designation because department staff had concluded, based on the information available at the time of the preliminary evaluation, that the proposed designation met the eligibility requirements which a water body must meet before it can be afforded the extra point source protection provided by such a designation. The Exceptional State Waters category of the Antidegradation Policy allows the board to designate waters which display exceptional environmental settings and either exceptional aquatic communities or exceptional recreational opportunities for added protection. The sections of these waters under consideration within the National Forest within Augusta and Scott Counties meet two of the necessary criteria: Exceptional Environmental Setting and Exceptional Recreational Opportunities. State classification of these waters as Exceptional State Waters will afford an additional layer of protection over that provided by the Antidegradation Policy (9VAC25-260-30 A 3 b) in that

no water quality degradation at all would be allowed in Exceptional Waters. The only exception would be temporary, limited impact activities. These are waters that are of a very high quality and possess ecological attributes or exceptional recreational usage that need the special protection and maintenance provided by not lowering water quality. By ensuring that no water quality degradation is allowed to occur in exceptional state waters, the board is protecting these special waters at their present quality for use and enjoyment by future generations of Virginians.

Because of the potential impact of an Exceptional State Waters designation on permitted discharges to the water body, §62.1-44.15:4 B of the Code of Virginia requires notification and opportunity for comment from potentially impacted localities and riparian property owners, so the decision by the Board to initiate a rulemaking to amend the water quality standards to designate these waters as Exceptional State Waters was made after providing an opportunity to comment and giving due consideration to their comments.

Rationale for Using Fast-Track Process: The proposed amendment is expected to be noncontroversial, and therefore justifies using the fast track process. The segments of the North River and Little Stony Creek intended for Exceptional State Waters designation are entirely on public lands (George Washington and Jefferson National Forests) and impacts are not expected for individual riparian landowners or businesses.

Substance: The proposed amendments to the Antidegradation Policy (9VAC25-260-30), designates portions of the North River and Little Stony Creek for special protection as Exceptional State Waters (9VAC25-260-30 A 3 c).

Issues: Upon permanent regulatory designation of a water body as an Exceptional State Water, the quality of that water body will be maintained and protected by not allowing any degradation except on a very short-term basis. No new, additional or increased point source discharge of sewage, industrial wastes or other pollution would be allowed into waters designated. In addition, no new mixing zones would be allowed in the Exceptional State Water and mixing zones from upstream or tributary waters could not extend into the Exceptional State Water section.

A potential disadvantage to the public may be the prohibition of new or expanded permanent point source discharges imposed within the segment once the regulatory designation is effective that would cause riparian landowners within the designated segment to seek alternatives to discharging to the designated segment and, therefore, to have additional financial expenditures associated with wastewater or storm water treatment. The segments of the water bodies under consideration for designation do not currently contain any permitted point source discharges.

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The primary advantage to the public is that the waters will be protected at their present high level of quality for the use and enjoyment of current and future generations of Virginians.

The factors to be considered in determining whether a nominated water body meets the eligibility decision criteria of exceptional environmental settings and possessing outstanding recreational opportunities and/or exceptional aquatic communities are described in the Department's November 15, 2004 "04-2021, Guidance for Exceptional State Waters Designations in Antidegradation Policy Section of Virginia Water Quality Standards Regulation (9VAC25-260-30 A 3)." Although the water bodies proposed for designation are located on public (federal) land, the locality and businesses located near the designated waters may experience financial benefits through an increase in eco-tourism to the area because of the exceptional nature of the water bodies that led to their designation.

There is no disadvantage to the agency or the Commonwealth that will result from the adoption of this amendment

Department of Planning and Budget's Economic Analysis:

Summary of the Proposed Amendments to Regulation. The State Water Control Board (Board) is proposing to amend the Antidegradation Policy section of the State's Water Quality Standards regulation to designate a segment of the North River in Augusta County and a segment of Little Stony Creek in Scott County for special protection as an Exceptional State Water, and therefore entitle them to special protection.

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

Estimated Economic Impact. The Board is proposing to designate Little Stony Creek in Scott County from Bark Camp Lake dam to its confluence with Bakers Branch, and North River in Augusta County from the Staunton Reservoir dam to the first crossing with National Forest lands boundary, Exceptional State Waters. This designation would entitle these bodies of water to the special protection afforded by the designation.

According to the Department of Environmental Quality (Department), the Exceptional State Waters category of the Antidegradation Policy (9VAC25-260-30) allows the Board to offer waters which display exceptional environmental settings and either exceptional aquatic communities or exceptional recreational opportunities added protection. These are waters that are of a very high quality and possess ecological attributes or exceptional recreational usage that need the special protection and maintenance provided by not lowering water quality. State classification as an Exceptional State Water affords an additional layer of protection over that provided by the Antidegradation Policy in that no water quality degradation at all is allowed in Exceptional Waters, except for temporary, limited impact activities. No new, additional, or increased point source discharge of sewage,

industrial wastes, or other pollution is allowed. In addition, no new mixing zones are allowed in Exceptional State Waters and mixing zones from upstream or tributary waters cannot extend into the Exceptional State Water section. This amendment was proposed because Department staff concluded, based on the information available at the time of preliminary evaluation, that the proposed designations meet the eligibility requirements which a water must meet to be afforded the extra point source protection.

One potential cost to the amendment is that new or expanded permanent point source discharges imposed within the designated segments of Little Stony Creek and the North River may be prohibited. The water segments under consideration do not currently contain any point source discharges. In fact, because these particular Exceptional State Waters designations are located on federal lands, the United States Forest Service is the only riparian landowner. Therefore, the proposed amendment is not anticipated to impact any business or locality.

The primary benefit of the proposed amendment, according to the Department, is that the waters will be protected at their present high level of quality for the use and enjoyment of current and future generations of Virginians. The sections of these waters under consideration within the National Forest in Augusta and Scott Counties meet two of the necessary eligibility decision criteria as described in the Department's November 15, 2004 "04-2021, Guidance for Exceptional State Waters Designations in Antidegradation Policy Section of Virginia Water Quality Standards Regulation (9VAC25-260-30 A 3)." These criteria are: Exceptional Environmental Setting and Exceptional Recreational Opportunities. Although the proposed water bodies are located on public (federal) land, the Department believes that another benefit of the proposed amendments is to increase eco-tourism to the area because of the exceptional nature of the water. An increase in tourism would offer financial benefits to local business and government.

Businesses and Entities Affected. Because the United States Forest Service is the only riparian landowner adjacent to the designated water body, only one entity—the federal government—will be impacted directly by the proposed amendments. Indirectly, businesses local to the areas could be positively affected by an increase in tourism.

Localities Particularly Affected. Augusta and Scott Counties are the only counties affected, but because the segments of water in question are located on federal lands, the proposed amendments are not expected to impose a cost on the counties or localities within the counties.

Projected Impact on Employment. The proposed changes are not anticipated to have any impact on employment.

Effects on the Use and Value of Private Property. The proposed amendments are not anticipated to have any

negative effect on the use and value of private property, although if these designations increase eco-tourism in the areas, businesses, housing values, and other private property could be positively impacted.

Small Businesses: Costs and Other Effects. The proposed changes are not anticipated to add cost or otherwise affect small businesses.

Small Businesses: Alternative Method that Minimizes Adverse Impact. The proposed amendments do not add cost or otherwise affect small businesses.

Real Estate Development Costs. The proposed amendments do not create additional costs related to the development of real estate for commercial or residential purposes.

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with §2.2-4007.04 of the Administrative Process Act and Executive Order Number 36 (06). Section 2.2-4007.04 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. Further, if the proposed regulation has adverse effect on small businesses, §2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

Agency's Response to the Department of Planning and Budget's Economic Analysis: The department has reviewed the economic impact analysis prepared by the Department of Planning and Budget and has no comment.

Summary:

The proposed amendment designates a segment of the North River in Augusta County and a segment of Little Stony Creek in Scott County for special protection as an Exceptional State Water.

9VAC25-260-30. Antidegradation policy.

A. All surface waters of the Commonwealth shall be provided one of the following three levels, or tiers, of antidegradation protection. This antidegradation policy shall be applied whenever any activity is proposed that has the potential to affect existing surface water quality.

1. As a minimum, existing instream water uses and the level of water quality necessary to protect the existing uses shall be maintained and protected.

2. Where the quality of the waters exceed water quality standards, that quality shall be maintained and protected unless the board finds, after full satisfaction of the intergovernmental coordination and public participation provisions of the Commonwealth's continuing planning process, that allowing lower water quality is necessary to accommodate important economic or social development in the area in which the waters are located. In allowing such degradation or lower water quality, the board shall assure water quality adequate to protect existing uses fully. Further, the board shall assure that there shall be achieved the highest statutory and regulatory requirements applicable to all new or existing point source discharges of effluent and all cost-effective and reasonable best management practices for nonpoint source control.

3. Surface waters, or portions of these, which provide exceptional environmental settings and exceptional aquatic communities or exceptional recreational opportunities may be designated and protected as described in subdivisions 3 a, b and c of this subsection.

a. Designation procedures.

(1) Designations shall be adopted in accordance with the provisions of the Administrative Process Act (§2.2-4000 et seq. of the Code of Virginia) and the board's public participation guidelines.

(2) Upon receiving a nomination of a waterway or segment of a waterway for designation as an exceptional state water pursuant to the board's antidegradation policy, as required by 40 CFR 131.12, the board shall notify each locality in which the waterway or segment lies and shall make a good faith effort to provide notice to impacted riparian property owners. The written notice shall include, at a minimum: (i) a description of the location of the waterway or segment; (ii) the procedures and criteria for designation as well as the impact of the designation; (iii) the name of the person making the nomination; and (iv) the name of a contact person at the Department of Environmental Quality who is knowledgeable about the nomination and the waterway or segment. Notice to property owners shall be based on names and addresses taken from local tax rolls. Such names and addresses shall be provided by the

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Commissioners of the Revenue or the tax assessor's office of the affected jurisdiction upon request by the board. After receipt of the notice of the nomination, localities shall be provided 60 days to comment on the consistency of the nomination with the locality's comprehensive plan. The comment period established by subdivision 3 a (2) of this subsection shall in no way impact a locality's ability to comment during any additional comment periods established by the board.

b. Implementation procedures.

(1) The quality of waters designated in subdivision 3 c of this subsection shall be maintained and protected to prevent permanent or long-term degradation or impairment.

(2) No new, additional, or increased discharge of sewage, industrial wastes or other pollution into waters designated in subdivision 3 c of this subsection shall be allowed.

(3) Activities causing temporary sources of pollution may be allowed in waters designated in subdivision 3 c of this subsection even if degradation may be expected to temporarily occur provided that after a minimal period of time the waters are returned or restored to conditions equal to or better than those existing just prior to the temporary source of pollution.

c. Surface waters designated under this subdivision are as follows:

(1) Little Stony Creek in Giles County from the first footbridge above the Cascades picnic area, upstream to the 3,300-foot elevation.

(2) Bottom Creek in Montgomery County and Roanoke County from Route 669 (Patterson Drive) downstream to the last property boundary of the Nature Conservancy on the southern side of the creek.

(3) Lake Drummond, located on U.S. Fish and Wildlife Service property, is nominated in its entirety within the cities of Chesapeake and Suffolk excluding any ditches and/or tributaries.

(4) North Creek in Botetourt County from the first bridge above the United States Forest Service North Creek Camping Area to its headwaters.

(5) Brown Mountain Creek, located on U.S. Forest Service land in Amherst County, from the City of Lynchburg property boundary upstream to the first crossing with the national forest property boundary.

(6) Laurel Fork, located on U.S. Forest Service land in Highland County, from the national forest property boundary below Route 642 downstream to the Virginia/West Virginia state line.

(7) North Fork of the Buffalo River, located on U.S. Forest Service land in Amherst County, from its confluence with Rocky Branch upstream to its headwaters.

(8) Pedlar River, located on U.S. Forest Service land in Amherst County, from where the river crosses FR 39 upstream to the first crossing with the national forest property boundary.

(9) Ramseys Draft, located on U.S. Forest Service land in Augusta County, from its headwaters (which includes Right and Left Prong Ramseys Draft) downstream to the Wilderness Area boundary.

(10) Whitetop Laurel Creek, located on U.S. Forest Service land in Washington County, from the national forest boundary immediately upstream from the second railroad trestle crossing the creek above Taylors Valley upstream to the confluence of Green Cove Creek.

(11) Ragged Island Creek in Isle of Wight County from its confluence with the James River at a line drawn across the creek mouth at N36°56.306'/W76°29.136' to N36°55.469'/W76°29.802' upstream to a line drawn across the main stem of the creek at N36°57.094'/W76°30.473' to N36°57.113'/W76°30.434', excluding wetlands and impounded areas and including only those tributaries completely contained within the Ragged Island Creek Wildlife Management Area on the northeastern side of the creek.

(12) Big Run in Rockingham County from its headwaters downstream to the first crossing with the Shenandoah National Park boundary and all tributaries to this segment of Big Run within the confines of Shenandoah National Park.

(13) Doyles River in Albemarle County from its headwaters to the first crossing with the Shenandoah National Park boundary and Jones Falls Run from its headwaters to its confluence with Doyles River and all tributaries to these segments of Doyles River and Jones Fall Run within the confines of Shenandoah National Park.

(14) East Hawksbill Creek in Page County from its headwaters downstream to the first crossing with the Shenandoah National Park boundary and all tributaries to this segment of East Hawksbill Creek within the confines of Shenandoah National Park.

(15) Jeremys Run in Page County from its headwaters downstream to the first crossing with the Shenandoah National Park boundary and all tributaries to this segment of Jeremys Run within the confines of Shenandoah National Park.

(16) East Branch Naked Creek in Page County from its headwaters downstream to the first crossing with the

Shenandoah National Park boundary and all tributaries to this segment of East Branch Naked Creek within the confines of Shenandoah National Park.

(17) Piney River in Rappahannock County from its headwaters downstream to the first crossing with the Shenandoah National Park boundary and all tributaries to this segment of the Piney River within the confines of Shenandoah National Park.

(18) North Fork Thornton River in Rappahannock County from its headwaters downstream to the first crossing with the Shenandoah National Park boundary and all tributaries to this segment of the North Fork Thornton River within the confines of Shenandoah National Park.

(19) Blue Suck Branch from its headwaters downstream to the first crossing with the George Washington National Forest boundary.

(20) Downy Branch from its headwaters downstream to the first crossing with the George Washington National Forest boundary.

(21) North Branch Simpson Creek (Brushy Run) from its headwaters downstream to its confluence with Simpson Creek.

(22) Roberts Creek from its confluence with the Pedlar River upstream to its first crossing with the National Forest boundary.

(23) Shady Mountain Creek from its headwaters downstream to its confluence with the Pedlar River.

(24) Cove Creek from its headwaters downstream to the National Forest boundary.

(25) Little Cove Creek and its tributaries from the headwaters downstream to the National Forest boundary.

(26) Rocky Branch from its headwaters downstream to its confluence with the North Fork of the Buffalo River.

(27) North Fork of the Buffalo River from its confluence with Rocky Branch downstream to the National Forest Boundary.

(28) Reserved

(29) Little Stony Creek in Scott County from Bark Camp Lake dam to its confluence with Bakers Branch.

(30) North River in Augusta County from the Staunton Reservoir dam to the first crossing with National Forest lands boundary (near Girl Scout Camp May Flather).

B. Any determinations concerning thermal discharge limitations made under §316(a) of the Clean Water Act will be considered to be in compliance with the antidegradation policy.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Reproposed Regulation

Title of Regulation: 12VAC5-230. State Medical Facilities Plan (amending 12VAC5-230-10, 12VAC5-230-30; adding 12VAC5-230-40 through 12VAC5-230-1000; repealing 12VAC5-230-20).

12VAC5-240. General Acute Care Services (repealing 12VAC5-240-10 through 12VAC5-240-60).

12VAC5-250. Perinatal Services (repealing 12VAC5-250-10 through 12VAC5-250-120).

12VAC5-260. Cardiac Services (repealing 12VAC5-260-10 through 12VAC5-260-130).

12VAC5-270. General Surgical Services (repealing 12VAC5-270-10 through 12VAC5-270-60).

12VAC5-280. Organ Transplantation Services (repealing 12VAC5-280-10 through 12VAC5-280-70).

12VAC5-290. Psychiatric and Substance Abuse Treatment Services (repealing 12VAC5-290-10 through 12VAC5-290-70).

12VAC5-300. Mental Retardation Services (repealing 12VAC5-300-10 through 12VAC5-300-70).

12VAC5-310. Medical Rehabilitation Services (repealing 12VAC5-310-10 through 12VAC5-310-70).

12VAC5-320. Diagnostic Imaging Services (repealing 12VAC5-320-10 through 12VAC5-320-480).

12VAC5-330. Lithotripsy Services (repealing 12VAC5-330-10 through 12VAC5-330-70).

12VAC5-340. Radiation Therapy Services (repealing 12VAC5-340-10 through 12VAC5-340-120).

12VAC5-350. Miscellaneous Capital Expenditures (repealing 12VAC5-350-10 through 12VAC5-350-60).

12VAC5-360. Nursing Home Services (repealing 12VAC5-360-10 through 12VAC5-360-70).

Statutory Authority: §§32.1-12 and 32.1-102.2 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comments: Public comments may be submitted until April 4, 2008.

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Agency Contact: Carrie Eddy, Senior Policy Analyst, Department of Health, 9960 Mayland Drive, Suite 401, Richmond, VA 23233, telephone (804) 367-2157, FAX (804) 527-4502, or email carrie.eddy@vdh.virginia.gov.

Basis: The State Medical Facilities Plan (SMFP) is promulgated by the Office of Licensure and Certification of the Virginia Department of Health, for the Board of Health, under the authority of §§32.1-102.1 through 32.1-102.3 of the Code of Virginia. Section 32.1-102.1 defines the SMFP as a planning document adopted by the Board of Health; §32.1-102.2 mandates that the board promulgate regulations to implement Virginia's Medical Care Facilities Certificate of Public Need (COPN) law in which, as set out in §32.1-102.3 of the Code, any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provision of the State Medical Facilities Plan." Existence of the SMFP, therefore, is mandated.

Purpose: The Virginia Medical Care Facilities Certificate of Public Need law requires owners or sponsors of medical care facility projects to secure a COPN from the State Health Commissioner prior to initiating such projects. The SMFP is essential to the implementation of the COPN program as it provides the criteria and standards for the full range of capital expenditure project categories that require review, including general acute care services, perinatal services, diagnostic imaging services, cardiac services, general surgical services, organ transplantation services, medical rehabilitation services, psychiatric/substance abuse services, mental retardation services, lithotripsy services, miscellaneous capital expenditures and nursing facility services. The SMFP provides applicants and reviewing agencies with a framework for examining the need for these projects.

Substance: This stage is a reproposal of a proposed regulation (published in 21:2 VA.R. 94-118 October 4, 2004) for public comment, developed after considerable public comment and lengthy stakeholder discussions.

Because of stakeholder interest in this project and the comprehensive revision as a result of that interest, it was determined that an additional review of the proposed document was appropriate to assure consensus prior to proceeding with the final promulgation stage. Except for changes required by legislative mandate, the State Medical Facilities Plan (SMFP) has not been reviewed and updated since it was first promulgated in 1993. The SMFP is one of 20 criteria used to determine public need in 11 categories of medical care facilities subject to the Certificate of Public Need (COPN) law. The goal of the revision project is to update the criteria and standards to reflect current national and health care industry standards, remove archaic language and ambiguities, and consolidate all portions of the SMFP into one comprehensive document. Because of the consolidation of the current 14 separate regulations into one comprehensive document, 12VAC5-240 through 12VAC5-

360 are being repealed as 12VAC5-230 is amended and promulgated.

The substantive changes are technical in nature, providing clarity, continuity and better direction than the proposed draft. For example, a number of sections have been created from existing text or added to each part to facilitate identification of specific topics to ease the use of the SMFP as a planning document. As a result, sections beginning with Part II have been renumbered. Changes include:

Part I. Definitions and General Information.

Definitions added, deleted, and amended. "Preface" section repealed. Sections on guiding principles, application filing, project costs, and competing applications technically amended to provide better direction and clarify intent. "Emerging technologies" section reallocated to "prorating of mobile service." "Compliance with terms of condition" section deleted.

Part II. Diagnostic Imaging.

Article 1. Computed Tomography: "Need for new services" section amended, e.g. increasing volume standard to 10,000 procedures, and standards rearranged; technical amendments to "expansion of services" and "staffing" sections; section on mobile CT services added; "space" section deleted.

Article 2. Magnetic Resonance Imaging: "Need for new services," "expansion," and staffing sections technically amended; section on mobile MRI services added; "space" section deleted.

Article 4. Positron Emission Tomography: "Need for new service" and "expansion of services" sections technically amended for clarity, in addition to increasing the service volume standards; section added to address mobile PET services; "staffing" section amended to reflect current law regarding professional credentials.

Article 5. Noncardiac nuclear Imaging: "Need for new service" section technically amended for clarity; "staffing" section amended to reflect current law regarding professional credentials.

Part III. Radiation Therapy Services.

Article 1. Radiation therapy services: "Need for new services" section technically amended for clarity; "staffing" section amended to reflect current law regarding professional credentials; "expansion" section created from existing text; "equipment" section deleted.

Article 2. Stereotactic radiosurgery: "Need for new services" section amended and standards added to clarify and facilitate service identification; "expansion of services" section added; "staffing" section amended to reflect current law regarding professional credentials

Part IV. Cardiac Services.

Article 1. Cardiac catheterization services: "Need for new service" sections technically amended for clarity and to increase the service volume standard; "pediatric catheterization," "expansion of services" and "non-emergent catheterization" sections created from existing text for continuity and clarity; "staffing" section amended to reflect current law regarding professional credentials.

Article 2. Open heart surgery: "Travel time" and "need for new services" sections amended for clarity and to increase the service volume standard; "expansion" and "pediatric open heart" section created from existing text; "staffing" section amended to reflect current law regarding professional credentials.

Part V. General Surgical Services.

Formula for determining need amended to change population data source; "staffing" section added for consistency.

Part VI. Inpatient Bed Requirements.

New formulas to determining need created and added; new population data source referenced; three sections created from existing text for clarity and identification of service category; "expansion," "long-term acute care beds," and "staffing" added for clarity and to facilitate identification of services.

Part VII. Nursing Facilities.

Two sections created from existing text with concurrent deletion to the original section; new population data source referenced; "staffing" section added for document continuity and to reflect current law regarding professional credentials.

Part VIII. Lithotripsy Services.

"Expansion" and "mobile services" sections created from existing text; "need for new services" section technically amended for clarity and consistency.

Part IX. Organ Transplant Services.

"Expansion" section added from existing text; "staffing" section added for consistency within the document; "need for new service" and "volumes" section technically amended for clarity.

Part X. Miscellaneous Capital Expenditures.

Technical amendments made.

Part XI. Medical Rehabilitation.

"Expansion" section created from existing text; formula for determining need amended to change population data source amended in "need for new service" section.

Part XII. Mental Health Services.

Article 1. Acute psychiatric and acute substance abuse disorder treatment services. "Intermediate care substance

abuse disorder treatment" standards deleted (F thru J); technical amendments made for clarity and consistency.

Article 2. Mental retardation. Technical amendments made for clarity and consistency.

Part XIII. Perinatal Services.

Article 1. Obstetrical services. Technical amendments made; "staffing" section added for consistency.

Article 2. Neonatal special care services. "Need for new service" section added to clarify COPN requirements for providing such service; individual sections created from existing text for each level of special care (i.e., intermediate, specialty and subspecialty); "staffing" section added for consistency.

Issues: Since the SMFP is such an integral part of the COPN process, no discussion of the SMFP can be conducted without mentioning the COPN program. The COPN law states the program objectives: (i) promote comprehensive health planning to meet the needs of the public; (ii) promote the highest quality of care at the lowest price; (iii) avoid unnecessary duplication of medical care facilities; and (iv) provide an orderly procedure for resolving questions concerning the need to construct or modify medical care facilities. In other words, the program seeks to contain health care costs while ensuring financial viability and access to health care for all Virginians at a reasonable cost. The COPN program has long been a controversial feature of government efforts to contain health care costs. However, lacking a consensus on what might work better, Virginia, like 36 other states, has chosen to maintain its COPN program. That decision, however, does not prevent the department from taking steps to address and alleviate, where possible, some of the on-going controversy regarding the COPN program. There are two issues surrounding the COPN program and subsequently the SMFP: (i) the perception that the COPN program ensures quality health care services, and (ii) the perception that the program has become a guarantor of "franchise" providers, i.e., those providers already holding a COPN, making it difficult for new health care providers to enter the health care market in Virginia.

Over time, the COPN program has garnered a reputation as a program that monitors and ensures quality health care services to Virginia's citizens. In reality, the COPN program addresses but a small portion of the burgeoning health care market and only legislatively mandated licensure programs can actually assure quality health care service delivery. Since the COPN quality misperception stems from some of the criteria in the current SMFP, one of the objectives of the SMFP revision project was to remove criteria that the program does not revisit once the certificate has been granted, such as meeting specific staffing requirements or requiring national accreditation. The COPN law does not provide enforcement of the individual sections of the SMFP. Rather, a

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COPN can be revoked only when: (i) substantial and continuing progress towards project completion has not been made; (ii) the maximum capital expenditure is exceeded, (iii) the applicant has willfully or recklessly misrepresented intentions or facts to obtain a COPN, or (iv) a continuous care retirement community has failed to establish a nursing facility as required by law. However, it is unlikely that VDH would seek revocation of a COPN pursuant to "willful or reckless misrepresented intentions" because a provider fails to obtain national accreditation. The COPN law does not permit inspection after issuing the COPN, which is the only method by which such 'quality' failures can be identified. The SMFP impacts quality only through the service volume and utilization standards established within each of the services specific sections. It is well known in the health care industry that the volume of service provision results in better outcomes and survival rates for patients and service recipients. Therefore, as part of the revision project, the service volume and utilization standards were carefully reviewed and adjusted to meet nationally accepted practices.

Those same 'quality of care' standards in the current SMFP act as a deterrent or barrier for new providers applying for a COPN as they would have no quality service history. Therefore, it can be posited that the current "quality of care standards" contribute to the perception of the COPN program as a "franchise guarantor" as only those current COPN holders can meet the quality standards. This has the effect of limiting the field of health care services to Virginia's citizens, while denying access to legitimate health care providers. As has been stated, one of the goals of the revision project has been to assure equal access to all applicants for COPN.

The department believes the revised SMFP assists in correcting the perception that COPN restricts such fair market competition. By eliminating criteria that can only be measured after a COPN has been granted, such as the national accreditation standards, and adjusting quality to focus on measurable standards, such as volume and utilization criteria, the process is now open to a broader range of applicants, which will provide greater choices for Virginia's citizens. Since all service volume and utilization criteria were carefully reviewed, with appropriate adjustments made, and criteria that were outdated or not applicable to the application review process were deleted, VDH believes many of the difficulties to obtaining a COPN have been removed.

A third objective of the effort to revise the SMFP was to ensure the resultant document is clearly written and understandable. Much work was necessary to bring the SMFP up to currently accepted standards and practice. The approach used was to strive for simplicity, and avoid being burdensome, while meeting the requirements of the law. The department was careful to replace archaic language, which was ambiguous and subject to interpretation, with common vernacular to ensure the document's readability.

After the public comment period and because of continuing concerns expressed by stakeholders to the Board of Health at its October 2005 meeting, the board directed department staff to reconvene the advisory committee with the intent of discussing responses to the public comments received. That process was accomplished over the course of eight months and 10 meetings. Using a series of matrices of the public comments received, stakeholders had an opportunity to fully express their concerns and suggest improvements. Consensus was achieved on the majority of concerns; "no consensus" meant there was no consensus from the stakeholder community. The completed matrices are available on the web at www.townhall.virginia.gov.

As a result of the overall project objectives and the reconvened advisory committee meetings, the department considers the proposed SMFP to fulfill its commitment to develop a document that addresses the myriad concerns expressed during development of the final document while being user-friendlier and providing more opportunity for new health facility and service providers to obtain a COPN. Therefore, the proposed SMFP is advantageous for Virginia's citizens as well as the health care industry as it has the potential for allowing more competition.

Small businesses or organizations contracting with COPN applicants for development services would be affected by the revised document. This would include consultants and lawyers hired to help guide applicants through the COPN process.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The proposed changes will make many of the measurable criteria used in assessing the public need for the proposed projects less stringent while making a few criteria more stringent. The proposed changes will also significantly edit and reorganize the State Medical Facilities Plan regulations to improve clarity.

Result of Analysis. The benefits likely exceed the costs for most of the proposed changes. Less stringent volume standards for Computed Tomography, Magnetic Resonance Imaging, and organ transplant services would likely yield the same benefits at lower cost.

Estimated Economic Impact. The proposed regulations contain rules for the State Medical Facilities Plan (SMFP) component of the Certificate of Public Need (COPN) program. Under the COPN program, a certificate is required before expanding certain medical services, or creating a new facility. SMFP is one of the 20 criteria used in evaluating a COPN application, but it has a significant impact on approval/denial decisions. SMFP establishes facility need projection methodologies and project review standards. The medical services subject to SMFP include general acute care

services, perinatal services, diagnostic imaging services, cardiac services, general surgical services, organ transplantation services, medical rehabilitation services, lithotripsy services, miscellaneous capital expenditures, and nursing facility services.

Numerous proposed changes will significantly reorganize the regulations by eliminating redundant sections, by combining duplicative sections, by deleting philosophical and irrelevant statements, by removing obsolete or non-related definitions, by adding new sections, and by adding new definitions. These changes are primarily editorial and are not expected to create any significant economic effects, but are expected to improve the clarity of the regulations. Improved clarity would probably streamline the application process, reduce potential confusions, and produce some economic benefits in terms of administrative cost savings, avoided delays, or communication costs.

A significant proposed change is the proposal to allow providers to apply for additional services based on institutional need. This proposed change will make it possible for providers to get approval for services when data determine there is no need for more services within a planning district or region. This, change is expected to make the current regulations less stringent.

Moreover, another significant proposed change will increase the maximum facility size for mental retardation services from four beds to twelve beds that must obtain a certificate of need making the SMFP less stringent.

The proposed changes also include a methodology for establishing measurable criteria in determining the need for mobile services. Currently, the need for mobile services is determined based on the guiding principles of the regulations. VDH indicated that the proposed methodology is consistent with the practice followed currently. Thus, while the proposed methodology for establishing mobile service measurable criteria is likely to improve the clarity of the regulations, no significant economic effect is expected.

Another change will incorporate a statutory change that increases the limit of capital expenditures projects requiring approval from \$5 million to \$15 million making the regulations less stringent.

More importantly, the proposed changes will revise a significant number of measurable criteria and travel times established in the regulations. These criteria and travel times are used to evaluate the need for a proposed facility, equipment, or project and play a crucial role in approval/denial decisions. With the exception of volume standards for Computed Tomography, Magnetic Resonance Imaging, and organ transplant services, all of the proposed changes to measurable criteria appear to be less stringent. A table is provided to compare the proposed volume and travel time changes to current standards.

Summary Table for Proposed Volume and Travel Time Changes:

Service	Is the proposed standard more or less stringent than the current standard?	
	Volumes	Travel Times
Computed Tomography (CT)	More Stringent	Less Stringent
Magnetic Resonance Imaging (MRI)	More Stringent	Less Stringent
Positron Emission Tomography (PET)	Less Stringent	Less Stringent
Noncardiac Nuclear Imaging (Formerly SPECT)	Less Stringent	Less Stringent
Radiation Therapy	Less Stringent	Less Stringent
Stereotactic Radiosurgery (SR)	Neutral	Less Stringent
SR – Gamma Knife	Less Stringent	Less Stringent
Cardiac Services - Catheterization	Neutral	Less Stringent
Cardiac Services -Open Heart Surgery	Neutral	Less Stringent
General Surgical	No Change	Less Stringent
Inpatient Beds	Less Stringent	Less Stringent
Nursing Facilities	Less Stringent	Less Stringent
Lithotripsy Services	Less Stringent	Less Stringent
Organ Transplant	More Stringent	Neutral
Medical Rehab	No Change	Less Stringent
MH: Acute Psychiatric/substance Abuse	Less Stringent	No Change
Obstetrics	Less Stringent	Less Stringent
Perinatal Services	No Change	Less Stringent

Less stringent quantitative criteria are expected to cause a small number of applicants to come forward who would not have under somewhat stricter SMFP criteria. We may see a small increase in applications in service areas where the

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proposed standards are less restrictive. However, a reliable estimate for the potential increase in applications is not available, as this would require extensive resources to develop.

Since the number of approvable projects in certain service areas is likely to increase, this could be seen as less restrictive entry requirements into regulated service areas. To the extent the proposed changes makes the issuance of a COPN less stringent, the economic effects would be akin to those of COPN discussed below. Based on the available empirical literature, we should expect no significant changes in healthcare costs and charity care. We could also see some negative or positive effects on quality and access varying from one service type to another. However, as restrictions on competition are reduced, we would expect a reduction in the welfare transferred from consumers to producers and a reduction in the economic inefficiencies embedded in the COPN program.

In short, we believe that when all proposed volume and travel time changes taken into account, the resulting SMFP regulation will be somewhat less stringent than the current regulations on net increasing the likelihood of obtaining a favorable COPN decision. Higher likelihood of obtaining a favorable COPN decision has significant economic benefits. These potential benefits are discussed below.

History of the COPN program:

A brief history of the Virginia's COPN program is provided in a 1997 report of the Virginia Joint Commission on Health Care. According to this report, the Virginia COPN program was established in 1973 primarily as a response to 1972 amendments to the federal Social Security Act, which allowed the federal government to deny reimbursement under Medicare, Medicaid, and Child Health Programs for capital projects that are found to be inconsistent with the plans of designated state planning agencies. In 1974, the National Health Planning and Resources Development Act (NHPDA) mandated all states to develop a COPN program by 1980. Later, in 1988, the role of federal government was eliminated with the expiration of NHPDA. However, 36 states, including Virginia, still maintain their COPN programs.¹

The Virginia COPN program is administered by the Department of Health in cooperation with five regional planning agencies (Health System Agencies). Projects are first evaluated at the regional level and then considered at the state level. The Commissioner of Health is in charge of making the final decisions. Adverse decisions could be appealed through the court system. The decisions of the commissioner must be consistent with the SMFP or the commissioner must find the SMFP outdated. Based on the amendments to the COPN law in 1998, the commissioner may condition approvals on the provision of free or reduced rate care to indigents, the acceptance of patients with special

needs, or the facilitation of primary care for underserved areas.

In 2000, the General Assembly, through Senate Bill 337, required the Joint Commission on Health Care to develop a plan to eliminate the COPN program by July 2004. The deregulation plan was a "fragile" consensus among the stakeholders and contained several provisions for the support it needed. This fragile consensus was contingent upon provisions requiring the Commonwealth to provide \$135 million funding from the general fund for (i) indigent care at academic health centers, (ii) increased Medicaid access to the adult parents, the aged, and the disabled, (iii) undergraduate medical education, (iv) increased Medicaid reimbursement to hospitals, (v) increased reimbursement to physicians, and (vi) increased state matching dollars for indigent health care trust fund. Probably because of significant fiscal implications, the deregulation plan has not been approved and implemented by the General Assembly.

Economics of the COPN program:

Issues surrounding the COPN program can be grouped under medical care costs, quality, access, and charity care. Economic analysis of Virginia's COPN on each one of these variables requires extensive resources which are beyond the scope of this analysis. Even if significant resources are devoted for this purpose, we suspect that such an analysis would be unable to produce conclusive evidence on every facet of the COPN program and be of little practical importance due to data limitations. Instead, we rely on the economic theory and readily available empirical evidence to assess likely costs and benefits of the COPN program in Virginia.²

Costs. The initial driving force for the COPN programs, in addition to the 1974 federal mandate, appears to be the concern that excess capacity and capital investment contributed to publicly funded medical care costs, as early 1970s health care payments were based on cost-based reimbursement methodologies. Under cost-based reimbursement methodologies, providers were being reimbursed for their capital costs and had incentives to build excess capacity.

Since the inception of COPN programs, many changes occurred in health care financing and delivery rendering most of the fiscal benefits expected from COPN obsolete in today's market place. A significant change is the shift from cost-based reimbursement methodologies toward service-based payment methodologies. Many private health care insurance companies as well as large public programs such as Medicare and Medicaid adopted service based payments methods such as inpatient prospective payment system, diagnostic related groups, resource utilization groups, outpatient prospective system, ambulatory payment classification system, and managed care capitation rates over the last two decades. The trend toward service-based payments reduced provider

incentives to build excess capacity or take on unneeded capital investment projects, as they cannot directly recover the cost of their investments. Thus, this concern does not seem to have validity in today's health care market as it did 30 years ago.

Additionally, proponents argue that COPN programs lead to fewer, larger firms to provide services, which in turn reduces cost of care. So, in the absence of COPN programs, we could see an increase in health care costs. This argument suggests that large health care firms produce services at lower average costs due to increased plant size, which is a well-known possibility in economics, termed as "economies of scale." While economies of scale may well exist in production of some health care services over certain plant sizes, generalizing this possibility for all services covered under the COPN programs and for any quantity of production is bound to be wrong.

Even for those services where there are economies of scale, forcefully leading fewer firms to produce more output through the COPN program has certain social costs. These social costs should be weighed against the benefits expected from lower average production costs. These social costs stem from restricting entry into an otherwise competitive market. Under the COPN umbrella, incumbents are protected against competition from new entrants. Firms with significant market power are well known to charge prices that maximize their revenues rather than those reflect their average costs. And, prices charged definitely exceed the average cost of production if the firm is to make above normal profit, which is the case in a non-competitive market.

In addition, the revenue-maximizing output level is known to be lower and the revenue-maximizing price is known to be higher than what it would be if entry were not restricted. In other words, if entry is limited through COPN, providers are likely to offer less and charge more. This profit maximizing behavior in the absence of competition takes welfare away from consumers and channels it to the providers and creates significant efficiency losses, known as "deadweight losses,"³ for the whole economy. A recent study by the Federal Trade Commission and the Department of Justice in 2004 goes on to state that these two agencies "...believe that CON programs can pose serious competitive concerns that generally outweigh CON programs' purported benefits. Where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry."

In short, the claim that leading fewer firms to produce more reduces cost of health care is not well founded because (i) lower average production costs does not necessarily mean the prices providers charge will be lower, (ii) quite the contrary, firms shielded from competition charge higher prices and produce less than optimal quantities, and (iii) other costs of COPN such as transferring welfare from consumers to

providers and deadweight efficiency losses likely exceed any savings expected from COPN.

Another source of social costs that seems to escape the attention of most is the inefficiencies created by ignoring the economies of scope that may exist in health care production. Economies of scope occur when production of one good creates savings for production of another good. In such cases, production costs are lower when the two goods are produced together than produced separately. Because the COPN review criteria focus on volume and capacity but does not directly take into account the other types of services already provided in conjunction with the service for which approval is sought, it is more than likely that the COPN program forgoes some potential savings that would be realized if entry into the market were not restricted.

Empirical research does not appear to support the claim that COPN reduce health care costs. COPN is not found to be effective in controlling overall per capita health care spending because many factors affecting costs such as labor and physician services are beyond the scope of the COPN programs. Also, COPN is not found to be effective in controlling hospital costs because (i) not all services are regulated under COPN, (ii) COPN is not always effective controlling supply, and (iii) when bed supply was controlled expenditures per bed are found to increase. [Arnold and Mendelson, 1992; Delaware Health Commission, 1996; Conover and Sloan, 1998; Custer, 1997; Lanning et al., 1991; Mendelson and Arnold, 1993; Salkever, 1978].

Quality. Proponents argue that COPN programs improve quality of care because (i) COPN causes high utilization of medical equipment or services leading to better outcomes, (ii) it helps filter good providers by screening quality records and by judging their ability to meet conditions associated with quality care, (iii) it helps stabilize health care market by filtering out financially unsound or professionally unprepared providers, and (iv) it restrains growth of for-profit providers that may offer lower quality care.

It is probable that COPN could improve quality of care through these channels with the exception of (iv). However, it is a wasteful way trying to improve quality of care through the COPN program. It is important to note that the primary reason behind the COPN program is not that it would improve quality but rather that it would contain costs in a cost-based payment environment and that it was mandated by federal legislation. Thus, improved quality should be evaluated as a secondary unintended benefit associated with COPN programs. If the object of a regulation were to improve quality of care, it would have never been done the way COPN does it. In this sense, COPN is not a necessary program to assure quality of care. Other approaches directly targeting quality of care as the primary goal would probably be economically more efficient. There are already some quality safeguards in place. For example, dissemination of health

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care information to consumers mitigates potential quality of care risks through the market mechanism. Also, there are various government programs to monitor quality of care in the absence of the COPN program. These include facility licensure programs and Medicare and Medicaid certification programs. Perhaps, tailoring these existing mechanisms to bolster quality would be much more cost effective in protecting public health and safety rather than relying on very questionable COPN spillover quality improvements.

Furthermore, COPN could have adverse effects on quality by slowing the diffusion of technology, by protecting low-quality providers, and by preventing innovative providers entering the market. For instance, one can easily argue that if the equipment is outdated or the staff is incompetent, a COPN program may be forcing more consumers to take risks they would not be otherwise willing to take. Thus, limitations COPN places on consumer choice may not be in the best interest of the public.

Empirical findings on the quality aspect of COPN appear to be mixed. Evidence is inconclusive regarding the ability of COPN in improving quality by forcing high utilization of equipment or services even though high utilization is found to improve outcomes. There is some evidence that COPN protects quality in the home health sector by filtering out unprepared or unqualified providers. COPN's effect on keeping out for-profit providers and resulting effects on quality are mixed. Finally, findings indicate that COPN does not provide an ongoing mechanism for monitoring quality. [Arnold and Mendelson, 1992; Brown et al., 1992; Collins and Keane, 1997; Conover and Sloan, 1998; Deemez et al., 1992; Delaware Health Care Commission, 1996; Federal Trade Commission, 1986; Griffiths et al., 1994; Lanning et al., 1991; Lewin/ICF and Alpha Center, 1991; Luft and Garnick, 1990; National Home Care Association Newsletter, 1998; Irvin, 1998; Burling, 1998; U.S. General Accounting Office, 1998].

Access. Proponents of the COPN program argue that the program improves access to health care (i) by limiting entry of new providers who may undermine the ability of incumbents to provide unprofitable services, (ii) by restricting expansion of facilities in overbuilt areas leading providers to expand services in underserved areas, and (iii) by requiring providers to serve all patients needing care in a particular geographic area. Again, it is generally unlikely that the COPN program could be effectively used to improve access to care. COPN is simply a wasteful way of trying to improve access. Based on economic theory, it can be reliably inferred that economic costs associated with trying to improve access through the COPN would far outweigh any ancillary access benefits.

Preventing entry of new competitors so that incumbents could continue to provide unprofitable services such as trauma or burn units, amounts to financing of such unprofitable

operations through above normal profits the incumbents are allowed to make under the COPN umbrella. While many examples could be offered, teaching hospitals' status in Virginia is a particularly interesting case given their ability to shift costs. Teaching hospitals are able to collect revenues from high technology services under the COPN umbrella to make up their losses from providing uncompensated indigent care. If ownership were not restricted, new entrants would offer these lucrative revenue-generating services, thereby exacerbating teaching hospitals' losses. Thus, the COPN program shields teaching hospitals from competition and allows them to finance the cost centers by the revenue centers.

In this particular case, while proponents may argue COPN improves access to indigent, this mechanism distorts the prices of high technology revenue generating services upward, causes under consumption of these services by paying consumers, and results in inefficient allocation of resources. Economic theory predicts that such social costs would far outweigh the social benefits that can be expected from improved access. Furthermore, the economic theory suggests that in such cases it is best to address the market failure (i.e. provision of unprofitable services in this example) through direct payments and allow the remaining market forces to operate with no intervention.

In general, similar conclusions apply to other cases where COPN is used as a non-market tool to enhance access to care.

The empirical evidence on the access aspect of COPN appears to be limited and conflicting. In some cases, COPN is found to protect inner city facilities and enhance access while in some other cases COPN may have restricted needed services as the opponents argue would happen. Also, access effects seem to vary from state to state and from service to service. Finally, there appears to be lack of empirical evidence to understand the rural access effects of COPN. [Arnold and Mendelson, 1992; Brown et al, 1992; Delaware Health Care Commission, 1996; Hackey, 1993; Kiel, 1993; Lewin/ICF and Alpha Center, 1991; McGinley, 1995; Mendelson and Arnold, 1993; Rettig, 1992; Sloan, 1988; Weaver, 1995].

Charity Care. Proponents argue that COPN enhances provision of charity care (i) by explicitly requiring a certain level of charity care as a condition of approval, (ii) indirectly by improving the profit margins of existing providers, (iii) by preventing new entrants who would "cherry pick" lucrative services, and (iv) by favoring not-for-profit providers who would provide more charity care.

In Virginia, the COPN program is used as a tool to provide incentives to providers to offer services to indigent patients at reduced rates through the conditioning process adopted in 1988. In fact, there are claims made by some researchers that the implicit purpose of the COPN program is to issue licenses and restrict competition to create an incentive to provide care

to the indigent rather than to prevent duplication of services and investment in costly excess capacity.

This conditioning process was created as a response to findings that the burden of uncompensated care is shared unevenly among the hospitals and there was no mechanism to correct this inequality. The 1988 General Assembly introduced the conditioning process into the COPN program and at the same time created the Indigent Health Care Trust fund to more evenly distribute the uncompensated care burden. With the conditioning mechanism, the state would be able to ensure provision of services to the indigent and uninsured who may have otherwise experienced difficulties with access to care if the intent of a provider were to prioritize paying patients.

The conditioning of certificates can be characterized as a mechanism that allows entry into an otherwise restricted market in exchange for providing uncompensated care. In economic terms, certificate holders are allowed to make above normal profits in the health care market and then required to use some of these proceeds to finance health care for the indigent and the uninsured. Even though it may be difficult to find out whether these above normal profits are commensurate with the cost of uncompensated care provided, economic theory unambiguously predicts that such mechanism would be less efficient compared to financing of uncompensated care through direct payments. In other words, the society as a whole would be better off (particularly given the transfer of welfare from consumers to providers and the deadweight efficiency losses as discussed earlier) if the conditioning mechanism is abandoned and uncompensated providers are paid directly.

Empirical evidence indicates that COPN programs initially screen for the likelihood of a facility providing charity care, but do not monitor ongoing compliance. There is some evidence showing that some states are more likely to approve providers offering more charity care. While COPN's effect on favoring not-for-profit providers is conflicting, evidence suggests that for-profits tend to provide less charity care, and public and teaching hospitals provide the most charity care. Some evidence shows that COPN improves operating margins of existing providers, which may lead to increased charity care. [Campbell and Ahern, 1993; Campbell and Fournier, 1993; Conover and Sloan, 1998; Hackey, 1993; Lanning et al., 1991; Lewin/ICF and Alpha Center, 1991; Mendelson and Arnold, 1993; Pennsylvania Legislative Budget and Finance Committee, 1996].

Summary. COPN programs emerged during 1970s as a response to a federal mandate introduced by the National Health Planning and Resources Development Act (NHPDA) and to health care cost containment concerns associated with cost-based reimbursement methodologies. In today's environment, none of these original reasons seem to have validity as they did three decades ago. In 1988, when

NHPDA expired, COPN programs were no longer federally mandated. Also, the trend toward service-based payment methodologies coupled with expansion of managed care significantly mitigated the original cost containment concerns that existed when cost-based payment methodologies were being used. Finally, most empirical research has failed to find support for the claim that COPN programs reduce health care costs.

While these developments were taking place, several ancillary benefits seem to have emerged as primary justifications for the continued existence of these regulatory programs. This view severely suffers from several shortcomings. First, theoretically it is just as easy to conjecture that COPN programs could reduce quality, access, and charity care. In fact, empirical evidence on these matters is mixed showing both negative and positive effects. Second, economic theory unambiguously predicts that the use of COPN as an indirect mechanism to improve quality, access, and charity care is inferior to the use of direct mechanisms addressing the same issues. Finally, while COPN may produce some ancillary benefits, it channels significant welfare from consumers to providers, and creates economic inefficiencies known as deadweight losses. Thus, maintaining the COPN program for highly speculative and unreasonable ancillary benefits that may or may not occur is a waste of society's resources.

The balance of economic theory and empirical findings suggest that the repeal of the COPN program and simultaneous adoption of other regulatory programs directly addressing quality, access, and charity care issues would produce net economic benefits for the Commonwealth. The Federal Trade Commission and the Department of Justice further support this conclusion by urging "states with CON programs to reconsider whether they are best serving their citizen's health care needs by allowing these programs to continue." [Federal Trade Commission and the Department of Justice, 2004].

Businesses and Entities Affected. The proposed regulations apply to nursing facilities, hospitals, and other medical facility providers. Current inventory of regulated facilities/beds/equipment include 51 outpatient surgical hospitals, 273 nursing homes, 68 freestanding diagnostic imaging facilities, 88 general hospitals, 8 rehabilitation hospitals, 22 freestanding radiation therapy facilities, 5 long-term acute care hospitals, 28 ICF/MR facilities (only 4 larger than 12 beds), 1 freestanding cardiac catheterization center, 5 psychiatric hospitals, 1 freestanding substance abuse treatment facility, 31,415 nursing home beds, 17,606 acute care beds, 1,730 psychiatric beds, 585 ICF/MR beds, 876 operating rooms, 104 cardiac catheterization labs, 345 computed tomography scanners, 138 magnetic resonance imaging scanners, 27 positron emission tomography scanners, 79 radiation therapy equipment, 49 lithotripsy equipment, 20

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open-heart surgery programs, and 5 organ transplant programs. Approximately, 100 applications for regulated services are reviewed each year. Additionally, these regulations affect five Health System Agencies as well as indigent and non-indigent patients receiving services from regulated providers. Approximately, 100 applications for regulated services are reviewed annually. Additionally, these regulations affect five Health System Agencies as well as indigent and non-indigent patients receiving services from regulated providers.

Localities Particularly Affected

The proposed regulations apply throughout the Commonwealth. However, a locality may be particularly affected if it chooses to own or operate a regulated facility, as the facility would be subject to these regulations.

Projected Impact on Employment. The proposed regulations are expected to slightly increase the number of providers seeking approval. As they start providing services, they would hire new medical and support personnel contributing to the employment in Virginia. Whether these new facilities/services would significantly affect the employment by current providers is not known.

On the other hand, the proposed volume standards may reduce the number of providers seeking approval for CT, MRI, and organ transplant services and equipment. As the certificate applications for these services declines, demand for medical and support personnel involved in CT, MRI, and organ transplant services and equipment would be slightly lower than what it would be without the proposed regulations.

Effects on the Use and Value of Private Property. The proposed regulations are not expected to have an effect on the value of physical private property. However, by allowing more providers to operate services already regulated or by allowing providers to offer new services, the proposed regulations are expected to contribute, on average, to value of medical businesses in the Commonwealth. Whether the increased number of providers in the market would significantly affect the asset value of existing medical businesses is not known.

Also, more stringent requirements to offer new CT, MRI, and organ transplant services or expand existing services may positively affect the asset values of existing certificate owners while negatively affecting the asset values of providers who will no longer be able to obtain a certificate under the revised standards.

Small Businesses: Costs and Other Effects. According to VDH, all of the 28 ICF/MR facilities, one cardiac catheterization laboratory, one freestanding substance abuse treatment facility, twenty nursing homes, and five outpatient surgical hospitals could be considered as small businesses. Less stringent SMFP regulations may make it less difficult for small businesses to start offering new medical services or

expanding existing services. However, more stringent volume standards for CT, MRI, and organ transplant services may make it more difficult for small businesses to start offering new or expanding existing CT, MRI, and organ transplant services.

Small Businesses: Alternative Method that Minimizes Adverse Impact. The alternative method that minimizes the adverse impact would be to remove the proposed more stringent CT, MRI, and organ transplant volume standards from this proposed action.

Real Estate Development Costs. The proposed regulations are not anticipated to have any direct effect on real estate development costs.

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Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with §2.2-4007.04 of the Administrative Process Act and Executive Order Number 36 (06). Section 2.2-4007.04 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. Further, if the proposed regulation has adverse effect on small businesses, §2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

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¹ Between 1989 and 1992 specialty services, non-hospital facilities, specialized medical equipment, and other capital expenditures were deregulated.

² Empirical findings are primarily obtained from the State of Washington Joint Legislative Audit and Review Committee, 1999, literature review to minimize research costs.

³ Deadweight losses" occur because a distortion to the market mechanism (such as restricting competition through the COPN program) takes welfare away from suppliers and buyers and no one in the economy receives them. In other words, it is the net loss in economic welfare that occurs due to distortions in the market. Thus, everyone could be better off if the distortion is removed.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Virginia Department of Health does not oppose the economic impact analysis pertaining to the proposed State Medical Facilities Plan developed by the Department of Planning and Budget.

Summary:

The regulation is one of 20 criteria used to determine public need in 11 categories of medical care facilities subject to the certificate of public need law. The proposed amendments update the criteria and standards to reflect current national and health care industry standards, remove archaic language and ambiguities, and consolidate all portions of the State Medical Facilities Plan into one comprehensive document. Because of the consolidation of the current 14 separate regulations into 12VAC5-230, 12VAC5-240 through 12VAC 5-360 are being repealed.

In an effort to clarify the regulations, the repropoed amendments reorganize the regulations by eliminating redundant sections, combining duplicative sections, deleting irrelevant and obsolete provisions, and adding new provisions. Significant changes (i) allow providers to apply for additional services based on institutional need; (ii) increase the maximum facility size for mental retardation services from four beds to 12 beds that must obtain a certificate of public need; (iii) include a methodology for establishing measurable criteria in determining the need for mobile services; (iv) incorporate a statutory change that increases the limit of capital expenditures projects requiring approval from \$5 million to \$15 million; and (v) revise measurable criteria and travel times used to evaluate the need for a proposed facility, equipment, or project.

Part I

Definitions and General Information

12VAC5-230-10. Definitions.

The following words and terms when used in ~~Chapters 230 (12VAC5 230) through 360 (12VAC5 360)~~ this chapter shall have the following meanings unless the context clearly indicates otherwise:

~~"Acceptability" means to the level of satisfaction expressed by consumers with the availability, accessibility, cost, quality, continuity and degree of courtesy and consideration afforded them by the health care system.~~

~~["Accessibility" means the ability of a population or segment of the population to obtain] appropriate, [available services.] This ability is determined by economic, temporal, locational, architectural, cultural, psychological, organizational and informational factors which may be barriers or facilitators to obtaining services.~~

"Acute psychiatric services" means hospital-based inpatient psychiatric services provided in distinct inpatient units in general hospitals or freestanding psychiatric hospitals.

"Acute substance abuse disorder treatment services" means short-term hospital-based inpatient treatment services with access to the resources of (i) a general hospital, (ii) a psychiatric unit in a general hospital, (iii) an acute care addiction treatment unit in a general hospital licensed by the Department of Health, or (iv) a chemical dependency specialty hospital with acute care medical and nursing staff and life support equipment licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

~~["Applicant" means any individual, corporation, partnership, association, trust, or other legal entity, whether governmental or private, submitting an application for a Certificate of Public Need.~~

~~"Availability" means the quantity and types of health services that can be produced in a certain area, given the supply of resources to produce those services.~~

"Bassinets" means an infant care station, including warming stations and isolettes, whether located in a hospital nursery or labor and delivery unit.

"Bed" means that unit, within the complement of a medical are facility, subject to COPN review as required by §32.1-102.1 of the Code of Virginia and designated for use by patients of the facility or service. For the purposes of this chapter, bed includes cribs and bassinets used for pediatric patients outside the nursery or labor and delivery setting.]

"Cardiac catheterization" means a procedure where a flexible tube is inserted into the patient through an extremity blood vessel and advanced under fluoroscopic guidance into the heart chambers [to perform (i) a hemodynamic, electrophysiologic or angiographic examination of the left or right heart chamber or the coronary arteries; (ii) aortic root injections to examine the degree of aortic root regurgitation or deformity of the aortic valve; or (iii) angiographic procedures to evaluate the coronary arteries. Therapeutic intervention in a coronary artery may also be performed using cardiac catheterization]. Cardiac catheterization [may include therapeutic intervention, but] does not include a simple right heart catheterization for monitoring purposes as might be performed in an electrophysiology laboratory, pulmonary angiography as an isolated procedure, or cardiac pacing through a right electrode catheter.

~~["Certificate of Public Need" or "COPN" means the orderly administrative process used to make medical care facilities and services needs decisions.~~

~~"Charges" means all expenses incurred by the provider in the production and delivery of health services.]~~

~~"Commissioner" means the State Health Commissioner.~~

~~"Competing applications" means applications for the same or similar services and facilities that are proposed for the same planning district [, or same planning region for projects reviewed on a regional basis,] and are in the same batch review cycle.~~

~~"Computed tomography" or "CT" means a noninvasive diagnostic technology that uses computer analysis of a series of cross-sectional scans made along a single axis of a bodily structure or tissue to construct [a three dimensional an] image of that structure.~~

~~["Condition" means the agreed upon qualifications placed on a project by the commissioner when granting a Certificate of Public Need. Such conditions shall direct an applicant to provide a level of care to indigents, accept patients requiring specialized needs, or facilitate the development and operation of primary care services in designated medically underserved areas of the applicant's service area.]~~

~~"Continuing care retirement community" or "CCRC" means a retirement community consistent with the requirements of Chapter 49 (§38.2-4900 et seq.) of Title 38.2 of the Code of Virginia. CCRCs can have nursing home services available on site or at licensed facilities off site.~~

~~["COPN" means the Medical Care Facilities Certificate of Public Need Program as contained in Article 1.1 (§32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia, used to make medical care facilities and services needs decisions.]~~

~~"Continuity of care" means the extent of effective eoordination of services provided to individuals and the community over time, within and among health care settings.~~

~~"Cost" means all expenses incurred in the production and delivery of health services.~~

~~["Department" means the Virginia Department of Health.~~

~~"DEP" means diagnostic equivalent procedure, a method for weighing the relative value of various cardiac catheterization procedures as follows: a diagnostic procedure equals 1 DEP, a therapeutic procedure equals 2 DEPs, a same session procedure (diagnostic and therapeutic) equals 3 DEPs, and a pediatric procedure equals 2 DEPs.~~

~~"Direction" means guidance, supervision or management of a function or activity.~~

~~"General inpatient hospital beds" means beds located in the following units or categories:~~

- ~~1. Medical/surgical units available for the care and treatment of adults not requiring specialized services; and~~
- ~~2. Pediatric units that are maintained and operated as a distinct unit for use by patients younger than 21. Newborn cribs and bassinets are excluded from this definition.]~~

~~"Health planning region" means a contiguous geographic area of the Commonwealth as designated by the [department Board of Health] with a population base of at least 500,000 persons, characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.~~

~~["Health system" means an organization of two or more medical care facilities, including but not limited to hospitals, that are under common ownership or control and are located within the same planning district, or planning region for projects reviewed on a regional basis.]~~

~~"Hospital" means a medical care facility licensed as [a general, community, or special hospital licensed an inpatient hospital or outpatient surgical center] by the Department of Health or [as] a psychiatric hospital [licensed] by the Department of Mental Health, Mental Retardation, and Substance Abuse Services.~~

~~["Hospital-based" means a service operating physically within, connected to a hospital, or on the hospital campus, and legally associated with a hospital.~~

~~"ICF/MR" means an intermediate care facility for the mentally retarded.]~~

~~"Indigent [or uninsured]" means [persons eligible to receive reduced rate or uncompensated care at or below Income Level E as defined in 12VAC5-200-10 of the Virginia Administrative Code any person whose gross family income is equal to or less than 200% of the federal Nonfarm Poverty Level or income levels A through E of 12VAC5-200-10 and who is uninsured.]~~

~~"Inpatient [beds]" means [accommodations in a medical care facility with] continuous support services, such as food, laundry, housekeeping, and staff to provide health or health-related services to patients who generally remain in [the a medical care] facility [in excess of] 24 hours [or longer]; [Such accommodations are known by various nomenclatures including but not limited to: nursing facility, intensive care, minimal or self care, isolation, hospice, observation beds equipped and staffed for overnight use, obstetric, medical/surgical, psychiatric, substance abuse disorder, medical rehabilitation, and pediatric. Bassinets and incubators and beds in labor and birthing rooms, emergency rooms, preparation or anesthesia induction rooms, diagnostic or~~

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~~treatment procedure rooms, or on-call staff rooms are excluded from this definition.]~~

~~"Intensive care beds" [or "ICU"] means [acute care inpatient] beds located in the following units or categories:~~

~~1. General intensive care units are those units where patients are concentrated by reason of serious illness or injury regardless of diagnosis. Special lifesaving techniques and equipment are immediately available and patients are under continuous observation by nursing staff;~~

~~2. Cardiac care units [, also known as Coronary Care Units or CCUs,] are units staffed and equipped solely for the intensive care of cardiac patients; and~~

~~3. Specialized intensive care units are any units with specialized staff and equipment for the purpose of providing care to seriously ill or injured patients [for based on age] selected categories of diagnoses, including units established for burn care, trauma care, neurological care, pediatric care, and cardiac surgery recovery [. This category of beds , but] does not include [bassinets in] neonatal intensive care units.~~

~~["Intermediate care substance abuse disorder treatment services" means long-term hospital-based inpatient treatment services that provide structured programs of assessment, counseling, vocational rehabilitation, and social rehabilitation.]~~

~~"Lithotripsy" means a noninvasive therapeutic procedure [of crushing kidney, to (i) crush] renal and biliary stones using shock waves [. Lithotripsy can also be used to fragment matter such as calcifications or bone, i.e., renal lithotripsy or (ii) to treat certain musculoskeletal conditions] and to relieve the pain associated with tendonitis [i.e., orthopedic lithotripsy].~~

~~["Long-term acute care hospital" or "LTACH" means an inpatient hospital that provides care for patients who require a length of stay greater than 25 days and is, or proposes to be, certified by the Centers for Medicare and Medicaid Services as a long-term care inpatient hospital pursuant to 42 CFR Part 412. For the purpose of granting a COPN, the Board of Health pursuant to §32.1-102.2 A 6 of the Code of Virginia has designated LTACH as a type of extended care facility. An LTACH may be either a free standing facility or located within an existing or host hospital.]~~

~~"Magnetic resonance imaging" or "MRI" means a noninvasive diagnostic technology using a nuclear spectrometer to produce electronic images of specific atoms and molecular structures in solids, especially human cells, tissues and organs.~~

~~["Medical/surgical" or "med/surge" means those services available for the care and treatment of patients not requiring specialized services.]~~

~~"Minimum survival rates" means the lowest percentage of those receiving organ transplants who survive at least one year or for such other period of time as specified by the United Network for Organ Sharing.~~

~~["MRI relevant patients" means the sum of: 0.55 times the number of patients with a principal diagnosis involving neoplasms (ICD-9 CM codes 140-239); 0.70 times the number of patients with a principal diagnosis involving diseases of the central nervous system (ICD-9 CM codes 320-349); 0.40 times the number of patients with a principal diagnosis involving cerebrovascular disease (ICD-9 CM codes 430-438); 0.40 times the number of patients with a principal diagnosis involving chronic renal failure (ICD-9 CM code 585); 0.19 times the number of patients with a principal diagnosis involving dorsopathies (ICD-9 CM codes 720-724); 0.40 times the number of patients with a principal diagnosis involving diseases of the prostate (ICD-9 CM codes 600-602); and 0.40 times the number of patients with a principal diagnosis involving inflammatory disease of the ovary, fallopian tube, pelvic cellular tissue or peritoneum (ICD-9 CM code 614). The applicant shall have discharged all patients in these categories during the most recent 12-month reporting period.]~~

~~"Neonatal special care" means care for infants in one or more of the [three higher] service levels designated in [12VAC5-410-440 D-2 12VAC5-410-443] of the Rules and Regulations for the Licensure of Hospitals, i.e., [a hospital elevates its services from general level normal newborn to] intermediate level newborn services, specialty level newborn services, or subspecialty level newborn services.~~

~~["Network" means a group of medical care facilities, including hospitals, or health care systems, legally or operationally associated with one or more hospitals in a planning region.]~~

~~"Nursing facility" means those facilities or components thereof licensed to provide long-term nursing care.~~

~~["Nursing facility beds" means inpatient beds that are located in distinct units of general hospitals that are licensed as long-term care units by the department. Beds in these long-term units are not included in the calculations of inpatient bed need.]~~

~~"Obstetrical services" means the distinct organized program, equipment and care related to pregnancy and the delivery of newborns in inpatient facilities.~~

~~"Off-site replacement" means the relocation of existing beds or services from an existing medical care facility site to another location within the same planning district.~~

~~"Open heart surgery" means [a set of surgical procedures using a heart-lung bypass machine or pump to perform extracorporeal circulation and oxygenation during surgery. This technique is used when the heart must be slowed down~~

~~to correct congenital and acquired cardiac and coronary artery disease; a surgical procedure requiring the use or immediate availability of a heart-lung bypass machine or "pump."] The use of the pump during the procedure distinguishes "open heart" from "closed heart" surgery.~~

~~"Operating room" means a room [, ~~meeting the requirements of 12VAC5 410 820, in a licensed general or outpatient surgical hospital] used solely or principally for the provision of surgical procedures, [~~excluding endoscopic and cystoscopic procedures especially those involving the administration of anesthesia, multiple personnel, recovery room access, and a fully controlled environment. This does not include rooms designated as procedure rooms or rooms dedicated exclusively for the performance of cesarean sections.]~~~~~~

~~"Operating room use" means the amount of time a patient occupies an operating room [, ~~plus the estimated or actual and includes] room preparation and cleanup time.~~~~

~~"Operating room visit" means one session in one operating room in [~~a licensed general inpatient] hospital or outpatient surgical [~~hospital center~~], which may involve several procedures. Operating room visit may be used interchangeably with "operation" or "case."~~~~

~~"Outpatient [~~surgery~~]" means [~~services those surgical procedures] provided to individuals who are not expected to require overnight hospitalization but who require treatment in a medical care facility exceeding the normal capability found in a physician's office. For the purposes of this chapter, outpatient [~~services surgery~~] refers only to surgical services provided in operating rooms in [~~licensed general inpatient] hospitals or [~~licensed~~] outpatient surgical [~~hospitals centers~~], and does not include [~~surgical~~] services provided in outpatient departments, emergency rooms, or [~~treatment procedure~~] rooms of hospitals, or physicians' offices.~~~~~~

~~["Pediatric" means patients 18 years of age and younger. Newborns in nurseries are excluded from this definition.]~~

~~"Pediatric cardiac catheterization" means the cardiac catheterization of patients [~~less than 21 years of age 18 years of age and younger~~].~~

~~"Perinatal services" means those resources and capabilities that all hospitals offering general level newborn services as described in [~~12VAC5 410 440 D 2 a (1) 12VAC5-410-443~~] of the Rules and Regulations for the Licensure of Hospitals must provide routinely to newborns.~~

~~["PET/CT scanner" means a single machine capable of producing a PET image with a concurrently produced CT image overlay to provide anatomic definition to the PET image. For the purpose of grating a COPN, the Board of Health pursuant to §32.1-102.2 A 6 of the Code of Virginia has designated PET/CT as a specialty clinical services. A PET/CT scanner shall be reviewed under the PET criteria as~~

~~an enhanced PET scanner unless the CT unit will be used independently. In such cases, a PET/CT scanner that will be used to take independent PET and CT images will be reviewed under the applicable PET and CT services criteria.]~~

~~["Physician" means a person licensed by the Board of Medicine to practice medicine or osteopathy in Virginia.]~~

~~"Planning district" means a contiguous area within the boundaries established by the Virginia Department of Housing and Community Development or its successor.~~

~~"Planning horizon year" means the particular year for which bed [~~or service~~] needs are projected.~~

~~"Population" means the census figures shown in the most current series of projections published by [~~the Virginia Employment Commission~~] a demographic entity as determined by the commissioner].~~

~~"Positron emission tomography" or "PET" means a noninvasive diagnostic [~~or imaging modality~~] using the computer-generated image of local metabolic and physiological functions in tissues produced through the detection of gamma rays emitted when introduced radio-nuclids decay and release positrons. [~~A PET system includes two major elements: (i) a cyclotron that produces radio-pharmaceuticals and (ii) a scanner that includes a data acquisition system and a computer A PET device or scanner may include an integrated CT to provide anatomic structure definition.]~~~~

~~["Primary service area" means the geographic territory from which 75% of the patients of an existing medical care facility originate with respect to a particular service being sought in an application.~~

~~"Procedure" means a study or treatment or a combination of studies and treatments identified by a distinct ICD9 or CPT code performed in a single session on a single patient.]~~

~~"Quality of care" means to the degree to which services provided are properly matched to the needs of the population, are technically correct, and achieve beneficial impact. Quality of care can include consideration of the appropriateness of physical resources, the process of producing and delivering services, and the outcomes of services on health status, the environment, and/or behavior.~~

~~["Qualified" means meeting current legal requirements of licensure, registration or certification in Virginia or having appropriate training, including competency testing, and experience commensurate with assigned responsibilities.]~~

~~"Radiation therapy" means [~~the treatment of disease with radiation, especially by selective irradiation with x-rays or other ionizing radiation and by ingestion of radioisotopes a clinical specialty, including radioisotope therapy, in which ionizing radiation is used for treatment of cancer or other diseases, often in conjunction with surgery or chemotherapy~~~~

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or both. The predominant form of radiation therapy involves an external source of radiation whose energy is focused on the diseased area. Radioisotope therapy is a process involving the direct application of a radioactive substance to the diseased tissue and usually requires surgical implantation].

"Relevant reporting period" means the most recent 12-month period, prior to the beginning of the applicable batch review cycle, for which data is available from [~~the Virginia Employment Commission, Virginia Health Information, or other source identified by the department~~ VHI or a demographic entity as determined by the commissioner].

"Rural" means territory, population, and housing units that are classified as "rural" by the Bureau of the Census of the United States Department of Commerce, Economic and Statistics Administration.

["~~State medical facilities plan" or "SMFP" means the planning document adopted by the Board of Health that includes, but is not limited to (i) methodologies for projecting need for medical facility beds and services; (ii) statistical information on the availability of medical facility beds and services; and (iii) procedures, criteria and standards for the review of applications for projects for medical care facilities and services~~ "SMFP" means the state medical facilities plan as contained in Article 1.1 (§32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia used to make medical care facilities and services needs decisions].

"Stereotactic radiosurgery" [or "SRS"] means a [~~noninvasive one session~~] therapeutic procedure for precisely locating [diseased] points within the body using [~~an external, a~~] 3-dimensional [~~frame of~~] reference. [~~A stereotactic instrument is attached to the body and used to localize precisely an area in the body by means of coordinates related to anatomical structures.~~] An example of a stereotactic radiosurgery instrument is a Gamma Knife® unit. [Stereotactic radiotherapy means more than one session is required. One SRS procedure equals three standard radiation therapy procedures.]

["~~Study" or "scan" means the gathering of data during a single patient visit from which one or more images may be constructed for the purpose of reaching a definitive clinical diagnosis.~~]

"Substance abuse disorder treatment services" means services provided to individuals for the prevention, diagnosis, treatment, or palliation of chemical dependency, which may include attendant medical and psychiatric complications of chemical dependency. [Substance abuse disorder treatment services are licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"Supervision" means to direct and watch over the work and performance of others.]

["~~The center" means the Center for Quality Health Care Services and Consumer Protection.~~]

"Use rate" means the rate at which an age cohort or the population uses medical facilities and services. The rates are determined from periodic patient origin surveys conducted for the department by the regional health planning agencies, or other health statistical reports authorized by Chapter 7.2 (§32.1-276.2 et seq.) of Title 32.1 of the Code of Virginia.

["VHI" means the health data organization defined in §32.1-276.4 of the Code of Virginia and under contract with the Virginia Department of Health.]

12VAC5-230-20. Preface. [~~Responsibility of the department.~~ (Repealed.)]

Virginia's Certificate of Public Need law defines the State Medical Facilities Plan as the "planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for medical facility beds and services; (ii) statistical information on the availability of medical facility beds and services; and (iii) procedures, criteria and standards for the review of applications for projects for medical care facilities and services." (§32.1-102.1 of the Code of Virginia.)

Section 32.1-102.3 of the Code of Virginia states that, "Any decision to issue or approve the issuance of a certificate (of public need) shall be consistent with the most recent applicable provisions of the State Medical Facilities Plan; provided, however, if the commissioner finds, upon presentation of appropriate evidence, that the provisions of such plan are not relevant to a rural locality's needs, inaccurate, outdated, inadequate or otherwise inapplicable, the commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan."

Subsection B of §32.1-102.3 of the Code of Virginia requires the commissioner to consider "the relationship" of a project "to the applicable health plans of the board" in "determining whether a public need for a project has been demonstrated."

This State Medical Facilities Plan is a comprehensive revision of the criteria and standards for COPN reviewable medical care facilities and services contained in the Virginia State Health Plan established from 1982 through 1987, and the Virginia State Medical Facilities Plan, last updated in July, 1988. This Plan supersedes the State Health Plan 1980-1984 and all subsequent amendments thereto save those governing facilities or services not presently addressed in this Plan.

[~~A. Sections 32.1-102.1 and 32.1-102.3 of the Code of Virginia requires the Board of Health to adopt a planning document for review of COPN applications and that decisions~~

~~to issue a COPN shall be consistent with the most recent provisions of the State Medical Facilities Plan.~~

~~B. The commissioner is the designated decision maker in the process of determining public need.~~

~~C. The center is a unit of the department responsible for administering the COPN program under the direction of the commissioner.~~

~~D. The regional health planning agencies assist the department in determining whether a certificate should be granted.~~

~~E. The center's COPN staff is available to answer questions and provide technical assistance throughout the application process.~~

~~F. In developing or revising standards for the COPN program, the board adheres to the requirements of the Administrative Process Act and the public participation process. The department, acting for the board, solicits input from applicants, applicant representatives, industry associations, and the general public in the development or revision of these criteria through informal and formal comment periods and may hold public hearings, as appropriate.~~

~~G. If, upon presentation of appropriate evidence, the commissioner finds that the provisions of this chapter are not relevant to a rural locality's needs, or are inaccurate, outdated, inadequate or otherwise inapplicable, he may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to this chapter.]~~

12VAC5-230-30. Guiding principles in [certificate of public need the development of project review criteria and standards].

~~[A.] The following general principles will be used in guiding the implementation of the Virginia Medical Care Facilities Certificate of Public Need (COPN) Program and have served serve as the basis for the development of the review criteria and standards for specific medical care facilities and services contained in this document:~~

~~1. The COPN program [will give preference to requests that encourage medical care facility and service development approaches] which can document improvement in [that improve the cost effectiveness of health care delivery. Providers should strive to develop new facilities and equipment and use already available facilities and equipment to deliver needed services at the same or higher levels of quality and effectiveness, as demonstrated in patient outcomes, at lower costs is based on the understanding that excess capacity and underutilization of medical facilities are detrimental to both cost effectiveness and quality of medical services in Virginia].~~

~~2. The COPN program will seek seeks [to achieve a balance between] appropriate [the levels of availability and access to medical care facilities and services for all] the citizens of Virginia [of Virginia's citizens and the need to constrain excess facility and service capacity the geographical dispersion of medical facilities and to promote the availability and accessibility of proven technologies].~~

~~3. The COPN program will seek [seeks to achieve economies of scale in development and operation], and optimal quality of care, [through establishing limits on the development of specialized medical care facilities and services, on a statewide, regional, or planning district basis promotes the development and maintenance of services and access to those services by every person who needs them without respect to their ability to pay] .~~

~~4. The COPN program will give preference to [seeks to promote the development and maintenance of needed services which are accessible to every person who can benefit from the services regardless of their ability to pay encourages the conversion of facilities to new and efficient uses and the reallocation of resources to meet evolving community needs] .~~

~~5. The COPN program will promote the elimination of excess facility and service capacity. The COPN program will promote the [promotes the elimination and conversion of excess facility and service capacity to meet identified needs discourages the proliferation of services that would undermine the ability of essential community providers to maintain their financial viability]. The COPN program will not facilitate the survival of medical care facilities and services which have rendered superfluous by changes in health care delivery and financing.~~

12VAC5-230-40. General application filing criteria.

~~A. In addition to meeting the [applicable] requirements of [the State Medical Facilities Plan this chapter], applicants for a Certificate of Public Need shall [provide include] documentation [in their application] that their [proposal project] addresses the applicable [20 considerations requirements] listed in §32.1-102.3 of the Code of Virginia.~~

~~B. [Facilities and services shall be provided in locations that meet established zoning regulations, as applicable The burden of proof shall be on the applicant to produce information and evidence that the project is consistent with the applicable requirements and review policies as required under Article 1.1 (§32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia] .~~

~~C. [The department shall consider an application complete when all requested information, and the application fee, is submitted on the form required. If the department finds the application incomplete, the applicant will be notified in~~

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~~writing and the application may be held for possible review in the next available applicable batch review cycle. The commissioner may condition the approval of a COPN by requiring an applicant to: (i) provide a level of care at a reduced rate to indigents, (ii) accept patients requiring specialized care, or (iii) facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area. The applicant must actively seek to comply with the conditions place on any granted COPN].~~

12VAC5-230-50. Project costs.

~~[The capital development and operating costs for providing services should be comparable to similar services in the health planning region. The capital development costs of a facility and the operating expenses of providing the authorized services should be comparable to the costs and expenses of similar facilities with the health planning region].~~

12VAC5-230-60. [Preferences When competing applications received].

~~In [the review of reviewing] competing applications, [preference consideration] will be given to [applicants the applicant who]:~~

1. ~~[Who have Has]~~ an established performance record in completing projects on time and within the authorized [operating expenses and] capital costs;

2. ~~[Whose proposals have Has both]~~ lower [direct construction costs and cost of equipment capital costs and operating expenses] than [their his] competitors and can demonstrate that [their cost his] estimates are credible;

~~[3. Who can demonstrate a commitment to facilitate the transport of patients residing in rural areas or medically underserved areas of urban localities to needed services, directly or through coordinated efforts with other organizations;~~

4. ~~Who can~~ 3. Can] demonstrate a consistent compliance with state licensure and federal certification regulations and a consistent history of few documented complaints, where applicable; or

~~[5. Who can~~ 4. Can] demonstrate a commitment to [enhancing financial accessibility to services through the provision of documented charity care, exclusive of bad debts and disallowances from payers, and services to Medicaid beneficiaries serving their community or service area as evidenced by unreimbursed services to the indigent and providing needed but unprofitable services, taking into account the demands of the particular service area].

12VAC5-230-70. [Emerging technologies Prorating of mobile service volume requirements].

~~[Inasmuch as the SMFP cannot contemplate all possible future applications and advances in the regulated technologies, these future applications and technological advances will be evaluated based on emerging national trends and evidence in the peer review literature. Until such time as the SMFP can be updated to reflect changes, emerging technologies should be registered with the center following 12VAC5-220-110 of the Virginia Administrative Code.~~

A. The required minimum service volumes for the establishment of services and the addition of capacity for mobile services shall be prorated on a "site by site" basis based on the amount of time the mobile services will be operational at each site using the following formula:

Prorated annual volume (not to exceed the required full time volume)	=	Required full time annual volume	*	Number of days the services will be on site each week	*.02
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B. This section does not prohibit an applicant from seeking to obtain a COPN for a fixed site service provided capacity for the service has been achieved as described in the applicable service section.]

12VAC5-230-80. [Institutional need When institutional expansion needed].

~~[A.]~~ Notwithstanding any other provisions of this chapter, [consideration will be given to the commissioner may grant approval for] the expansion of services at [an] existing medical care [facilities facility] in [a] planning [districts district] with an excess supply of such services when the proposed expansion can be justified on the basis of [facility-specific utilization a facility's need having exceeded its current service capacity to provide such service] or [on the] geographic remoteness [of the facility].

~~[B.]~~ If a facility with an institutional need [to expand] is part of a [network health system], the underutilized services at other facilities within the [network should be relocated health system should be reallocated, when appropriate,] to the facility [within the planning district] with the institutional need [when possible to expand before additional services are approved for the applicant. However, underutilized services located at a health system's geographically remote facility may be disregarded when determining institutional need for the proposed project.

C. This section is not applicable to nursing facilities pursuant to §32.1-102.3:2 of the Code of Virginia.

~~D. Applicants shall not use this section to justify a need to establish new services.]~~

~~[**12VAC5-230-90. Compliance with the terms of a condition.**~~

~~A. The commissioner may condition the approval of a COPN to provide care to Virginia's indigent population, patients with specialized needs, or the medically underserved.~~

~~B. The applicant shall actively seek to provide opportunities to offer the conditioned service directly to indigent or uninsured persons at a reduced rate or free of charge to patients with specialized needs, or by the facilitation of primary care services in designated medically underserved areas.~~

~~C. If the direct provision of the conditioned services does not fulfill the terms of the condition, the center may determine the applicant to be in compliance with the terms of the condition when:~~

- ~~1. The applicant is part of a facility or provider network and the facility or provider network has provided reduced rate or uncompensated care at or above the regional standard; or~~
- ~~2. The applicant provides direct financial support for community based health care services at a value equal to or greater than the difference between the terms of the condition and the amount of direct care provided.~~

~~Such direct financial support shall be in addition to, and not a substitute for, other charitable giving chosen by the applicant.~~

~~D. Acceptable proof for direct financial support is a signed receipt indicating the number or amount of services or other support provided and dollar value of that service or support. Applicants providing direct financial support for community based health care services should render that support through one of the following organizations:~~

- ~~1. The Virginia Association of Free Clinics;~~
- ~~2. The Virginia Health Care Foundation; or~~
- ~~3. The Virginia Primary Care Association.~~

~~E. Applicants shall demonstrate compliance with the terms of a condition for the previous 12 month period. The written condition report shall be certified or affirmed by the applicants and filed with the center. Such report shall include, but is not limited to, the:~~

- ~~1. Facility or service name and address;~~
- ~~2. Certificate number;~~
- ~~3. Facility or service gross patient revenues;~~
- ~~4. Dollar value of the charity care provided, excluding bad debts and disallowances from payers; and~~

~~5. Number of individuals served by the direct provision of care or a receipt from one of the allowable organizations listed in subsection D of this section.]~~

~~[Part II
Diagnostic Imaging Services~~

~~Article 1
Criteria and Standards for Computed Tomography]~~

~~[**12VAC5-230-100. Accessibility 12VAC5-230-90. Travel time.**]~~

~~CT services should be within 30 minutes driving time one way [] under normal conditions [] of 95% of the population of the planning district.~~

~~[**12VAC5-230-110 12VAC5-230-100.**] **Need for new [fixed site] service.**~~

~~A. [No CT service should be approved at a location that is within 30 minutes driving time one way of:~~

- ~~1. A service that is not yet operational; or~~
- ~~2. An existing CT unit that has performed fewer than 3,000 scans during the relevant reporting period.~~

~~B.] No new [fixed site] CT service [or network shall should] be approved unless [all existing fixed site] CT services [or networks] in the planning district performed an average of [4,500 CT scans per machine during the relevant reporting period 10,000 procedures per existing and approved CT scanner during the relevant reporting period and the proposed new service would not significantly reduce the utilization of existing fixed site providers in the planning district below 10,000 procedures. The utilization of existing scanners operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of CT scanners in such planning district].~~

~~[C. Consideration may be given to new CT services proposed for sites located beyond 30 minutes driving time one way of existing facilities that do not meet the 4,500 scans per machine criterion if the proposed sites are in rural areas B. CT scanners to be used solely for simulation with radiation therapy treatment shall be exempt from this article].~~

~~[**12VAC5-230-120 12VAC5-230-110**]. **Expansion of [existing fixed site] service.**~~

~~Proposals to [increase the number of CT scanners in expand] an existing [medical care facility's] CT service [or network may through the addition of a CT scanner should] be approved [only if when] the existing [service or network services] performed an average of [3,000 CT scans 10,000 procedures per scanner] for the relevant reporting period. [The commissioner may authorize placement of a new unit at the applicant's existing medical care facility or at a separate location within the applicant's primary service area for CT~~

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services, provided the proposed expansion is not likely to significantly reduce the utilization of existing providers in the planning district below 10,000 procedures.]

[12VAC5-230-120. Adding or expanding mobile CT services.

A. Proposals for mobile CT scanners shall demonstrate that, for the relevant reporting period, at least 4,800 procedures were performed and that the proposed mobile unit will not significantly reduce the utilization of existing CT providers in the planning district below 10,000 procedures for fixed site scanners or 4,800 procedures for mobile scanners.

B. Proposals to convert mobile CT scanners to fixed site scanners shall demonstrate that, for the relevant reporting period, at least 6,000 procedures were performed and that the proposed conversion will not significantly reduce the utilization of existing CT providers in the planning district below 10,000 procedures for fixed site scanners or 4,800 procedures for mobile scanners.]

12VAC5-230-130. Staffing.

[~~Providers of~~] CT services should be under the [~~direct supervision of one or more board certified diagnostic radiologists~~ direction or supervision of one or more qualified physicians].

[~~12VAC5-230-140. Space.~~

~~Applicants shall provide documentation that:~~

- ~~1. A suitable environment will be provided for the proposed CT services, including protection against known hazards; and~~
- ~~2. Space will be provided for patient waiting, patient preparation, staff and patient bathrooms, staff activities, storage of records and supplies, and other space necessary to accommodate the needs of handicapped persons.]~~

[Article 2

Criteria and Standards for Magnetic Resonance Imaging]

[~~12VAC5-230-150. Accessibility. 12VAC5-230-140. Travel time.~~]

MRI services should be within 30 minutes driving time one way [$\frac{1}{2}$] under normal conditions [$\frac{1}{2}$] of 95% of the population of the planning district.

Article 2

Criteria and Standards for Magnetic Resonance Imaging

[12VAC5-230-160 12VAC5-230-150]. Need for new [fixed site] service.

[~~A~~] No new [fixed site] MRI services [~~shall should~~] be approved unless [~~all existing~~ fixed site MRI] services in the planning district performed an average of [~~4,000 scans per machine~~ 5,000 procedures per existing and approved fixed site MRI scanner] during the relevant reporting period [and

the proposed new service would not significantly reduce the utilization of existing fixed site MRI providers in the planning district below 5,000 procedures. The utilization of existing scanners operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of MRI scanners in such planning district.]

[~~B. Consideration may be given to new MRI services proposed for sites located beyond 30 minutes driving time one way of existing facilities that do not meet the 4,000 scans per machine criterion of the prospered sites are in rural areas.~~]

[~~12VAC5-230-170 12VAC5-230-160]. Expansion of [services fixed site service].~~

Proposals to expand [an] existing [medical care facility's] MRI services through the addition of [~~a new scanning unit of~~ an MRI scanner] may be approved [~~if when~~] the existing service performed [~~at least 4,000 scans an average of 5,000 MRI procedures~~] per [~~existing unit scanner~~] during the relevant reporting period. [The commissioner may authorize placement of the new unit at the applicant's existing medical care facility, or at a separate location within the applicant's primary service area for MRI services, provided the proposed expansion is not likely to significantly reduce the utilization of existing providers in the planning district below 5,000 procedures.

12VAC5-230-170. Adding or expanding mobile MRI services.

A. Proposals for mobile MRI scanners shall demonstrate that, for the relevant reporting period, at least 2,400 procedures were performed and that the proposed mobile unit will not significantly reduce the utilization of existing MRI providers in the planning district below 2,400 procedures for mobile scanners.

B. Proposals to convert mobile MRI scanners to fixed site scanners shall demonstrate that, for the relevant reporting period, 3,000 procedures were performed and that the proposed conversion will not significantly reduce the utilization of existing MRI providers in the planning district below 5,000 procedures for fixed site scanners and 2,400 procedures for mobile scanners.]

12VAC5-230-180. Staffing.

MRI [~~machines services~~] should be under the [~~direct, on-site supervision of one or more board certified diagnostic radiologists~~ direct supervision of one or more qualified physicians].

[~~12VAC5-230-190. Space.~~

~~Applicants should provide documentation that:~~

1. ~~A suitable environment will be provided for the proposed MRI services, including shielding and protection against known hazards; and~~
2. ~~Space will be provided for patient waiting, patient preparation, staff and patient bathrooms, staff activities, storage of records and supplies, and other space necessary to accommodate the needs of handicapped persons.]~~

[Article 3
Magnetic Source Imaging]

[~~12VAC5-230-200~~ **12 VAC5-230-190**] . **Policy for the development of MSI services.**

~~Because Magnetic Source Imaging (MSI) scanning systems are still in the clinical research stage of development with no third-party payment available for clinical applications, and because it is uncertain as to how rapidly this technology will reach a point where it is shown to be clinically suitable for widespread use and distribution on a cost-effective basis, [it is preferred that] the entry and development of this technology in Virginia should initially occur at or in affiliation with, the academic medical centers in the state.~~

[Article 4
Positron Emission Tomography]

[~~12VAC5-230-210~~ **12VAC5-230-200**], [~~Accessibility~~ **Travel time**],

~~[The service area for each proposed PET service shall be an entire planning district PET services should be within 60 minutes driving time one way under normal conditions of 95% of the planning district].~~

[Article 4
Positron Emission Tomography

~~12VAC5-230-220~~ 12VAC5-230-210]. Need for [new fixed site] service.

~~A. [Whether the applicant is a consortium of hospitals, a hospital network, or a single general hospital, at least 850 new PET appropriate cases should have been diagnosed in the planning district. If the applicant is a hospital, whether free-standing or within a hospital system, 850 new PET appropriate cases shall have been diagnosed and the hospital shall have provided radiation therapy services with specific ancillary services suitable for the equipment before a new fixed site PET service should be approved for the planning district.]~~

~~B. [If the applicant is a general hospital, the facility shall provide radiation therapy services and specific ancillary services suitable for the equipment, and have reported at least 500 new courses of treatment or at least 8,000 treatment visits in the most recent reporting period No new fixed site PET services should be approved unless an average of 6,000 procedures preexisting and approved fixed site PET scanner~~

were performed in the planning district during the relevant reporting period and the proposed new service would not significantly reduce the utilization of existing fixed site PET providers in the planning district below 6,000 procedures. The utilization of existing scanners operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of PET units in such panning district.

Note: For the purposes of tracking volume utilization, an image taken with a PET/CT scanner that takes concurrent PET/CT images shall be counted as one PET procedure. Images made with PET/CT scanners that can take PET or CT images independently shall be counted as individual PET procedures and CT procedures respectively, unless those images are made concurrently.]

~~[C. If the applicant is a consortium of general hospitals or a hospital network, at least one of the consortium or network members shall provide radiation therapy services and specific ancillary services suitable for the equipment, and have reported at least 500 new PET appropriate patients.~~

~~D. Future applications of PET equipment shall be evaluated based on review of national literature.]~~

[~~12VAC5-230-230. Additional scanners.~~ **12VAC5-230-220. Expansion of fixed site services.**]

~~[No additional PET scanners shall be added in a planning district unless the applicant can demonstrate that the utilization of the existing PET service was at least 1,200 PET scans for a fixed site unit and that the proposed new or expanded service would not reduce the utilization after for existing services below 850 PET scans for a fixed site unit. The applicant shall also provide documentation that he project complies with 12VAC50 230 240. Proposals to increase the number of PET scanners in an existing PET service should be approved only when the existing scanners performed an average of 6,000 procedures for the relevant reporting period and the proposed expansion would not significantly reduce the utilization of existing fixed site providers in the planning district below 6,000 procedures.]~~

[12VAC5-230-230. Adding or expanding mobile PET or PET/CT services.

A. Proposals for mobile PET or PET/CT scanners shall demonstrate that, for the relevant reporting period, at least 230 procedures were performed and that the proposed mobile unit will not significantly reduce the utilization of existing providers in the planning district below 6,000 procedures for the fixed site PET providers or 230 procedures for the mobile PET providers.

B. Proposals to convert mobile PET or PET/CT scanners to fixed site scanners should demonstrate that, for the relevant reporting period, at least 1,400 procedures were performed and that the proposed conversion will not significantly reduce

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the utilization of existing providers in the planning district below 6,000 procedures for the fixed site PET or 230 procedures of the mobile PET providers.]

12VAC5-230-240. Staffing.

PET services should be under the direction [~~of a physician who is a board certified radiologist~~ or supervision of one or more qualified physicians]. Such [~~physician~~ physicians] shall be [~~a~~] designated authorized [~~user~~ users] of isotopes used for PET by the Nuclear Regulatory Commission or licensed by the [~~Office Division~~] of Radiologic Health of the Virginia Department of Health, as applicable.

Article 5

Noncardiac Nuclear Imaging Criteria and Standards

12VAC5-230-250. [~~Accessibility~~ Travel time].

Noncardiac nuclear imaging services should be available within 30 minutes driving time one way [~~;~~] under normal driving conditions [~~;~~] of 95% of the population of the planning district.

12VAC5-230-260. [~~Introduction of a service~~ Need for new service].

[~~Any applicant proposing to establish a medical care facility for the provision of noncardiac nuclear imaging, or introducing nuclear imaging as a new service at an existing medical care facility, shall provide documentation that No new noncardiac imaging services should be approved unless] the service can achieve a minimum utilization level of [~~;~~]~~

[~~(i) 650 scans~~ 1. 650 procedures] in the first 12 months of operation [~~;~~]

[~~(ii) 1,000 scans~~ 2. 1,000 procedures] in the second 12 months of [~~services, and (iii) 1,250 scans service in the second 12 months of operation~~ service; and

3. The proposed new service would not significantly reduce the utilization of existing providers in the planning district.

Note: The utilization of an existing service operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of noncardiac nuclear imaging services in such planning district].

12VAC5-230-270. Staffing.

The proposed new or expanded [noncardiac] nuclear imaging service [~~shall~~ should] be under the direction [~~of a board certified physician~~ or supervision of one or more qualified physicians] . Such physicians shall be [~~a~~] designated authorized [~~user~~ users] of isotopes licensed by the Nuclear Regulatory Commission or the [~~Office Division~~] of Radiologic Health of the Virginia Department of Health, as applicable.

Part III Radiation Therapy Services

Article 1 Radiation Therapy Services

12VAC5-230-280. [~~Accessibility~~ Travel time].

Radiation therapy services should be available within 60 minutes driving time one way [~~;~~] under normal conditions [~~;~~] for of.] 95% of the population of the planning district.

12VAC5-230-290. [~~Availability~~ Need for new service].

A. No new radiation therapy service shall be approved unless:

[~~(i) existing~~ 1. Existing] radiation therapy machines located in the planning district [~~were used for at least 320 cancer cases and at least performed an average of~~] 8,000 treatment visits [~~for in~~] the relevant reporting period; and

[~~(ii) it can be reasonably projected that the~~ 2. The] new service will perform at least [~~6,000~~ 5,000] procedures by the [~~third~~ second] year of operation without [~~significantly~~] reducing the utilization of existing [~~radiation therapy machines within 60 minutes drive time one way, under normal conditions, such that less than 8,000 procedures will be performed by an existing machine~~ providers in the planning district] .

B. The number of radiation therapy machines needed in a [~~primary service area~~ planning district] will be determined as follows:

$$\frac{\text{Population} \times \text{Cancer Incidence Rate} \times 60\%}{320}$$

320

where:

1. The population is projected to be at least [~~75,000~~ 150,000] people three years from the current year as reported in the most current projections of [~~the Virginia Employment Commission~~ a demographic entity as determined by the commissioner];

2. The [~~;~~] cancer incidence rate [~~"is based on~~ as determined by] data from the Statewide Cancer Registry;

3. 60% is the estimated number of new cancer cases in a planning district that are treatable with radiation therapy; and

4. 320 is 100% utilization of a radiation therapy machine based upon an anticipated average of 25 treatment visits per case.

C. [~~Consideration will be given to the approval of~~ Proposals for] new radiation therapy services located [~~at a general hospital at least~~ less than] 60 minutes driving time one way, under normal conditions, from any site that radiation therapy services are available [~~if the applicant can~~ shall] demonstrate

that the proposed new services will perform [at least an average of] 4,500 treatment procedures annually by the second year of operation, without [significantly] reducing the utilization of existing [machines located within 60 minutes driving time one way, under normal conditions, from the proposed new service location providers in the planning region].

[~~D. Proposals for the expansion of radiation therapy services should not be approved unless all existing radiation therapy machines operated by the applicant in the planning district have performed at least 8,000 procedures for the relevant reporting period.]~~

12VAC5-230-300. [Statewide Cancer Registry Expansion of service].

[~~Facilities with radiation therapy services shall participate in the Statewide Cancer Registry as required by Article 9 (§32.1-70 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia~~

Proposals to increase radiation therapy services should be approved only when all existing radiation therapy machines operated by the applicant in the planning district have performed an average of 8,000 procedures for the relevant reporting period and the proposed expansion would not significantly reduce the utilization of existing providers below 8,000 procedures].

12VAC5-230-310. [Staffing Statewide Cancer Registry].

[~~Radiation therapy services shall be under the direction of a physician board certified in radiation oncology~~ Facilities with radiation therapy services shall participate in the Statewide Cancer Registry as required by Article 9 (§32.1-70 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia].

12VAC5-230-320. [Equipment, patient care, support services Staffing].

[~~In addition to the radiation therapy machine, the service should have direct access to:~~

- ~~1. Simulation equipment capable of precisely producing the geometric relations of the equipment to be used for treatment of the patient;~~
- ~~2. A computerized treatment planning system;~~
- ~~3. A custom block design and cutting system; and~~
- ~~4. Diagnostic, laboratory oncology services~~

Radiation therapy services should be under the direction or supervision of one or more qualified physicians. Such physicians shall be designated authorized users of isotopes licensed by the Nuclear Regulatory Commission or the Division of Radiologic Health of the Virginia Department of Health, as applicable].

Article 2

Criteria and Standards for Stereotactic Radiosurgery

12VAC5-230-330. [Availability; need for new service Travel time].

[~~No new services should be approved unless (i) the number of procedures performed with existing units in the planning region average more than 350 per year and (ii) it can be reasonably projected that the proposed new service will perform at least 250 procedures in the second year of operation without reducing patient volumes to existing providers to less than 350 procedures~~ Stereotactic radiosurgery services should be available within 60 minutes driving time one way under normal conditions of 95% of the population of a planning district].

12VAC5-230-340. [Statewide Cancer Registry Need for new service].

[~~Facilities shall participate in the Statewide Cancer Registry as required by Article 9 (§32.1-70 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia.~~

A. No new stereotactic radiosurgery services should be approved unless:

1. The number of procedures performed with existing units in the planning region averaged more than 350 per year; and
2. The proposed new service will perform at least 250 procedures in the second year of operation without significantly reducing the utilization of existing providers in the planning region below 350 treatments.

B. Consideration may be given to a stereotactic radiosurgery service incorporated within an existing standard radiation therapy service using a linear accelerator when an average of 8,000 treatments during the relevant reporting period were performed and the applicant can demonstrate that the volume and cost of the service is justified.

C. Consideration may be given to a dedicated Gamma Knife® incorporated within an existing radiation therapy service when:

1. At least 350 Gamma Knife® appropriate cases were referred out of the region in the relevant reporting period; and
2. The applicant can demonstrate that:
 - a. An average of 250 procedures will be preformed in the second year of operation;
 - b. Utilization of existing services in the planning region will not be significantly reduced below 350 treatments per year; and
 - c. The cost is justified.

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D. Consideration may be given to non-Gamma Knife® technology incorporated within an existing radiation therapy service when:

1. The unit is not part of a linear accelerator;
2. An average of 8,000 radiation treatments per year were performed by the existing radiation therapy services;
3. At least 250 procedures will be performed within the second year of operation; and
4. Utilization of existing services in the planning region will not be significantly reduced below 350 treatments.]

12VAC5-230-350. [Staffing Expansion of service],

[The proposed new or expanded stereotactic radiosurgery services shall be under the direction of a physician who is board certified in neurosurgery and a radiation oncologist with training in stereotactic radiosurgery

Proposals to increase the number of stereotactic radiosurgery services should be approved only when all existing stereotactic radiosurgery machines in the planning region have performed an average of 350 procedures for the relevant reporting period and the proposed expansion would not significantly reduce the utilization of existing providers in the planning region below 350 procedures]

[Part IV Cardiac Services

Article 1

Criteria and Standards for Cardiac Catheterization Services]

12VAC5-230-360. [Accessibility Statewide Cancer Registry],

[Adult cardiac catheterization services should be accessible within 60 minutes driving time one way, under normal conditions, for 95% of the population of the planning district Facilities shall participate in the Statewide Cancer Registry as required by Article 9 (§32.1-70 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia]

12VAC5-230-370. [Availability Staffing],

[A. No new fixed site cardiac catheterization laboratory should be approved unless:

1. All existing fixed site cardiac catheterization laboratories located in the planning district were used for at least 960 diagnostic equivalent cardiac catheterization procedures for the relevant reporting period; and
2. It can be reasonably projected that the proposed new service will perform at least 200 diagnostic equivalent procedures in the first year of operation, 500 diagnostic equivalent procedures in the second year of operation without reducing the utilization of existing laboratories in the planning district to less than 960 diagnostic equivalent procedures at any of those existing laboratories.

B. Proposals for the use of freestanding or mobile cardiac catheterization laboratories shall be approved only if such laboratories will be provided at a site located on the campus of a general or community hospital. Additionally, applicants for proposed mobile cardiac catheterization laboratories shall be able to project that they will perform 200 diagnostic equivalent procedures in the first year of operation, 350 diagnostic equivalent procedures in the second year of operation without reducing the utilization of existing laboratories in the planning district to less than 960 diagnostic equivalent procedures at any of those existing laboratories.

C. Consideration may be given for the approval of new cardiac catheterization services located at a general hospital located 60 minutes or more driving time one way, under normal conditions, from existing laboratories, if it can be projected that the proposed new laboratory will perform at least 200 diagnostic equivalent procedures in the first year of operation, 400 diagnostic equivalent procedures in the second year of operation without reducing the utilization of existing laboratories located within 60 minutes driving time one way, under normal conditions, of the proposed new service location.

D. Proposals for the addition of cardiac catheterization laboratories shall not be approved unless all existing cardiac catheterization laboratories operated in the planning district by the applicant have performed at least 1,200 diagnostic equivalent procedures for the relevant reporting period, and the applicant can demonstrate that the expanded service will achieve a minimum of 200 diagnostic equivalent procedures per laboratory in the first 12 months of operation, 400 diagnostic equivalent procedures in the second 12 months of operation without reducing the utilization of existing cardiac catheterization laboratories in the planning district below 960 diagnostic equivalent procedures.

E. Emergency cardiac catheterization services shall be available within 30 minutes of admission to the facility.

F. No new or expanded pediatric cardiac catheterization services should be approved unless the proposed service will be provided at a hospital that:

1. Provides open heart surgery services, provides pediatric tertiary care services, has a pediatric intensive care unit and provides neonatal special care or has a cardiac intensive care unit and provides pediatric open heart surgery services; and
2. The applicant can demonstrate that each proposed laboratory will perform at least 100 pediatric cardiac catheterization procedures in the first year of operation and 200 pediatric cardiac catheterization procedures in the second year of operation.

G. Applications for new or expanded cardiac catheterization services that include nonemergent interventional cardiology services should not be approved unless emergency open heart

~~surgery services are available within 15 minutes drive time in the hospital where the proposed cardiac catheterization service will be located.~~

~~Stereotactic radiosurgery services should be under the direction or supervision of one or more qualified physicians.]~~

~~[Part IV
Cardiac Services~~

~~Article 1~~

~~Criteria and Standards for Cardiac Catheterization Services]~~

~~12VAC5-230-380. [**Staffing Travel time**].~~

~~[A. Cardiac catheterization services should have a medical director who is board certified in cardiology and clinical experience in the performing physiologic and angiographic procedures.~~

~~In the case of pediatric cardiac catheterization services, the medical director should be board certified in pediatric cardiology and have clinical experience in performing physiologic and angiographic procedures.~~

~~B. All physicians who will be performing cardiac catheterization procedures should be board certified or board eligible in cardiology and clinical experience in performing physiologic and angiographic procedures.~~

~~In the case of pediatric catheterization services, each physician performing pediatric procedures should be board certified or board eligible in pediatric cardiology, and have clinical experience in performing physiologic and angiographic procedures.~~

~~C. All anesthesia services should be provided by or supervised by a board certified anesthesiologist.~~

~~In the case of pediatric catheterization services, the anesthesiologist should be experienced and trained in pediatric anesthesiology.~~

~~Cardiac catheterization services should be within 60 minutes driving time one way under normal conditions of 95% of the population of the planning district.]~~

~~Article 2~~

~~Criteria and Standards for Open Heart Surgery~~

~~12VAC5-230-390. [**Accessibility Need for new service**].~~

~~[Open heart surgery services should be available 24 hours per day 7 days per week and accessible within a 60 minutes driving time one way, under normal conditions, for 95% of the population of the planning district.~~

~~A. No new fixed site cardiac catheterization laboratory should be approved for a planning district unless:~~

~~1. Existing fixed site cardiac catheterization laboratories located in the planning district performed an average of~~

~~1,200 cardiac catheterization DEPs for the relevant reporting period; and~~

~~2. The proposed new service will perform an average of 200 DEPs in the first year of operation and 500 DEPs in the second year of operation; and~~

~~3. The utilization of existing services in the planning district will not be significantly reduced.~~

~~B. Proposals for mobile cardiac catheterization laboratories should be approved only if such laboratories will be provided at a site located on the campus of an inpatient hospital. Additionally, applicants for proposed mobile cardiac catheterization laboratories shall be able to project that they will perform an average of 200 DEPs in the first year of operation and 350 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the planning district below 1,200 procedures.~~

~~C. Consideration may be given for new cardiac catheterization services located at an inpatient hospital that is 60 minutes or more driving time one way under normal conditions from existing laboratories if the applicant can demonstrate that the proposed new laboratory will perform an average of 200 DEPs in the first year of operation and 400 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the planning district.]~~

~~12VAC5-230-400. [**Availability Expansion of services**].~~

~~[A. No new open heart services should be approved unless:~~

~~1. The service will be made available in a general hospital with established cardiac catheterization services that have been used for at least 960 diagnostic equivalent procedures for the relevant reporting period and have been in operation for at least 30 months;~~

~~2. All existing open heart surgery rooms located in the planning district have been used for at least 400 open heart surgical procedures for the relevant reporting period; and~~

~~3. It can be reasonably projected that the proposed new service will perform at least 150 procedures per room in the first year of operation and 250 procedures per room in the second year of operation without reducing the utilization of existing open heart surgery programs in the planning district to less than 400 open heart procedures performed at those existing services.~~

~~B. Notwithstanding subsection A of this subsection, consideration will be given to the approval of new open heart surgery services located at a general hospital more than 60 minutes driving time one way, under normal conditions, from any site in which open heart surgery services are currently available if it can be projected that the proposed new service will perform at least 150 open heart procedures in the first year of operation; and 200 procedures in the second year of~~

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~~operation without reducing the utilization of existing open heart surgery rooms to less than 400 procedures per room within 2 hours driving time one way, under normal conditions, from the proposed new service location.~~

~~Such hospitals should also have provided at least 960 diagnostic equivalent cardiac catheterization procedures during the relevant reporting period on equipment that has been in operation at least 30 months.~~

~~C. Proposals for the expansion of open heart surgery services should not be approved unless all existing open heart surgery rooms operated by the applicant have performed at least:~~

~~1. 400 adult equivalent open heart surgery procedures in the relevant reporting period when the proposed facility is within two hours driving time one way, under normal conditions, of an existing open heart surgery service; or~~

~~2. 300 adult equivalent open heart surgery procedures in the relevant reporting period when the applicant proposes expanding services in excess of two hours driving time, under normal conditions, of an existing open heart surgery service.~~

~~D. No new or expanded pediatric open heart surgery services should be approved unless the proposed new or expanded service is provided at a hospital that:~~

~~1. Has pediatric cardiac catheterization services that have been in operation for 30 months and have performed at least 200 pediatric cardiac catheterization procedures for the relevant reporting period; and~~

~~2. Has pediatric intensive care services and provides neonatal special care.~~

~~Proposals to increase cardiac catheterization services should be approved only when:~~

~~1. All existing cardiac catheterization laboratories operated by the applicant's facilities where the proposed expansion is to occur have performed an average of 1,200 DEPs for the relevant reporting period; and~~

~~2. The applicant can demonstrate that the expanded service will achieve an average of 200 DEPs per laboratory in the first 12 months of operation and 400 DEPs in the second 12 months of operation without significantly reducing the utilization of existing cardiac catheterization laboratories in the planning district.]~~

12VAC5-230-410. [Staffing Pediatric cardiac catheterization].

~~[A. Open heart surgery services should have a medical director certified by the American Board of Thoracic Surgery in cardiovascular surgery with special qualifications and experience in cardiac surgery.~~

~~In the case of pediatric open heart surgery, the medical director shall be certified by the American Board of Thoracic Surgery in cardiovascular surgery and experience in pediatric cardiovascular surgery and congenital heart disease.~~

~~B. All physicians performing open heart surgery procedures should be board certified or board eligible in cardiovascular surgery, with experience in cardiac surgery. In addition to the cardiovascular surgeon who performs the procedure, there should be a suitably trained board certified or board eligible cardiovascular surgeon acting as an assistant during the open heart surgical procedure. There should also be present at least one board certified or board eligible anesthesiologist with experience in open heart surgery.~~

~~In the case of pediatric open heart surgery services, each physician performing and assisting with pediatric procedures should be board certified or board eligible in cardiovascular surgery with experience in pediatric cardiovascular surgery. In addition to the cardiovascular surgeon who performs the procedure, there should be a suitably trained board certified or board eligible cardiovascular surgeon acting as an assistant during the open heart surgical procedure. All pediatric procedures should include a board certified anesthesiologist with experience in pediatric anesthesiology and pediatric open heart surgery.~~

~~No new or expanded pediatric cardiac catheterization services should be approved unless:~~

~~1. The proposed service will be provided at an inpatient hospital with open heart surgery services, pediatric tertiary care services or specialty or subspecialty level neonatal special care;~~

~~2. The applicant can demonstrate that the proposed laboratory will perform at least 100 pediatric cardiac catheterization procedures in the first year of operation and 200 pediatric cardiac catheterization procedures in the second year of operation; and~~

~~3. The utilization of existing pediatric cardiac catheterization laboratories in the planning district will not be reduced below 100 procedures per year.]~~

[Part V General Surgical Services]

12VAC5-230-420. [Accessibility Nonemergent cardiac catheterization].

~~[Surgical services should be available within 30 minutes driving time one way, under normal conditions, for 95% of the population of the planning district.~~

~~Proposals to provide elective interventional cardiac procedures such as PTCA, transseptal puncture, transthoracic left ventricle puncture, myocardial biopsy or any valvuloplasty procedures, diagnostic pericardiocentesis or therapeutic procedures should be approved only when open heart surgery~~

services are available on-site in the same hospital in which the proposed non-emergent cardiac service will be located.]

12VAC5-230-430. [Availability Staffing].

~~[A. The combined number of inpatient and outpatient general purpose surgical operating rooms needed in a planning district, exclusive of Level I and Level II Trauma Centers dedicated to the needs of the trauma service, dedicated cesarean section rooms, or operating rooms designated exclusively for open heart surgery, will be determined as follows:~~

$$FOR = ((ORV/POP) \times (PROPOP)) \times AHORV$$

~~1600~~

~~ORV = the sum of total operating room visits (inpatient and outpatient) in the planning district in the most recent five years for which operating room utilization data has been reported by Virginia Health Information; and~~

~~POP = the sum of total population in the planning district in the most recent five years for which operating room utilization data has been reported by Virginia Health Information, as found in the most current projections of the Virginia Employment Commission.~~

~~PROPOP = the projected population of the planning district five years from the current year as reported in the most current projections of the Virginia Employment Commission.~~

~~AHORV = the average hours per general purpose operating room visit in the planning district for the most recent year for which average hours per general purpose operating room visit has been calculated from information collected by Virginia Health Information.~~

~~FOR = future general purpose operating rooms needed in the planning district five years from the current year.~~

~~1600 = available service hours per operating room per year based on 80% utilization of an operating room that is available 40 hours per week, 50 weeks per year.~~

~~B. Projects involving the relocation of existing general purpose operating rooms within a planning district may be authorized when it can be reasonably documented that such relocation will improve the distribution of surgical services within a planning district by making services available within 30 minutes driving time one way, under normal conditions, of 95% of the planning district's population.~~

~~A. Cardiac catheterization services should have a medical director who is board certified in cardiology and has clinical experience in performing physiologic and angiographic procedures.~~

~~In the case of pediatric cardiac catheterization services, the medical director should be board-certified in pediatric~~

~~cardiology and have clinical experience in performing physiologic and angiographic procedures.~~

~~B. Cardiac catheterization services should be under the direct supervision or one or more qualified physicians. Such physicians should have clinical experience in performing physiologic and angiographic procedures.~~

~~Pediatric catheterization services should be under the direct supervision of one or more qualified physicians. Such physicians should have clinical experience in performing pediatric physiologic and angiographic procedures.]~~

~~[Part VI~~

~~General Inpatient Services]~~

~~Article 2~~

~~Criteria and Standards for Open Heart Surgery~~

12VAC5-230-440. [Accessibility Travel time].

~~[Acute care inpatient facility beds A. Open heart surgery services] should be within [30 60] minutes driving time one way [1/2] under normal conditions [1/2] of 95% of the population of [a the] planning district.~~

~~[B. Such services shall be available 24 hours a day, seven days a week.]~~

12VAC5-230-450. [Availability Need for new service].

~~[A. Subject to the provisions of 12VAC5-230-80, no new inpatient beds should be approved in any planning district unless:~~

- ~~1. The resulting number of beds does not exceed the number of beds projected to be needed, for each inpatient bed category, for that planning district for the fifth planning horizon year;~~
- ~~2. The average annual occupancy, based on the number of beds, is at least 70% (midnight census) for the relevant reporting period; or~~
- ~~3. The intensive care bed capacity has an average annual occupancy of at least 65% for the relevant reporting period, based on the number of beds.~~

~~A. No new open heart services should be approved unless:~~

- ~~1. The service will be available in an inpatient hospital with an established cardiac catheterization service that has performed an average of 1,200 DEPs for the relevant reporting period and has been in operation for at least 30 months;~~
- ~~2. Open heart surgery programs located in the planning district performed an average of 400 open heart and closed heart surgical procedures for the relevant reporting period; and~~

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3. The proposed new service will perform at least 150 procedures per room in the first year of operation and 250 procedures per room in the second year of operation without significantly reducing the utilization of existing open heart surgery programs in the planning district below 400 open and closed heart procedures.]

[B. No proposal to replace or relocate inpatient beds to a location not contiguous to the existing site should be approved unless:

1. Off site replacement is necessary to correct life safety or building code deficiencies;

2. The population currently served by the beds to be moved will have reasonable access to the beds at the new site, or to neighboring inpatient facilities;

3. The beds to be replaced experienced an average annual utilization of 70% (midnight census) for general inpatient beds and 65% for intensive care beds in the relevant reporting period;

4. The number of beds to be moved off site is taken out of service at the existing facility; and

5. The off site replacement of beds results in: (i) a decrease in the licensed bed capacity; (ii) a substantial cost savings, cost avoidance, or consolidation of underutilized facilities; or (iii) generally improved operating efficiency in the applicant's facility or facilities.

B. Consideration may be given to new open heart surgery services located at an inpatient hospital more than 60 minutes driving time one way under normal condition from any site in which open heart surgery services are currently available when:

1. The proposed new service will perform an average of 150 open heart procedures in the first year of operation and 200 procedures in the second year of operation without significantly reducing the utilization of existing open heart surgery rooms within two hours driving time one way under normal conditions from the proposed new service location below 400 procedures per room; and

2. The hospital provided an average of 1,200 cardiac catheterization DEPs during the relevant reporting period in a service that has been in operation at least 30 months.]

[C. For proposals involving a capital expenditure of \$5 million or more, and involving the conversion of underutilized beds to medical/surgical, pediatric or intensive care, consideration will be given to a proposal if: (i) there is a projected need in the category of inpatient beds that would result from the conversion; and (ii) it can be demonstrated that the average annual occupancy of the beds to be converted would reach the standard in subdivisions B 1, 2 and 3 for the bed category that would result from the conversion, by the first year of operation.

D. In addition to the terms of 12VAC5-230-80, a need for additional general inpatient beds may be demonstrated if the total number of beds in a given category in the planning district is less than the number of such beds projected as necessary to meet demand in the fifth planning horizon year for which the application is submitted.

E. The number of medical/surgical beds projected to be needed in a planning district shall be computed as follows:

1. Determine the projected total number of medical/surgical and pediatric inpatient days for the fifth planning horizon year as follows:

a. Add the medical/surgical and pediatric inpatient days for the past three years for all acute care inpatient facilities in the planning district as reported in the Annual Survey of Hospitals;

b. Add the projected planning district population for the same three year period as reported by the Virginia Employment Commission;

c. Divide the total of the medical/surgical and pediatric inpatient days by the total of the population and express the resulting rate in days per 1,000 population;

d. Multiply the days per 1,000 population rate by the projected population for the planning district (expressed in thousands) for the fifth planning horizon year.

2. Determine the projected number of medical/surgical and pediatric beds that may be needed in the planning district for the planning horizon year as follows:

a. Divide the result in subdivision E 1 d of this subsection by 365;

b. Divide the quotient obtained by 0.80 in planning districts in which 50% or more of the population resides in nonrural areas or 0.75 in planning districts in which less than 50% of the population resides in nonrural areas.

3. Determine the projected number of medical/surgical and pediatric beds that may be established or relocated within the planning district for the fifth planning horizon year as follows:

a. Determine the number of medical/surgical and pediatric beds as reported in the inventory;

b. Subtract the number of beds identified in subdivision E 1 from the number of beds needed as determined in subdivision E 2 b of this subsection. If the difference indicated is positive, then a need may exist for additional medical/surgical or pediatric beds. If the difference is negative, then no need for additional beds exists.

F. The projected need for intensive care beds shall be computed as follows:

1. Determine the projected total number of intensive care inpatient days for the fifth planning horizon year as follows:

a. Add the intensive care inpatient days for the past three years for all inpatient facilities in the planning district as reported in the annual survey of hospitals;

b. Add the planning district's projected population for the same three year period as reported by the Virginia Employment Commission;

c. Divide the total of the intensive care days by the total of the population to obtain the rate in days per 1,000 population;

d. Multiply the days per 1,000 population rate by the projected population for the planning district (expressed in thousands) for the fifth planning horizon year to yield the expected intensive care patient days.

2. Determine the projected number of intensive care beds that may be needed in the planning district for the planning horizon year as follows:

a. Divide the number of days projected in subdivision F 1 d of this subsection by 365 to yield the projected average daily census;

b. Calculate the beds needed to assure with 99% probability that an intensive care bed will be available for unscheduled admissions.

3. Determine the projected number of intensive care beds that may be established or relocated within the planning district for the fifth planning horizon year as follows:

a. Determine the number of intensive care beds as reported in the inventory.

b. Subtract the number of beds identified in subdivision F 3 a of this subsection from the number of beds needed as determined in subdivision F 2 b of this subsection. If the difference is positive, then a need may exist for additional intensive care beds. If the difference is negative, then no need for additional beds exists.

G. No hospital should relocate beds to a new location if underutilized beds (less than 85% average annual occupancy for medical/surgical and pediatric beds), when the relocation involves such beds, and less than 65% average annual occupancy for intensive care beds when relocation involves such beds, are available within 30 minutes of the site of the proposed hospital.]

[Part VII
Nursing Facilities]

12VAC5-230-460. [Accessibility Expansion of service]:

[A. Nursing facility beds should be accessible within 60 minutes driving time one way, under normal conditions, to 95% of the population in a planning region.

B. Nursing facilities should be accessible by public transportation when such systems exist in an area.

C. Preference will be given to proposals that improve geographic access and reduce travel time to nursing facilities within a planning district

Proposals to increase open heart surgery services shall demonstrate that existing open heart surgery rooms operated by the applicant have performed an average of:

1. 400 adult equivalent open heart surgery procedures in the relevant reporting period of the proposed increase is within one hour driving time one way under normal conditions of an existing open heart surgery service, or

2. 300 adult equivalent open heart surgery procedures in the relevant reporting period if the proposed service is in excess of one hour driving time one way under normal conditions of an existing open heart surgery service in the planning district].

12VAC5-230-470. [Availability Pediatric open heart surgery services]:

[A. No planning district shall be considered to have a need for additional nursing facility beds unless (i) the bed need forecast in that planning district (see subsection D of this section) exceeds the current inventory of beds in that planning district and (ii) the estimated average annual occupancy of all existing Medicaid-certified nursing facility beds in the planning district was at least 93% for the most recent two years following the first year of operation of new beds, excluding the bed inventory and utilization of the Virginia Veterans Care Center.

B. No planning district shall be considered to have a need for additional beds if there are unconstructed beds designated as Medicaid certified.

C. Proposals for expanding existing nursing facilities should not be approved unless the facility has operated for at least two years and the average annual occupancy of the facility's existing beds was at least 93% in the most recent year for which bed utilization has been reported to the department.

Exceptions will be considered for facilities that operated at less than 93% average annual occupancy in the most recent year for which bed utilization has been reported when the facility has a rehabilitative or other specialized care focus that

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results in a relatively short average length of stay, causing an average annual occupancy lower than 93% for the facility.

D. The bed need forecast will be computed as follows:

$PDBN = (UR64 \times PP64) + (UR69 \times PP69) + (UR74 \times PP74) + (UR79 \times PP79) + (UR84 \times PP84) + (UR85 \times PP85)$ where:

PDBN = Planning district bed need.

UR64 = The nursing home bed use rate of the population aged 0 to 64 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP64 = The population aged 0 to 64 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR69 = The nursing home bed use rate of the population aged 65 to 69 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP69 = The population aged 65 to 69 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR74 = The nursing home bed use rate of the population aged 70 to 74 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP74 = The population aged 70 to 74 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR79 = The nursing home bed use rate of the population aged 75 to 79 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP79 = The population aged 75 to 79 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR84 = The nursing home bed use rate of the population aged 80 to 84 in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP84 = The population aged 80 to 84 projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

UR85+ = The nursing home bed use rate of the population aged 85 and older in the planning district as determined in the most recent nursing home patient origin study authorized by the department.

PP85+ = The population aged 85 and older projected for the planning district three years from the current year as most recently published by the Virginia Employment Commission.

Planning district bed need forecasts will be rounded as follows:

<u>Planning District Bed Need</u>	<u>Rounded Bed Need</u>
<u>1-29</u>	<u>0</u>
<u>30-44</u>	<u>30</u>
<u>45-84</u>	<u>60</u>
<u>85-104</u>	<u>90</u>
<u>105-134</u>	<u>120</u>
<u>135-164</u>	<u>150</u>
<u>165-194</u>	<u>180</u>
<u>195-224</u>	<u>210</u>
<u>225+</u>	<u>240</u>

The above applies, except in the case of a planning district that has two or more nursing facilities, has had an average annual occupancy rate in excess of 93% for the most recent two years for which bed utilization has been reported to the department, and has a forecasted bed need of 15 to 29 beds. In such a case, the bed need for this planning district will be rounded to 30.

E. No new freestanding nursing facilities of less than 90 beds should be authorized. Consideration will be given to new freestanding facilities with fewer than 90 nursing facility beds when such facilities can be justified on the basis of a lack of local demand for a larger facility and a maldistribution of nursing facility beds within a planning district.

F. Proposals for the development of new nursing facilities or the expansion of existing facilities by continuing care retirement communities will be considered when:

1. The total number of new or additional beds plus any existing nursing facility beds operated by the continuing care provider does not exceed 10% of the continuing care provider's total existing or planned independent living and adult care residence;

2. The proposed beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility;

3. The applicant agrees in writing not to seek certification for the use of such new or additional beds by persons eligible to receive Medicaid;

4. The applicant agrees in writing to obtain the resident's written acknowledgement, prior to admission, that the applicant does not serve Medicaid recipients and that, in the event such resident becomes a Medicaid recipient and is eligible for nursing facility placement, the resident will not be eligible for placement in the CCRC's nursing facility unit;

5. The applicant agrees in writing that only continuing care contract holders who have resided in the CCRC as independent living residents or adult care residents will be admitted to the nursing facility unit after the first three years of operation.

G. The construction cost of proposed nursing facilities should be comparable to the most recent cost for similar facilities in the same health planning region. Consideration should be given to the current capital cost reimbursement methodology utilized by the Department of Medical Assistance Services.

H. Consideration should be given to applicants proposing to replace outdated and functionally obsolete facilities with modern nursing facilities that will result in the more cost efficient delivery of health care services to residents in a more aesthetically pleasing and comfortable environment. Proponents of the replacement and relocation of nursing facility beds should demonstrate that the replacement and relocation are reasonable and could result in savings in other cost centers, such as realized operational economies of scale and lower maintenance costs.

No new or expanded pediatric open heart surgery service should be approved unless the proposed new or expended service is provided at an inpatient hospital that:

1. Has pediatric cardiac catheterization services that have been in operation for 30 months and have performed an average of 200 pediatric cardiac catheterization procedures for the relevant reporting period; and
2. Has pediatric intensive care services and provides specialty or subspecialty neonatal special care.]

[Part VIII

Lithotripsy Services]

12VAC5-230-480. [Accessibility Staffing],

A. [The waiting time for lithotripsy services should be no more than one week Open heart surgery services should have a medical director who is board certified in cardiovascular or cardiothoracic surgery by the appropriate board of the American Board of Medical Specialists.

In the case of pediatric cardiac surgery, the medical director should be board certified in cardiovascular or cardiothoracic surgery, with special qualifications and experience in pediatric cardiac surgery and congenital heart disease, by the appropriate board of the American Board of Medical Specialists];

B. [Lithotripsy services should be available within 30 minutes driving time in urban areas and 45 minutes driving time one way, under normal conditions, for 95% of the population of the health planning region Cardiac surgery should be under the direct supervision of one or more qualified physicians.

Pediatric cardiac surgery services should be under the direct supervision of one or more qualified physicians];

[Part V

General Surgical Services]

12VAC5-230-490. [Availability Travel time],

[A. Consideration will be given to new lithotripsy services established at a general hospital through contract with, or by lease of equipment from, an existing service provider authorized to operate in Virginia, provided the hospital has referred at least two patients per week, or 100 patients annually, for the relevant reporting period to other facilities for lithotripsy services.

B. A new service may be approved at the site of any general hospital or hospital based clinic or licensed outpatient surgical hospital provided the service is provided by:

1. A vendor currently providing services in Virginia;
2. A vendor not currently providing services who can demonstrate that the proposed unit can provide at least 750 procedures annually at all sites served; or
3. An applicant who can demonstrate that the proposed unit can provide at least 750 procedures annually at all sites to be served.

C. Proposals for the expansion of services by existing vendors or providers of such services may be approved if it can be demonstrated that each existing unit owned or operated by that vendor or provider has provided a minimum of 750 procedures annually at all sites served by the vendor or provider.

D. A new or expanded lithotripsy service may be approved when the applicant is a consortium of hospitals or a hospital network, when a majority of procedures will be provided at sites or facilities owned or operated by the hospital consortium or by the hospital network.

Surgical services should be available within 30 minutes driving time one way under normal conditions for 95% of the population of the planning district.]

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[~~Part IX~~

~~Organ Transplant]~~

~~12VAC5-230-500. [**Accessibility Need for new service**].~~

~~A. [Organ transplantation services should be accessible within two hours driving time one way, under normal conditions, of 95% of Virginia's population. The combined number of inpatient and outpatient general purpose surgical operating rooms needed in a planning district, exclusive of dedicated cesarean section rooms, operating rooms designated exclusively for cardiac surgery, procedures rooms or VDH designated trauma services, shall be determined as follows:~~

$$\text{FOR} = \frac{((\text{ORV}/\text{POP}) \times (\text{PROPOP})) \times \text{AHORV}}{1600}$$

1600

Where:

~~ORV = the sum of total inpatient and outpatient general purpose operating room visits in the planning district in the most recent three years for which general purpose operating room utilization data has been reported by VHI; and~~

~~POP = the sum of total population in the planning district as reported by a demographic entity as determined by the commissioner, for the same three year period as used in determining ORV.~~

~~PROPOP = the projected population of the planning district five years from the current year as reported by a demographic program as determined by the commissioner.~~

~~AHORV = the average hours per general purpose operating room visit in the planning district for the most recent year for which average hours per general purpose operating room visits have been calculated as reported by VHI.~~

~~FOR = future general purpose operating rooms needed in the planning district five years from the current year.~~

~~1600 = available service hours per operating room per year based on 80% utilization of an operating room available 40 hours per week, 50 weeks per year.]~~

~~B. [Providers of organ transplantation services should facilitate access to pre and post transplantation services needed by patients residing in rural locations by establishing part time satellite clinics. Projects involving the relocation of existing general purpose operating rooms within a planning district may be authorized when it can be reasonably documented that such relocation will improve the distribution of surgical services within a planning district by making services available within 30 minutes driving time one way under normal conditions of 95% of the planning district's population.]~~

12VAC5-230-510. [Availability Staffing].

~~[A. There should be no more than one program for each transplantable organ in a health planning region.~~

~~B. Proposals to expand existing transplantation programs shall demonstrate that existing organ transplantation services comply with all applicable Medicare program coverage criteria. Surgical services should be under the direction or supervision of one or more qualified physicians.]~~

[Part VI

Inpatient Bed Requirements]

12VAC5-230-520. [~~Minimum utilization; minimum survival rate; service proficiency; systems operations Travel time~~].

~~[A. Proposals to establish or expand organ transplantation services should demonstrate that the minimum number of transplants would be performed annually. The minimum number of transplants required by organ system is:~~

Kidney	30
Pancreas or kidney/pancreas	12
Heart	17
Heart/Lung	12
Lung	12
Liver	21
Intestine	2

~~Performance of minimum transplantation volumes does not indicate a need for additional transplantation capacity or programs.~~

~~B. Preference will be given to expansion of successful existing services, either by enabling necessary increases in the number of organ systems being transplanted or by adding transplantation capability for additional organ systems, rather than developing additional programs that could reduce average program volume.~~

~~C. Facilities should demonstrate that they will achieve and maintain minimum transplant patient survival rates. Minimum one year survival rates, listed by organ system, are:~~

Kidney	95%
Pancreas or kidney/pancreas	90%
Heart	85%
Heart/Lung	60%
Lung	77%
Liver	86%
Intestine	77%

D. Proposals to add additional organ transplantation services should demonstrate at least two years successful experience with all existing organ transplantation systems.

E. All physicians that perform transplants should be board-certified by the appropriate professional examining board, and should have a minimum of one year of formal training and two years of experience in transplant surgery and post-operative care.

Inpatient beds should be within 30 minutes driving time one way under normal conditions of 95% of the population of a planning district.]

[~~Part X~~

~~Miscellaneous Capital Expenditures]~~

12VAC5-230-530. [Purpose Need for new service].

[This part of the SMFP is intended to provide general guidance in the review of projects that require COPN authorization by virtue of their expense but do not involve changes in the bed or service capacity of a medical care facility addressed elsewhere in this chapter. This part may be used in coordination with other parts of the SMFP addressing changes in bed or service capacity used in the COPN review process.

A. No new inpatient beds should be approved in any planning district unless:

1. The resulting number of beds for each bed category contained in this article does not exceed the number of beds projected to be needed for that planning district for the fifth planning horizon year; and
2. The average annual occupancy based on the number of beds in the planning district for the relevant reporting period is:
 - a. 80% at midnight census for medical/surgical or pediatric beds;
 - b. 65% at midnight census for intensive care beds.

B. For proposals to convert under-utilized beds that require a capital expenditure of \$15 million or more, consideration may be given to such proposal if:

1. There is a projected need in the applicable category of inpatient beds; and
2. The applicant can demonstrate that the average annual occupancy of the converted beds would meet the utilization standard for the applicable bed category by the first year of operation.

For the purposes of this part, "underutilized" means less than 80% average annual occupancy for medical/surgical or pediatric beds, when the relocation involves such beds and

less than 65% average annual occupancy for intensive care beds when relocation involves such beds.]

12VAC5-230-540. [Project — need Need for medical/surgical beds].

[All applications involving the expenditure of \$5 million dollars or more by a medical care facility should include documentation that the expenditure is necessary in order for the facility to meet the identified medical care needs of the public it serves. Such documentation should clearly identify that the expenditure:

1. Represents the most cost effective approach to meeting the identified need; and
2. The ongoing operational costs will not result in unreasonable increases in the cost of delivering the services provided.

The number of medical/surgical beds projected to be needed in a planning district shall be computed as follows:

1. Determine the use rate for the medical/surgical beds for the planning district using the formula:

$$\text{BUR} = (\text{IPD}/\text{PoP}) \times 1,000$$

Where:

BUR = the bed use rate for the planning district.

IPD = the sum of total inpatient days in the planning district for the most recent three years for which inpatient day data has been reported by VHI; and

PoP = the sum of total population greater than 18 years of age in the planning district for the same three years used to determine IPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of medical/surgical beds needed for the planning district in five years from the current year using the formula:

$$\text{ProBed} = ((\text{BUR} \times \text{ProPop})/365)/0.80$$

Where:

ProBed = The projected number of medical/surgical beds needed in the planning district for five years from the current year.

BUR = the bed use rate for the planning district determined in subdivision 1 of this section.

ProPop = the projected population greater than 18 years of age of the planning district five years from the current year as reported by a demographic program as determined by the commissioner.

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3. Determine the number of medical/surgical beds that are needed in the planning district for the five planning horizon years as follows:

$$\text{NewBed} = \text{ProBed} - \text{CurrentBed}$$

Where:

NewBed = the number of new medical/surgical beds that can be established in a planning district, if the number is positive. If NewBed is a negative number, no additional medical/surgical beds should be authorized for the planning district.

ProBed = the projected number of medical/surgical beds needed in the planning district for five years from the current year determined in subdivision 2 of this section.

CurrentBed = the current inventory of licensed and authorized medical/surgical beds in the planning district.]

12VAC5-230-550. [Facilities expansion Need for pediatric beds]:

[Applications for the expansion of medical care facilities should document that the current space provided in the facility for the areas or departments proposed for expansion are inadequate. Such documentation should include:

1. An analysis of the historical volume of work activity or other activity performed in the area or department;
2. The projected volume of work activity or other activity to be performed in the area or department; and
3. Evidence that contemporary design guidelines for space in the relevant areas or departments, based on levels of work activity or other activity, are consistent with the proposal.

The number of pediatric beds projected to be needed in a planning district shall be computed as follows:

1. Determine the use rate for pediatric beds for the planning district using the formula:

$$\text{PBUR} = (\text{PIPD}/\text{PedPop}) \times 1,000$$

Where:

PBUR = The pediatric bed use rate for the planning district.

PIPD = The sum of total pediatric inpatient days in the planning district for the most recent three years for which inpatient days data has been reported by VHI; and

PedPop = The sum of population under 19 years of age in the planning district for the same three years used to determine PIPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of pediatric beds needed to the planning district in five years from the current year using the formula:

$$\text{ProPedBed} = ((\text{PBUR} \times \text{ProPedPop})/365)/0.80$$

Where:

ProPedBed = The projected number of pediatric beds needed in the planning district for five years from the current year.

PBUR = The pediatric bed use rate for the planning district determined in subdivision 1 of this section.

ProPedPop = The projected population under 19 years of age of the planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of pediatric beds needed within the planning district for the fifth planning horizon year as follows:

$$\text{NewPedBed} = \text{ProPedBed} - \text{CurrentPedBed}$$

Where:

NewPedBed = the number of new pediatric beds that can be established in a planning district, if the number is positive. If NewPedBed is a negative number, no additional pediatric beds should be authorized for the planning district.

ProPedBed = the projected number of pediatric beds needed in the planning district for five years from the current year determined in subdivision 2 of this section.

CurrentPedBed = the current inventory of licensed and authorized pediatric beds in the planning district.]

12VAC5-230-560. [Renovation or modernization Need for intensive care beds]:

[A. Applications for the renovation or modernization of medical care facilities should provide documentation that:

1. The timing of the renovation or modernization expenditure is appropriate within the life cycle of the affected building or buildings; and
2. The benefits of the proposed renovation or modernization will exceed the costs of the renovation or modernization over the life cycle of the affected building or buildings to be renovated or modernized.

B. Such documentation should include a history of the affected building or buildings, including a chronology of major renovation and modernization expenses.

C. Applications for the general renovation or modernization of medical care facilities should include downsizing of beds or other service capacity when such capacity has not operated at a reasonable level of efficiency as identified in the relevant

~~sections of this chapter during the most recent three year period.~~

The projected need for intensive care beds in a planning district shall be computed as follows:

1. Determine the use rate for ICU beds for the planning district using the formula:

$$ICUBUR = (ICUPD/Pop) \times 1,000$$

Where:

ICUBUR = The ICU bed use rate for the planning district.

ICUPD = The sum of total ICU inpatient days in the planning district for the most recent three years for which inpatient day data has been reported by VHI; and

Pop = The sum of population greater than 18 years of age in the planning district for the same three years used to determine ICUPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of ICU beds needed for the planning district, including bed availability for unscheduled admissions, five years from the current year using the formula:

$$ProICUBed = ((ICUBUR \times ProPop)/365)/0.65$$

Where:

ProICUBed = The projected number of ICU beds needed in the planning district for five years from the current year;

ICUBUR = The ICU bed use rate for the planning district as determine in subdivision 1 of this section;

ProPop = The projected population greater than 18 years of age of the planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of ICU beds that may be established or relocated within the planning district for the fifth planning horizon planning year as follows:

$$NewICUB = ProICUBed - CurrentICUBed$$

Where:

NewICUBed = The number of new ICU beds that can be established in a planning district, if the number is positive. If NewICUBed is a negative number, no additional ICU beds should be authorized for the planning district.

ProICUBed = The projected number of ICU beds needed in the planning district for five years from the current year as determined in subdivision 2 of this section.

CurrentICUBed = The current inventory of licensed and authorized ICU beds in the planning district.]

12VAC5-230-570. [Equipment Expansion or relocation of services].

~~[Applications for the purchase and installation of equipment by medical care facilities that are not addressed elsewhere in this chapter should document that the equipment is needed. Such documentation should clearly indicate that the (i) proposed equipment is needed to maintain the current level of service provided, or (ii) benefits of the change in service resulting from the new equipment exceed the costs of purchasing or leasing and operating the equipment over its useful life.~~

A. Proposals to relocate beds to a location not contiguous to the existing site should be approved only when:

1. Off-site replacement is necessary to correct life safety or building code deficiencies;
2. The population currently served by the beds to be moved will have reasonable access to the beds at the new site, or to neighboring inpatient facilities;
3. The number of beds to be moved off-site is taken out of service at the existing facility;
4. The off-site replacement of beds results in:
 - a. A decrease in the licensed bed capacity;
 - b. A substantial cost savings, cost avoidance, or consolidation of underutilized facilities; or
 - c. Generally improved operating efficiency in the applicant's facility or facilities; and
5. The relocation results in improved distribution of existing resources to meet community needs.

B. Proposals to relocate beds within a planning district where underutilized beds are within 30 minutes driving time one way under normal conditions of the site of the proposed relocation should be approved only when the applicant can demonstrate that the proposed relocation will not materially harm existing providers.]

[Part XI
Medical Rehabilitation]

12VAC5-230-580. [Accessibility Long-term acute care hospitals (LTACHs)].

~~[Comprehensive inpatient rehabilitation services should be available within 60 minutes driving time one way, under normal conditions, of 95% of the population of the planning region.~~

A. LTACHs will not be considered as a separate category for planning or licensing purposes. All LTACH beds remain part of the inventory of inpatient hospital beds.

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B. A LTACH shall only be approved if an existing hospital converts existing medical/surgical beds to LTACH beds or if there is an identified need for LTACH beds within a planning district. New LTACH beds that would result in an increase in total licensed beds above 165% of the average daily census for the planning district will not be approved. Excess inpatient beds within an applicant's existing acute care facilities must be converted to fill any unmet need for additional LTACH beds.

C. If an existing or host hospital converts existing beds for use as LTACH beds, those beds must be delicensed from the bed inventory of the existing hospital. If the LTACH ceases to exist, terminates its services, or does not offer services for a period of 12 months within its first year of operation, the beds delicensed by the host hospital to establish the LTACH shall revert back to that host hospital.

If the LTACH ceases operation in subsequent years of operation, the host hospital may reacquire the LTACH beds by obtaining a COPN, provided the beds are to be used exclusively for their original intended purpose and the application meets all other applicable project delivery requirements. Such an application shall not be subject to the standard batch review cycle and shall be processed as allowed under Part VI (12VAC5-220-280 et seq.) of the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.

D. The application shall delineate the service area for the LTACH by documenting the expected areas from which it is expected to draw patients.

E. A LTACH shall be established for 10 or more beds.

F. A LTACH shall become certified by the Centers for Medicare and Medicaid Services (CMS) as a long-term acute care hospital and shall not convert to a hospital for patients needing a length of stay of less than 25 days without obtaining a certificate of public need.

1. If the LTACH fails to meet the CMS requirements as a LTACH within 12 months after beginning operation, it may apply for a six-month extension of its COPN.

2. If the LTACH fails to meet the CMS requirements as a LTACH within the extension period, then the COPN granted pursuant to this section shall expire automatically.]

12VAC5-230-590. [Availability Staffing] :

[A. The number of comprehensive and specialized rehabilitation beds needed in a health planning region will be projected as follows:

((UR x PROJ. POP.)/365)/.90

Where UR = the use rate expressed as rehabilitation patient days per population in the health planning region as reported in the most recent "Industry Report for

Virginia Hospitals and Nursing Facilities" published by Virginia Health Information; and

PROJ.POP. = the most recent projected population of the health planning region three years from the current year as published by the Virginia Employment Commission.

B. No additional rehabilitation beds should be authorized for a health planning region in which existing rehabilitation beds were utilized at an average annual occupancy of less than 90% in the most recently reported year.

Preference will be given to the development of needed rehabilitation beds through the conversion of underutilized medical/surgical beds.

C. Notwithstanding subsection A of this section, the need for proposed inpatient rehabilitation beds will be given consideration when:

1. The rehabilitation specialty proposed is not currently offered in the health planning region; and

2. A documented basis for recognizing a need for the service or beds is provided by the applicant.

Inpatient services should be under the direction or supervision of one or more qualified physicians.]

[Part VII Nursing Facilities]

12VAC5-230-600. [Staffing Travel time]:

[Medical rehabilitation facilities should have full time medical direction by a psychiatrist or other physician with a minimum of two years experience in the proposed specialized inpatient medical rehabilitation program:

A. Nursing facility beds should be accessible within 30 minutes driving time one way under normal conditions to 95% of the population in a planning district.

B. Nursing facilities should be accessible by public transportation when such systems exist in an area.

C. Consideration will be given to proposals that improve geographic access and reduce travel time to nursing facilities within a planning district.]

[Part XII Mental Health Services

Article 1

Psychiatric and Substance Abuse Disorder Treatment Services]

12VAC5-230-610. [Accessibility Need for new service]:

[A. Acute psychiatric, acute substance abuse disorder treatment services, and intermediate care substance abuse disorder treatment services should be available within 60 minutes driving time one way, under normal conditions, of 95% of the population.

~~B. Existing and proposed acute psychiatric, acute substance abuse disorder treatment, and intermediate care substance abuse disorder treatment service providers shall have established plans for the provision of services to indigent patients which include, at a minimum: (i) the minimum number of unreimbursed patient days to be provided to indigent patients who are not Medicaid recipients; (ii) the minimum number of Medicaid-reimbursed patient days to be provided, unless the existing or proposed facility is ineligible for Medicaid participation; (iii) the minimum number of unreimbursed patient days to be provided to local community services boards; and (iv) a description of the methods to be utilized in implementing the indigent patient service plan and assuring the provision of the projected levels of unreimbursed and Medicaid-reimbursed patient days.~~

~~C. Proposed acute psychiatric, acute substance abuse disorder treatment, and intermediate care substance abuse disorder treatment service providers shall have formal agreements with their identified community services boards that: (i) specify the number of charity care patient days that will be provided to the community service board; (ii) describe the mechanisms to monitor compliance with charity care provisions; (iii) provide for effective discharge planning for all patients, including return to the patients place of origin or home state if not Virginia; and (iv) consider admission priorities based on relative medical necessity.~~

~~D. Providers of acute psychiatric, acute substance abuse disorder treatment, and intermediate care substance abuse disorder treatment services serving large geographic areas should establish satellite outpatient facilities to improve patient access, where appropriate and feasible.~~

A. A planning district should be considered to have a need for additional nursing facility beds when:

1. The bed need forecast exceeds the current inventory of beds for the planning district; and
2. The average annual occupancy of all existing and authorized Medicaid-certified nursing facility beds in the planning district was at least 93%, excluding the bed inventory and utilization of the Virginia Veterans Care Centers.

Exception: When there are facilities that have been in operation less than three years in the planning district, their occupancy can be excluded from the calculation of average occupancy if the facilities has an annual occupancy of at least 93% in one of its first three years of operation.

B. No planning district should be considered in need of additional beds if there are unconstructed beds designated as Medicaid-certified. This presumption of 'no need' for additional beds extends for three years or the date on the certificate, whichever is longer, for the unconstructed beds.

C. The bed need forecast will be computed as follows:

$$PDBN = (UR64 \times PP64) + (UR69 \times PP69) + (UR74 \times PP74) + (UR79 \times PP79) + (UR84 \times PP84) + (UR85 \times PP85)$$

Where:

PDBN = Planning district bed need.

UR64 = The nursing home bed use rate of the population aged 0 to 64 in the planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP64 = The population aged 0 to 64 projected for the planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR69 = The nursing home bed use rate of the population aged 65 to 69 in the planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP69 = The population aged 65 to 69 projected for the planning district three years from the current year as most recently published by the a demographic program as determined by the commissioner.

UR74 = The nursing home bed use rate of the population aged 70 to 74 in the planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP74 = The population aged 70 to 74 projected for the planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR79 = The nursing home bed use rate of the population aged 75 to 79 in the planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP79 = The population aged 75 to 79 projected for the planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR84 = The nursing home bed use rate of the population aged 80 to 84 in the planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP84 = The population aged 80 to 84 projected for the planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR85+ = The nursing home bed use rate of the population aged 85 and older in the planning district as

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determined in the most recent nursing home patient origin study authorized by VHI.

PP85+ = The population aged 85 and older projected for the planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

Planning district bed need forecasts will be rounded as follows:

<u>Planning District Bed Need</u>	<u>Rounded Bed Need</u>
<u>1-29</u>	<u>0</u>
<u>30-44</u>	<u>30</u>
<u>45-84</u>	<u>60</u>
<u>85-104</u>	<u>90</u>
<u>105-134</u>	<u>120</u>
<u>135-164</u>	<u>150</u>
<u>165-194</u>	<u>180</u>
<u>195-224</u>	<u>210</u>
<u>225+</u>	<u>240</u>

Exception: When a planning district has:

1. Two or more nursing facilities;

2. Had an average annual occupancy rate in excess of 93% for the most recent two years for which bed utilization has been reported to VHI; and

3. Has a forecasted bed need of 15 to 29 beds, then the bed need for this planning district will be rounded to 30.

D. No new freestanding nursing facilities of less than 90 beds should be authorized. However, consideration may be given to a new freestanding facility with fewer than 90 nursing facility beds when the applicant can demonstrate that such a facility is justified based on a locality's preference for such smaller facility and there is a documented poor distribution of nursing facility beds within the planning district.

E. When evaluating the cost of a project, consideration may be given to projects that use the current methodology as determined by the Department of Medical Assistance Services.

F. Consideration may be given to proposals to replace outdated and functionally obsolete facilities with modern facilities that result in the more cost-efficient resident services in a more aesthetically pleasing and comfortable environment.]

12VAC5-230-620. [Availability Expansion of services].

[A. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a planning

district with existing acute psychiatric or acute substance abuse disorder treatment beds or both will be determined as follows:

$$\frac{((UR \times PROJ.POP.) / 365) / .75}{}$$

Where UR = the use rate of the planning district expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five year period; and

PROJ.POP. = the projected population of the planning district five years from the current year as reported in the most recent published projections of the Virginia Employment Commission.

For purposes of this methodology, no beds shall be included in the inventory of psychiatric or substance abuse disorder beds when these beds (i) are in facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (ii) have been converted to other uses; (iii) have been vacant for six months or more; or (iv) are not currently staffed and cannot be staffed for acute psychiatric or substance abuse disorder patient admissions within 24 hours.

B. Subject to the provisions of 12VAC5-230-80, no additional acute psychiatric or acute substance abuse disorder treatment beds should be authorized for a planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both if the existing inventory of such beds is greater than the need identified using the above methodology.

However, consideration will be given to the addition of acute psychiatric or acute substance abuse disorder beds by existing medical care facilities in planning districts with an excess supply of beds when such additions can be justified on the basis of facility-specific utilization or geographic remoteness, i.e., driving time of 60 minutes or more, one way under normal conditions, to alternate acute care facilities. If the facility with the institutional need for beds is part of a hospital network, underutilized beds at the other facilities within the network should be relocated to the facility with the institutional need if possible.

C. No existing acute psychiatric or acute substance disorder abuse treatment beds should be relocated unless it can be reasonably projected that the relocation will not have a negative impact on the ability of existing acute psychiatric or substance abuse disorder treatment providers or both to continue to provide historic levels of service to Medicaid or other indigent patients.

D. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a planning district without existing acute psychiatric or acute substance abuse disorder treatment beds will be determined as follows:

~~((UR x PROJ.POP.)/365)/.80~~

~~Where UR = the use rate of the health planning region in which the planning district is located expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five year period;~~

~~PROJ.POP. = the projected population of the planning district five years from the current year as reported in the most recent published projections of the Virginia Employment Commission.~~

~~E. Preference will be given to the development of needed acute psychiatric and intermediate substance abuse disorder treatment beds through the conversion of unused general hospital beds. Preference will also be given to proposals for acute psychiatric and substance abuse beds demonstrating a willingness to accept persons under temporary detention orders (TDO) and to have contractual agreements to serve populations served by Community Services Boards, whether through conversion of underutilized general hospital beds or development of new beds.~~

~~F. The number of intermediate care substance abuse disorder treatment beds needed in a planning district with existing intermediate care substance abuse disorder treatment beds will be determined as follows:~~

~~((UR x PROJ.POP.)/365)/.75~~

~~Where UR = the use rate of the planning district expressed as the average intermediate care substance abuse disorder treatment patient days per population reported for the most recent three year period; and~~

~~PROJ.POP. = the projected population of the planning district three years from the current year as reported in the most recent published projections of the Virginia Employment Commission.~~

~~G. Subject to the provisions of 12VAC5-230-80, no additional intermediate care substance abuse disorder treatment beds should be authorized for a planning district with existing intermediate care substance abuse disorder treatment beds if the existing inventory of such beds is greater than the need identified. No beds in facilities operated by DMHMRSAS will be included in the inventory of intermediate care substance abuse disorder beds.~~

~~However, consideration will be given to the addition of intermediate care substance abuse disorder treatment beds by existing medical care facilities in planning districts with an excess supply of beds when such addition can be justified on the basis of facility-specific utilization or geographic remoteness, i.e., driving time of 60 minutes or more one way under normal conditions, to alternate acute care facilities. If the facility with the institutional need for beds is part of a hospital network, underutilized beds at the other facilities~~

~~within the network should be relocated to the facility with the institutional need if possible.~~

~~H. No existing intermediate care substance abuse disorder treatment beds should be relocated from one site to another unless it can be reasonably projected that the relocation will not have a negative impact on the ability of existing intermediate care substance abuse disorder treatment providers to continue to provide historic levels of service to indigent patients.~~

~~I. The number of intermediate care substance abuse disorder treatment beds needed in a planning district without existing intermediate care substance abuse disorder treatment beds will be determined as follows:~~

~~((UR x PROJ.POP.)/365)/.75~~

~~Where UR = the use rate of the health planning region in which the planning district is located expressed as the average intermediate care substance abuse disorder treatment patient days per population reported for the most recent three year period;~~

~~PROJ.POP. = the projected population of the planning district three years from the current year as reported in the most recent published projections of the Virginia Employment Commission.~~

~~J. Preference will be given to the development of needed intermediate care substance abuse disorder treatment beds through the conversion of underutilized general hospital beds.~~

~~Proposals to increase existing nursing facility bed capacity should not be approved unless the facility has operated for at least two years and the average annual occupancy of the facility's existing beds was at least 93% in the relevant reporting period as reported to VHI.~~

~~Note: Exceptions will be considered for facilities that operated at less than 93% average annual occupancy in the most recent year for which bed utilization has been reported when the facility has a rehabilitative or other specialized care program causing a short average length of stay resulting in an average annual occupancy lower than 93% for the facility.]~~

~~[Article 2
Mental Retardation]~~

~~12VAC5-230-630. [Availability Continuing care retirement communities]:~~

~~[The establishment of new ICF/MR facilities should not be authorized unless the following conditions are met:~~

- ~~1. Alternatives to the proposed service are not available in the area to be served by the new facility;~~
- ~~2. There is a documented source of referrals for the proposed new facility;~~

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~~3. The manner in which the proposed new facility fits into the continuum of care for the mentally retarded is identified;~~

~~4. There are distinct and unique geographic, socioeconomic, cultural, transportation, or other factors affecting access to care that require development of a new ICF/MR;~~

~~5. Alternatives to the development of a new ICF/MR consistent with the Medicaid waiver program have been considered and can be reasonably discounted in evaluating the need for the new facility.~~

~~6. The proposed new facility is consistent with the current DMHMRSAS Comprehensive Plan and the mental retardation service priorities for the catchment area identified in the plan;~~

~~7. Ancillary and supportive services needed for the new facility are available; and~~

~~8. Service alternatives for residents of the proposed new facility who are ready for discharge from the ICF/MR setting are available.~~

Proposals for the development of new nursing facilities or the expansion of existing facilities by continuing care retirement communities (CCRC) will be considered when:

1. The total number of new or additional beds plus any existing nursing facility beds operated by the continuing care provider does not exceed 20% of the continuing care provider's total existing or planned independent living and adult care residence;

2. The proposed beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility; and

3. The applicant certifies that:

a. The CCRC has, or will have, a qualified resident assistance fund and that the facility will not rely on federal and state public assistance funds for reimbursement of the proposed beds;

b. The continuing care contract or disclosure statement, as required by §38.2-4902 of the Code of Virginia, has been filed with the State Corporation Commission and that the commission has deemed the contract or disclosure statement in compliance with applicable law; and

c. Only continuing care contract holders residing in the CCRC as independent living residents or adult care residents or who is a family member of a contract holder residing in a non-nursing facility portion of the CCRC will be admitted to the nursing facility unit after the first three years of operation.]

12VAC5-230-640. [Continuity; integration Staffing],

~~[Each facility should have a written transfer agreement with one or more hospitals for the transfer of emergency cases if such hospitalization becomes necessary. Nursing facilities shall be under the direction or supervision of a licensed nursing home administrator and staffed by licensed and certified nursing personnel qualified as required by law.]~~

~~[Part VIII
Lithotripsy Service]~~

12VAC5-230-650. [Acceptability Travel time],

~~[Mental retardation facilities should meet all applicable licensure standards as specified in 12VAC35-105, Rules and Regulations of the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services. Lithotripsy services should be available within 30 minutes driving time one way under normal conditions for 95% of the population of the health planning region.]~~

~~[Part XIII
Perinatal Services~~

~~Article 1
Criteria and Standards for Obstetrical Services]~~

12VAC5-230-660. [Accessibility Need for new service],

~~[Obstetrical services should be located within 30 minutes driving time one way, under normal conditions, of 95% of the population in rural areas and within 30 minutes driving time one way, under normal conditions, in urban and suburban areas.~~

~~A. Consideration may be given to new renal or orthopedic lithotripsy services established at a new facility through contract with, or by lease of equipment from, an existing service provider authorized to operate in Virginia, provided the facility has referred at least two appropriate patients per week, or 100 appropriate patients annually, for the relevant reporting period to other facilities for either renal or orthopedic lithotripsy services.~~

~~B. A new renal lithotripsy service may be approved if the applicant can demonstrate that the proposed service can provide at least 750 renal lithotripsy procedures annually.~~

~~C. A new orthopedic lithotripsy service may be approved if the applicant can demonstrate that the proposed service can provide at least 500 orthopedic lithotripsy procedures annually.]~~

12VAC5-230-670. [Availability Expansion of services],

~~[A. Proposals to establish new obstetrical services in rural areas should demonstrate that obstetrical volumes within the travel times listed in 12VAC5-230-660 will not be negatively affected.~~

~~B. Proposals to establish new obstetrical services in urban and suburban areas should demonstrate that a minimum of 2,500 deliveries will be performed annually by the second year of operation and that obstetrical volumes of existing providers located within the travel times listed in 12VAC5-230-660 will not be negatively affected.~~

~~C. Applications to improve existing obstetrical services, and to reduce costs through consolidation of two obstetrical services into a larger, more efficient service will be given preference over the addition of new services or the expansion of single service providers.~~

A. Proposals to increase renal lithotripsy services should demonstrate that each existing unit owned or operated by that vendor or provider has provided at least 750 procedures annually at all sites served by the vendor or provider.

B. Proposals to increase orthopedic lithotripsy services should demonstrate that each existing unit owned or operated by that vendor or provider has provided at least 500 procedures annually at all sites served by the vendor or provider.]

12VAC5-230-680. [Continuity Adding or expanding mobile lithotripsy services].

~~[A. Perinatal service capacity should be developed and sized to provide routine newborn care to infants delivered in the associated obstetrics service, and shall have the capability to stabilize and prepare for transport those infants requiring the care of a neonatal special care services unit.~~

~~B. The application should identify the primary and secondary neonatal special care center nearest the proposed service and provide travel time one way, under normal conditions, to those centers.~~

A. Proposals for mobile lithotripsy services should demonstrate that, for the relevant reporting period, at least 125 procedures were performed and that the proposed mobile unit will not reduce the utilization of existing machines in the planning region.

B. Proposals to convert a mobile lithotripsy service to a fixed site lithotripsy service should demonstrate that, for the relevant reporting period, at least 430 procedures were performed and the proposed conversion will not reduce the utilization of existing providers in the planning district.]

[Article 2
Neonatal Special Care Services]

12VAC5-230-690. [Accessibility Staffing].

~~[Neonatal special care services should be located within an average of 45 minutes driving time one way, under normal conditions, in urban and suburban areas of hospitals providing general level newborn services. Lithotripsy~~

services should be under the direction or supervision of one or more qualified physicians.]

[Part IX

Organ Transplant]

12VAC5-230-700. [Availability Travel time].

~~A. [Existing neonatal special care units located within the travel times listed in 12VAC5-230-660 should achieve 65% average annual occupancy before new services can be added to the planning region Organ transplantation services should be accessible within two hours driving time one way under normal conditions of 95% of Virginia's population].~~

~~B. [Preference will be given to the expansion of existing services rather than the creation of new services Providers of organ transplantation services should facilitate access to pre and post transplantation services needed by patients residing in rural locations be establishing part-time satellite clinics].~~

12VAC5-230-710. [Neonatal services Need for new service].

~~[The application should identify the service area, levels of service, and capacity of the current general level newborn service hospitals to be served within the identified area.~~

A. There should be no more than one program for each transplantable organ in a health planning region.

B. Performance of minimum transplantation volumes as cited in 12VAC5-230-720 does not indicate a need for additional transplantation capacity or programs.

12VAC5-230-720. Transplant volumes; survival rates; service proficiency; systems operations.

A. Proposals to establish organ transplantation services should demonstrate that the minimum number of transplants would be performed annually. The minimum number transplants of required by organ system is:

<u>Kidney</u>	<u>30</u>
<u>Pancreas or kidney/pancreas</u>	<u>12</u>
<u>Heart</u>	<u>17</u>
<u>Heart/Lung</u>	<u>12</u>
<u>Lung</u>	<u>12</u>
<u>Liver</u>	<u>21</u>
<u>Intestine</u>	<u>2</u>

Note: Any proposed pancreas transplant program must be a part of a kidney transplant program that has achieved a minimum volume standard of 30 cases per year for kidney transplants as well as the minimum transplant survival rates stated in subsection B of this section.

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B. Applicants shall demonstrate that they will achieve and maintain at least the minimum transplant patient survival rates. Minimum one-year survival rates listed by organ system are:

<u>Kidney</u>	<u>95%</u>
<u>Pancreas or kidney/pancreas</u>	<u>90%</u>
<u>Heart</u>	<u>85%</u>
<u>Heart/Lung</u>	<u>70%</u>
<u>Lung</u>	<u>77%</u>
<u>Liver</u>	<u>86%</u>
<u>Intestine</u>	<u>77%</u>

12VAC5-230-730. Expansion of transplant services.

A. Proposals to increase organ transplantation services shall demonstrate at least two years successful experience with all existing organ transplantation systems at the hospital.

B. Consideration will be given to expanding successful existing services through increases in the number of organ systems being transplanted rather than developing new programs that could reduce existing program volumes.

12VAC5-230-740. Staffing.

Organ transplant services should be under the direct supervision of one or more qualified physicians.

Part X

Miscellaneous Capital Expenditures

12VAC5-230-750. Purpose.

This part of the SMFP is intended to provide general guidance in the review of projects that require COPN authorization by virtue of their expense but do not involve changes in the bed or service capacity of a medical care facility addressed elsewhere in this chapter. This part may be used in coordination with other service specific parts addressed elsewhere in this chapter.

12VAC5-230-760. Project need.

All applications involving the expenditure of \$15 million or more by a medical care facility should include documentation that the expenditure is necessary in order for the facility to meet the identified medical care needs of the public it serves. Such documentation should clearly identify that the expenditure:

1. Represents the most cost-effective approach to meeting the identified need; and
2. The ongoing operational costs will not result in unreasonable increases in the cost of delivering the services provided.

12VAC5-230-770. Facilities expansion.

Applications for the expansion of medical care facilities should document that the current space provided in the facility for the areas or departments proposed for expansion is inadequate. Such documentation should include:

1. An analysis of the historical volume of work activity or other activity performed in the area or department;
2. The projected volume of work activity or other activity to be performed in the area or department; and
3. Evidence that contemporary design guidelines for space in the relevant areas or departments, based on levels of work activity or other activity, are consistent with the proposal.

12VAC5-230-780. Renovation or modernization.

A. Applications for the renovation or modernization of medical care facilities should provide documentation that:

1. The timing of the renovation or modernization expenditure is appropriate within the life cycle of the affected building or buildings; and
2. The benefits of the proposed renovation or modernization will exceed the costs of the renovation or modernization over the life cycle of the affected building or buildings to be renovated or modernized.

B. Such documentation should include a history of the affected building or buildings, including a chronology of major renovation and modernization expenses.

C. Applications for the general renovation or modernization of medical care facilities should include downsizing of beds or other service capacity when such capacity has not operated at a reasonable level of efficiency as identified in the relevant sections of this chapter during the most recent five-year period.

12VAC5-230-790. Equipment.

Applications for the purchase and installation of equipment by medical care facilities that are not addressed elsewhere in this chapter should document that the equipment is needed. Such documentation should clearly indicate that the (i) proposed equipment is needed to maintain the current level of service provided, or (ii) benefits of the change in service resulting from the new equipment exceed the costs of purchasing or leasing and operating the equipment over its useful life.

Part XI

Medical Rehabilitation

12VAC5-230-800. Travel time.

Medical rehabilitation services should be available within 60 minutes driving time one way under normal conditions of 95% of the population of the planning district.

12VAC5-230-810. Need for new service.

A. The number of comprehensive and specialized rehabilitation beds shall be determined as follows:

$$\frac{((UR \times PROPOP)/365)}.85$$

Where:

UR = the use rate expressed as rehabilitation patient days per population in the planning district as reported by VHI; and

PROPOP = the most recent projected population of the planning district five years from the current year as published by a demographic entity as determined by the commissioner.

B. Proposals for new medical rehabilitation beds should be considered] when [the applicant can demonstrate that:

1. The rehabilitation specialty proposed is not currently offered in the planning district; and
2. There is a documented need for the service or beds in the planning district.

12VAC5-230-820. Expansion of services.

No additional rehabilitation beds should be authorized for a planning district in which existing rehabilitation beds were utilized with an average annual occupancy of less than 85% in the most recently reported year.

Exception: Consideration may be given to expanding rehabilitation beds through the conversion of underutilized medical/surgical beds.

12VAC5-230-830. Staffing.

Medical rehabilitation facilities should be under the direction or supervision of one or more qualified physicians.

Part XII
Mental Health Services

Article 1

Acute Psychiatric and Acute Substance Abuse Disorder Treatment Services

12VAC5-230-840. Travel time.

Acute psychiatric and acute substance abuse disorder treatment services should be available within 60 minutes driving time one way under normal conditions of 95% of the population.

12VAC5-230-850. Continuity; integration.

A. Existing and proposed acute psychiatric and acute substance abuse disorder treatment providers shall have established plans for the provision of services to indigent patients that include:

1. The minimum number of unreimbursed patient days to be provided to indigent patients who are not Medicaid recipients;

2. The minimum number of Medicaid-reimbursed patient days to be provided, unless the existing or proposed facility is ineligible for Medicaid participation;

3. The minimum number of unreimbursed patient days to be provided to local community services boards; and

4. A description of the methods to be utilized in implementing the indigent patient service plan and assuring the provision of the projected levels of unreimbursed and Medicaid-reimbursed patient days.

B. Proposed acute psychiatric and acute substance abuse disorder treatment providers shall have formal agreements with the appropriate local community services boards or behavioral health authority that:

1. Specify the number of patient days that will be provided to the community service board;

2. Describe the mechanisms to monitor compliance with charity care provisions;

3. Provide for effective discharge planning for all patients, including return to the patient's place of origin or home state if not Virginia; and

4. Consider admission priorities based on relative medical necessity.

C. Providers of acute psychiatric and acute substance abuse disorder treatment serving large geographic areas should establish satellite outpatient facilities to improve patient access where appropriate and feasible.

12VAC5-230-860. Need for new service.

A. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both will be determined as follows:

$$\frac{((UR \times PROPOP)/365)}.75$$

Where:

UR = the use rate of the planning district expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five-year period; and

PROPOP = the projected population of the planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

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For purposes of this methodology, no beds shall be included in the inventory of psychiatric or substance abuse disorder beds when these beds (i) are in facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (ii) have been converted to other uses; (iii) have been vacant for six months or more; or (iv) are not currently staffed and cannot be staffed for acute psychiatric or substance abuse disorder patient admissions within 24 hours.

B. Subject to the provisions of 12VAC5-230-70, no additional acute psychiatric or acute substance abuse disorder treatment beds should be authorized for a planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both if the existing inventory of such beds is greater than the need identified using the above methodology.

Consideration may also be given to the addition of acute psychiatric or acute substance abuse beds dedicated for the treatment of geriatric patients in planning districts with an excess supply of beds when such additions are justified on the basis of the specialized treatment needs of geriatric patients.

C. No existing acute psychiatric or acute substance disorder abuse treatment beds should be relocated unless it can be reasonably projected that the relocation will not have a negative impact on the ability of existing acute psychiatric or substance abuse disorder treatment providers or both to continue to provide historic levels of service to Medicaid or other indigent patients.

D. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a planning district without existing acute psychiatric or acute substance abuse disorder treatment beds will be determined as follows:

((UR x PROPOP)/365)/.75

Where:

UR = the use rate of the health planning region in which the planning district is located expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five-year period;

PROPOP = the projected population of the planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

E. Preference will be given to the development of needed acute psychiatric beds through the conversion of unused general hospital beds. Preference will also be given to proposals for acute psychiatric and substance abuse beds demonstrating a willingness to accept persons under temporary detention orders (TDO) and that have contractual

agreements to serve populations served by community services boards, whether through conversion of underutilized general hospital beds or development of new beds.

Article 2 Mental Retardation

12VAC5-230-870. Need for new service.

The establishment of new ICF/MR facilities with more than 12 beds shall not be authorized unless the following conditions are met:

1. Alternatives to the proposed service are not available in the area to be served by the new facility;
2. There is a documented source of referrals for the proposed new facility;
3. The manner in which the proposed new facility fits into the continuum of care for the mentally retarded is identified;
4. There are distinct and unique geographic, socioeconomic, cultural, transportation, or other factors affecting access to care that require development of a new ICF/MR;
5. Alternatives to the development of a new ICF/MR consistent with the Medicaid waiver program have been considered and can be reasonably discounted in evaluating the need for the new facility;
6. The proposed new facility will have a maximum of 20 beds and is consistent with any plan of the Department of Mental Health, Mental Retardation and Substance Abuse Services and the mental retardation service priorities for the catchment area identified in the plan;
7. Ancillary and supportive services needed for the new facility are available; and
8. Service alternatives for residents of the proposed new facility who are ready for discharge from the ICF/MR setting are available.

12VAC5-230-880. Continuity; integration.

Each facility should have a written transfer agreement with one or more hospitals for the transfer of emergency cases if such hospitalization becomes necessary.

12VAC5-230-890. Compliance with licensure standards.

Mental retardation facilities should meet all applicable licensure standards as specified in 12VAC35-105, Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services.

Part XIII
Perinatal Services

Article 1

Criteria and Standards for Obstetrical Services

12VAC5-230-900. Travel time.

Obstetrical services should be located within 30 minutes driving time one way under normal conditions of 95% of the population of the planning district.

12VAC5-230-910. Need for new service.

A. No new obstetrical services should be approved unless the applicant can demonstrate that, based on the population and utilization of current services, there is a need for such services in the planning district without reducing the utilization of existing providers in the planning district.

B. Applications to improve existing obstetrical services, and to reduce costs through consolidation of two obstetrical services into a larger, more efficient service should be given preference over establishing new services or expanding single service providers.

12VAC5-230-920. Continuity.

A. Perinatal service capacity, including service availability for unscheduled admissions, should be developed to provide routine newborn care to infants delivered in the associated obstetrics service, and shall be able to stabilize and prepare for transport those infants requiring the care of a neonatal special care services unit.

B. The proposal shall identify the primary and secondary neonatal special care center nearest the proposed service shall provide transport one-way to those centers.

12VAC5-230-930. Staffing.

Obstetric services should be under the direction or supervision of one or more qualified physicians.

Article 2

Neonatal Special Care Services

12VAC5-230-940. Travel time.

A. Intermediate level neonatal special care services should be located within 30 minutes driving time one way under normal conditions of hospitals providing general level newborn services.

B. Specialty and subspecialty neonatal special care services should be located within 90 minutes driving time one way under normal conditions of hospitals providing general or intermediate level newborn services.

12VAC5-230-950. Need for new service.

A. No new level of neonatal service shall be offered by a hospital unless that hospital has first obtained a COPN granting approval to provide each such level of service.

B. Preference will be given to the expansion of existing services, rather than to the creation of new services.

12VAC5-230-960. Intermediate level newborn services.

A. Existing neonatal special care units providing intermediate level newborn services as designated in 12VAC5-410-443, located within 30 minutes driving time one way under normal conditions should achieve 85% average annual occupancy before new intermediate level newborn services can be added to the planning region.

B. Neonatal special care units providing intermediate level newborn services as designated in 12VAC5-410-443 should contain a minimum of six bassinets, stations or beds.

C. No more than four bassinets, stations and beds for intermediate level newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each planning region, with a bassinet or station counting as the equivalent of one bed.

12VAC5-230-970. Specialty level newborn services.

A. Existing neonatal special care units providing specialty level newborn services as designated in 12VAC5-410-443 located within 90 minutes driving time one way under normal conditions should achieve 85% average annual occupancy before new specialty level newborn services can be added to the planning region.

B. Neonatal special care units providing specialty level newborn services as designated in 12VAC5-410-443 should contain a minimum of 18 bassinets, stations or beds. A station shall equal one bed.

C. No more than four bassinets, stations and beds for specialty level newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each planning region, with a bassinet or station counting as the equivalent of one bed.

D. Proposals to establish specialty level neonatal special care services as designated in 12VAC5-410-443 shall demonstrate that service volumes of existing specialty level neonatal special care providers located within the travel time listed in 12VAC5-230-940 will not be reduced.

12VAC5-230-980. Subspecialty level newborn services.

A. Existing neonatal special care units providing subspecialty level newborn services as designated in 12VAC5-410-443 located within 90 minutes driving time one way under normal conditions should achieve 85% average

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annual occupancy before new subspecialty level newborn services can be added to the planning region.

B. Neonatal special care units providing subspecialty level newborn services as designated in 12VAC5-410-443 should contain a minimum of 18 bassinets, stations or beds. A station shall equal one bed.

C. No more than four bassinets, stations and beds for subspecialty level newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each planning region, with a bassinet or station counting as the equivalent of one bed.

D. Proposals to establish subspecialty level neonatal special care services as designated in 12VAC5-410-443 shall demonstrate that service volumes of existing subspecialty level neonatal special care providers located within the travel time listed in 12VAC5-230-940 will not be reduced.

12VAC5-230-990. Neonatal services.

The application shall identify the service area and the levels of service of all the hospitals to be served by the proposed service.

12VAC5-230-1000. Staffing.

All levels of neonatal special care services should be under the direction or supervision of one or more qualified physicians as described in 12VAC5-410-443.]

VA.R. Doc. No. R03-117; Filed February 11, 2008, 3:28 p.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Fast-Track Regulation

Title of Regulation: 12VAC30-120. Waivered Services (amending 12VAC30-120-70, 12VAC30-120-90, 12VAC30-120-140, 12VAC30-120-211, 12VAC30-120-213, 12VAC30-120-225, 12VAC30-120-229, 12VAC30-120-237, 12VAC30-120-247, 12VAC30-120-700, 12VAC30-120-710, 12VAC30-120-754, 12VAC30-120-758, 12VAC30-120-762, 12VAC30-120-770, 12VAC30-120-900, 12VAC30-120-910, 12VAC30-120-920, 12VAC30-120-970, 12VAC30-120-1500, 12VAC30-120-1510, 12VAC30-120-1550; adding 12VAC30-120-1560, 12VAC30-120-2000, 12VAC30-120-2010, 12VAC30-120-2030).

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

Public Hearing Information: No public hearings are scheduled.

Public Comments: Public comments may be submitted until 5 p.m. on April 2, 2008.

Effective Date: July 1, 2008.

Agency Contact: Jason Rachel, Project Manager, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 225-2984, FAX (804) 786-1680, or email jason.rachel@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 provides the authority to DMAS to promulgate regulations pertaining to the Money Follows the Person Demonstration grant.

Purpose: The amendments are required in order to establish the regulatory structure for the successful implementation of the Money Follows the Person (MFP) Demonstration. This regulation must be promulgated and the regulations must be in effect in order to receive CMS approval to begin the MFP Demonstration in May 2008.

The purpose of the MFP Demonstration is to strengthen Virginia's long-term services and supports using available funds to "follow the person" by supporting individuals who choose to transition from long-term care institutions into the community. The MFP Demonstration is one of the Governor's set priorities for community integration of persons who reside in institutions. This initiative also reflects a strong collaborative approach with this administration and the legislature to coordinate and continually build upon rebalancing efforts of the Commonwealth's long-term support system (i.e., increasing the use of home- and community-based care services (HCBS) rather than institutional long-term care services). This collaborative approach has enabled the Commonwealth over the past several years to be resourceful in balancing the state's budget without cutting Medicaid long-term support services.

Rationale for Using Fast-Track Process: The fast-track regulatory process is required in order to meet the Centers for Medicare and Medicaid's deadline for Virginia to successfully implement the Money Follows the Person Demonstration by May 2008. If this regulation is not promulgated in this timeframe, Virginia would be in jeopardy of losing the four-year MFP Demonstration and the enhanced federal funding that is provided as a part of the demonstration. This fast-track regulation is not controversial because the changes being made to existing regulations are minimal, addressing only those new services being added to each waiver program pursuant to MFP; new sections are also being added that address only those new services, such as Transition Coordinator and Transition Services, and Consumer-Directed Supported Employment, which are being added under the MFP grant.

Much of the preliminary work to develop the MFP regulatory language was completed by a regulatory review team of DMAS staff. Other individuals involved with the MFP Demonstration regulation include representatives from the Department of Mental Health, Mental Retardation and Substance Abuse Services and key external stakeholders involved with the DMAS Waiver program population. These individuals reviewed and provided input to this fast-track regulation.

Substance: These fast-track regulations reflect the needed changes to the following six HCBS waivers to support individuals who choose to transition from long-term care institutions into the community. They are the Technology Assisted (Tech), HIV/AIDS, Elderly or Disabled with Consumer Direction (EDCD), Mental Retardation (MR), MR Day Support (DS) and Individual and Family Developmental Disabilities Support (IFDDS) Waivers.

The changes to these six waivers include (i) adding the services of Personal Emergency Response System (PERS), Medication Monitoring, and Transition Services to the Tech Waiver; (ii) adding the services of Transition Coordination, Environmental Modifications, Assistive Technology, and Transition Services to the EDCD Waiver; (iii) adding the services of PERS and Medication Monitoring, Environmental Modifications, Assistive Technology, Transition Services to the HIV/AIDS Waiver; (iv) adding Consumer-Directed Supported Employment services to the DS Waiver; and (v) adding the services of Consumer-Directed Supported Employment and Transition Services to the MR and IFDDS Waivers.

Three of these services, Transition Coordination, Consumer-Directed Supported Employment, and Transition Services, are new waiver services. Language has been developed based on CMS guidelines and a review of how other states define and utilize these services. In addition, existing waiver services (PERS, Medication Monitoring, Environmental Modifications and Assistive Technology) are being expanded to other waivers in an effort to facilitate the transition from institutional living to community living. The new services being added are as follows: Transition Services is being added to the AIDS, EDCD, DS, IFDDS, MR and Tech Waivers to provide one-time funding (up to \$5,000 per person, per lifetime) to assist with costs incurred by individuals who are transitioning into the community. Examples of expenses include rent and utility deposits and necessary furniture. One other service, Transition Coordination, is added to the EDCD Waiver to assist institutionalized transitioning into the EDCD Waiver because a case management service currently does not exist in this program. This service will be time limited and the coordinator will assist the individual up to three months prior to leaving the institutional setting and up to nine months following the individual's discharge into the community. All other HCBS

wavers already have a case management service that can assist institutionalized individuals with transitioning into these programs.

Finally, this regulation addresses changes to units of service for provider billing purposes. DMAS is currently being directed by the federal Medicaid authority, the Centers for Medicare and Medicaid Services (CMS), to no longer use preset units of service for Medicaid waiver reimbursement. DMAS is working with CMS to establish time-based billing for the DMAS fee schedule for waiver services, and this is reflected in the MFP regulations.

Issues: The primary advantage of these fast-track regulations is that they allow greater support and services for individuals who choose to transition from long-term care institutions into the community. These fast-track changes will improve the infrastructure for community-based long-term support services by adding new services to six of the HCBS waiver programs.

This demonstration will support Virginia's implementation of the Olmstead decision and will complement the efforts of the recently awarded Systems Transformation Grant that aims to improve the infrastructure for community-based long-term support services.

There are no disadvantages to the public or the Commonwealth.

This fast-track regulatory action will have a positive impact on families in that individuals who are currently residing in an institution will have the option of transferring to the community and have the opportunity to live in a more family-like environment in their community.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Regulation. The proposed regulations establish a Medicaid waiver program known as "Money Follows the Person." Nationally, this program is designed to create a system of long-term services and supports that enables available funds to "follow the person" by supporting the transition of individuals from institutional long-term care setting into community-based care settings.

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

Estimated Economic Impact. Pursuant to Item 302 HHH of the 2007 Appropriation Act, these regulations establish a waiver program as part of the federal Money Follows the person Demonstration grant to allow individuals transitioning from institutions to receive care in the community. The waiver program is established under section 1915(c) of the federal Social Security Act, which encourages the states to provide home and community based services as alternatives to institutionalized care. The main purpose of the waiver

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program is to prevent or delay placement of persons in institutions by providing care for individuals in their homes and communities consequently avoiding high long-term care costs. States wishing to implement such waiver programs are required to demonstrate that the costs would be lower under a waiver than they would be without it.

The effect of proposed changes on the services provided is two fold. First, three new services will be provided to recipients of certain waivers. Second, existing services will be expanded to more waivers. The three new services are transition services, transition coordination services, and consumer-directed supported employment services. Transition services will pay for such costs as rent and utility deposits and furniture expenses (up to \$5,000 per person per lifetime) associated with individuals transitioning into the community from institutions. Transition coordination services will cover expenses associated with coordinator expenses up to three months before and up to 12 months after leaving the institutional setting.

The three new services and expanded existing services will be added to six waivers as follows: 1) personal emergency response system (PERS) services, medication monitoring, and transitional services will be added to the technology assisted (TECH) waiver; 2) transition coordination services, environmental modification services, assistive technology services, and transition services will be added to the elderly or disabled with consumer direction (EDCD) waiver; 3) PERS services, medication monitoring services, environmental modification services, and assistive technology services, and transitional services will be added to the HIV/AIDS waiver; 4) consumer directed supported employment services will be added to the MR day support (DS) waiver; 5) consumer directed-supported employment and transitional services to the mental retardation (MR) waiver; 6) consumer directed-supported employment and transitional services to the individual and family developmental disabilities support (IFDDS) waiver.

The Department of Medical Assistance Services (DMAS) anticipates that approximately 1,041 recipients will participate in this new waiver program. The estimated fiscal cost for medical and administrative expenses is approximately \$1 million in Fiscal Year (FY) 2008 and \$7.2 million in FY 2009. As opposed to standard 50 percent federal match, this program will receive 75 percent federal match for services provided to individuals for a period of one year after the individual leaves the institution. Thus, the total estimated cost to the Commonwealth is about \$418,821 in FY 2009 and \$3.1 million in 2009 while the federal share is estimated to be \$602,617 in FY 2008 and \$4.1 million in FY 2009.

Of the total estimated expenses, approximately \$968,213 is the state share of ongoing administrative expenses in FY 2009 and approximately \$229,873 is the state share of one time administrative expenses that are expected in FY 2008.

The administrative costs are made up of contractual services, system services and personnel costs.

As mentioned, the main goal of the new services is to increase the supports available to individuals currently living institutional based care settings so that they can transition into community based care settings. Thus, the proposed changes are likely to have economic effects on the recipients, the state, and the health care system.

The net impact on the recipients is expected to be positive as the proposed program is voluntary. The voluntary nature of the program helps ensure that the program results in net benefits as individuals would be taking advantage of this option only if it is beneficial to them.

Also, caring for individuals in a community is known to be less expensive than caring in an institution. Thus, the additional costs associated with providing three new services and making existing new services available in additional waivers will be offset by some amount. The estimated savings are \$65,232 in FY 2008 and \$3.2 million in FY 2009 in state funds.

The proposed program is also expected to have some distributional economic effects among the Medicaid providers. As individuals move from institutions into communities the mix of services provided will change. Institutional care providers are expected to experience a reduction in their Medicaid reimbursements. On the other hand, providers of services that are newly offered or expanded are likely to experience an increase in their revenues from Medicaid.

Finally, it should be noted that the increased expenditures from the proposed program will result in approximately \$602,617 in FY 2008 and \$4.1 million in FY 2009 in additional federal funds coming into the Commonwealth which could have an expansionary economic effect on the overall economic activity, all things being equal.

Businesses and Entities Affected. Approximately 21,000 home and community based service waiver recipients will be eligible to participate in the proposed program. Of these, approximately 1,041 recipients are expected to participate. The estimated number of providers who provides services covered under the proposed regulations is approximately 2,500.

Localities Particularly Affected. The proposed regulations apply throughout the Commonwealth.

Projected Impact on Employment. The proposed changes are expected to increase the demand for labor by providers in order to provide new and expanded services to recipients. Some of this expected increase in demand may be offset by the reduced demand for labor due to possibly declining need for institutional care services. Also, the administration of the program adds to the staffing needs of the Department of

Medical Assistance Services creating a positive effect on demand for labor.

Effects on the Use and Value of Private Property. The proposed regulations are expected to increase the asset value of community based service providers as their revenues and profits are expected to be positively affected while there may be an offsetting effect on the asset value of institutional care provider businesses.

Small Businesses: Costs and Other Effects. Approximately 400 of the 2,500 community based care providers are estimated to be small businesses. However, the proposed regulations are not likely to create any significant costs for the affected small businesses.

Small Businesses: Alternative Method that Minimizes Adverse Impact. The proposed regulations are not expected to have any adverse impact on small businesses.

Real Estate Development Costs. The proposed regulations are not expected to have any effect on real estate development costs.

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with §2.2-4007.04 of the Administrative Process Act and Executive Order Number 36 (06). Section 2.2-4007.04 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. Further, if the proposed regulation has adverse effect on small businesses, §2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning the fast-track regulations, Money Follow the Person Program changes. The agency raises no issues with this analysis.

Summary:

The amendments establish the regulatory structure for implementation of the Money Follows the Person Demonstration program, which provides for available funding to "follow the person" by supporting individuals who choose to transition from long-term care institutions into community-based care. The amendments provide three new services to recipients of certain waivers and expand existing services to more waivers. The three new services are transition services, transition coordination services, and consumer-directed supported employment services. Transition services will pay for such as costs rent and utility deposits and furniture expenses (up to \$5,000 per person per lifetime) associated with individuals transitioning into the community from institutions. Transition coordination services will cover expenses associated with coordinator expenses up to three months before and up to 12 months after leaving the institutional setting.

The new and expanded services add six waivers as follows: (i) personal emergency response system (PERS) services, medication monitoring, and transitional services are added to the technology assisted (TECH) waiver; (ii) transition coordination services, environmental modification services, assistive technology services, and transition services are added to the elderly or disabled with consumer direction (EDCD) waiver; (iii) PERS services, medication monitoring services, environmental modification services, assistive technology services, and transitional services are added to the HIV/AIDS waiver; (iv) consumer-directed supported employment services are added to the MR day support (DS) waiver; (v) consumer-directed supported employment and transitional services are added to the mental retardation (MR) waiver; and (vi) consumer-directed supported employment and transitional services are added to the individual and family developmental disabilities support (IFDDS) waiver.

Part II

Home and Community-Based Services for Technology Assisted Individuals

12VAC30-120-70. Definitions.

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

"Activities of daily living (ADL)" means personal care tasks, i.e., bathing, dressing, toileting, transferring, bowel/bladder control, and eating/feeding. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services.

"Adult" means an individual who either is 21 years of age or is past 21 years of age.

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"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

"Child" means an individual who has not yet reached his 21st birthday.

"Congregate living arrangement" means one in which two or more recipients live in the same household and may share receipt of health care services from the same provider or providers.

"Congregate private duty nursing" means nursing provided to two or more recipients in a group setting.

"DMAS" means the Department of Medical Assistance Services.

"Environmental modifications" means physical adaptations to a house, or place of residence, which shall be necessary to ensure the individual's health or safety, or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual. Such modifications must exceed reasonable accommodation requirements of the Americans with Disabilities Act (42 USC §1201 et seq.).

"Health care coordinator" means the registered nurse who is responsible for ensuring that the assessment, care planning, monitoring, and review activities as required by DMAS are accomplished. This individual may be either an employee of DMAS or a DMAS contractor.

"Health care coordination" means a comprehensive needs assessment, determination of cost effectiveness, and the coordination of the service efforts of multiple providers in order to avoid duplication of services and to ensure the individual's access to and receipt of needed services.

"Instrumental activities of daily living (IADL)" means social tasks, i.e., meal preparation, shopping, housekeeping, laundry, money management. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services. The provision of IADLs is limited to the individual receiving services and not to family members or other person in the household. Meal preparation is planning, preparing, cooking and serving food. Shopping is getting to and from the store, obtaining/paying for groceries and carrying them home. Housekeeping is dusting, washing dishes, making beds, vacuuming, cleaning floors, and cleaning kitchen/bathroom. Laundry is washing/drying clothes. Money management is

paying bills, writing checks, handling cash transactions, and making change.

"Medical equipment and supplies" means those articles prescribed by the attending physician, generally recognized by the medical community as serving a diagnostic or therapeutic purpose and as being a medically necessary element of the home care plan. Items covered are medically necessary equipment and supplies needed to assist the individual in the home environment, without regard to whether those items are covered by the Plan.

"Objective Scoring Criteria" means the evaluative tool to be used to determine the appropriateness for an individual's admission to these services.

"Personal emergency response systems" or "PERS" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. 12VAC30-120-970 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"Personal assistance" means care provided by an aide or respiratory therapist trained in the provision of assistance with ADLs or IADLs.

"Plan of care" means the written plan of services and supplies certified by the attending physician needed by the individual to ensure optimal health and safety for an extended period of time.

~~"Primary caregiver" means either a family member or other person who takes primary responsibility for providing assistance to the recipient or recipients for care they are unable to provide for himself or themselves.~~ the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for such care.

"Private duty nursing" means individual and continuous nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.

"Providers" means those individuals or facilities registered, licensed, or certified, or both, as appropriate, and enrolled by DMAS to render services to Medicaid recipients eligible for services.

"Respite care services" means temporary skilled nursing services designed to relieve the family of the care of the technology assisted individual for a short period or periods of time (a maximum of 15 days per year or 360 hours per 12-month period). In a congregated living arrangement, this same limit shall apply per household. Respite care shall be provided in the home of the individual's family or caretaker.

~~"Routine respiratory therapy" means services that can be provided on a regularly scheduled basis. Therapy interventions may include: (i) monitoring of oxygen in blood; (ii) evaluation of pulmonary functioning; and (iii) maintenance of respiratory equipment.~~

"State Plan for Medical Assistance" or "the Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Technology assisted" means any individual defined as chronically ill or severely impaired who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability and whose illness or disability would, in the absence of services approved under this waiver, require admission to or prolonged stay in a hospital, nursing facility, or other medical long-term care facility.

"Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.

12VAC30-120-90. Covered services and provider requirements.

A. Private duty nursing service shall be covered for individuals enrolled in the technology assisted waiver services. This service shall be provided through either a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and with which DMAS has a contract for private duty nursing or a day care center licensed by the Virginia Department of Social Services which employs registered nurses and is enrolled by DMAS to provide congregate private duty nursing. At a minimum, the private duty nurse shall either be a licensed practical nurse or a registered nurse with a current and valid license issued by the Virginia State Board of Nursing.

1. For individuals under 21 whether living separately or congregately, during the first 30 days after the individual's admission to the waiver service, private duty nursing is covered for 24 hours per day if needed and appropriate to assist the family in adjustment to the care associated with technology assistance. After 30 days, private duty nursing shall be reimbursed for a maximum of 16 hours per 24-hour period per household. The department may grant individual exceptions, not to exceed 30 total days per annum, to these maximum limits based on documented emergency needs of the individual and the case, which continue to meet requirements for cost effectiveness of

community services. Such consideration of documented emergency needs shall not include applicable additional emergency costs.

2. For individuals over the age of 21 years whether living separately or congregately, private duty nursing shall be reimbursed for a maximum of 16 hours within a 24-hour period per household provided that the cost-effectiveness standard is not exceeded for the individual's care.

3. In no instance, shall DMAS approve an ongoing plan of care or ongoing multiple plans of care per household which result in approval of more than 16 hours of private duty nursing in a 24-hour period per household.

4. Individuals who no longer meet the patient qualifications for either children or adults cited in 12VAC30-120-80 may be eligible for private duty nursing for the number of hours per 24-hour period previously approved in the plan of care not to exceed two weeks from the date the attending physician certifies the cessation of daily technology assistance.

5. The hours of private duty nursing approved for coverage shall be limited by either medical necessity or cost effectiveness or both.

6. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two waiver recipients. When three or more waiver recipients share a home, ratios will be determined by the combined needs of the residents.

B. Provided that the cost-effectiveness standard shall not be exceeded, respite care service shall be covered for a maximum of 360 hours within a ~~12-month period~~ calendar year per household for individuals who are qualified for technology assisted waiver services and who have a primary caregiver, other than the provider, who requires relief from the burden of caregiving. This service shall be provided by skilled nursing staff (registered nurse or licensed practical nurse licensed to practice in the Commonwealth) under the direct supervision of a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and with which DMAS has a contract to provide private duty nursing.

C. Provided that the cost-effectiveness standard shall not be exceeded, durable medical equipment and supplies shall be provided for individuals qualified for technology services. All durable medical equipment and supplies, including nutritional supplements, which are covered under the State Plan and those medical equipment and supplies, including such items which may be defined as assistive technology and environmental modifications which are not covered under the State Plan but are medically necessary and cost effective for the individual's maintenance in the community, shall be covered. This service shall be provided by persons qualified

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to render it. Durable medical equipment and supplies shall be necessary to maintain the individual in the home environment.

1. Medical equipment and supplies shall be prescribed by the attending physician and included in the plan of care, and must be generally recognized as serving a diagnostic or therapeutic purpose and being medically necessary for the home care of the individual.

2. Vendors of durable medical equipment and supplies related to the technology upon which the individual is dependent shall have a contract with DMAS to provide services.

3. In addition to providing the ventilator or other respiratory-devised support and associated equipment and supplies, the vendor providing the ventilator shall ensure the following:

- a. 24 hour on-call for emergency services;
- b. Technicians to make regularly scheduled maintenance visits at least every 30 days and more often if called;
- c. Replacement or repair of equipment and supplies as required; and
- d. Respiratory therapist registered or certified with the National Board for Respiratory Care (NBRC) on call 24 hours per day and stationed within two hours of the individual's home to facilitate immediate response. The respiratory therapist shall be available for routine respiratory therapy as well as emergency care. In the event that the Department of Health Professions implements through state law a regulation requiring registration, certification or licensure for respiratory therapists to practice in the Commonwealth, DMAS shall require all respiratory therapists providing services to this technology assisted population to be duly registered, licensed or certified.

D. Provided that the cost-effectiveness standard shall not be exceeded, personal assistance services shall be covered for individuals over the age of 21 who require some assistance with activities of daily living and instrumental activities of daily living but do not require and are able to do without skilled interventions during portions of their day or are able to self perform a portion of their ADLs or IADLs or direct their skilled care needs during the period when personal assistance would be provided. Personal assistance services shall be rendered by a provider who has a DMAS provider agreement to provide personal care, home health care, and private duty nursing. At a minimum, the staff providing personal assistance must have been certified through coursework as either personal care aides, home health aides, homemakers, personal care attendants, or registered or certified respiratory therapists.

E. Assistive technology services shall be covered for individuals enrolled in the technology assisted waiver. 12VAC30-120-762 provides the service description, criteria, service units and limitations, and provider requirements for this service.

F. Environmental modifications services shall be covered for individuals enrolled in the technology assisted waiver. 12VAC30-120-758 provides the service description, criteria, service units and limitations, and provider requirements for this service.

G. Transition services shall be covered for individuals enrolled in the technology assisted waiver. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.

Part III

Home and Community-Based Services for Individuals with Acquired Immunodeficiency Syndrome (AIDS) and AIDS-Related Complex

12VAC30-120-140. Definitions.

"Acquired Immune Deficiency Syndrome" or "AIDS" means the most severe manifestation of infection with the Human Immunodeficiency Virus (HIV). The Centers for Disease Control and Prevention (CDC) lists numerous opportunistic infections and cancers that, in the presence of HIV infection, constitute an AIDS diagnosis.

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

"Agency-directed services" means services for which the provider agency is responsible for hiring, training, supervising, and firing of the staff.

"Appeal" means the process used to challenge DMAS when it takes action or proposes to take action that will adversely affect, reduce, or terminate the receipt of benefits.

"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment. 12VAC30-120-762 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"Asymptomatic" means without symptoms. This term is usually used in the HIV/AIDS literature to describe an individual who has a positive reaction to one of several tests

for HIV antibodies but who shows no clinical symptoms of the disease.

"Case management" means continuous reevaluation of need, monitoring of service delivery, revisions to the plan of care and coordination of services for individuals enrolled in the HIV/AIDS waiver.

"Case manager" means the person who provides services to individuals who are enrolled in the waiver that enable the continuous assessment, coordination, and monitoring of the needs of the individuals who are enrolled in the waiver. The case manager must possess a combination of work experience and relevant education that indicates that the case manager possesses the knowledge, skills, and abilities at entry level, as established by the Department of Medical Assistance Services in 12VAC30-120-170 to conduct case management.

"Cognitive impairment" means a severe deficit in mental capability that affects areas such as thought processes, problem solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

"Consumer-directed services" means services for which the individual or family/caregiver is responsible for hiring, training, supervising, and firing of the staff.

"Consumer-directed (CD) services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the consumer-directed plan of care, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed personal assistance and respite care services. The CD services facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver who is responsible for employing the assistant.

"Current functional status" means the degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"DMAS-96 form" means the Medicaid Funded Long-Term Care Service Authorization Form, which is a part of the preadmission screening packet and must be completed by a Level One screener on a Preadmission Screening Team. It designates the type of service the individual is eligible to receive.

"DMAS-122 form" means the Patient Information Form used by the provider and the local DSS to exchange information regarding the responsibility of a Medicaid-eligible individual to make payment toward the cost of

services or other information that may affect the eligibility status of an individual.

"DSS" means the Department of Social Services.

"Designated preauthorization contractor" means the entity that has been contracted by DMAS to perform preauthorization of services.

"Enteral nutrition products" means enteral nutrition listed in the durable medical equipment manual that is prescribed by a physician to be necessary as the primary source of nutrition for the individual's health care plan (due to the prevalence of conditions of wasting, malnutrition, and dehydration) and not available through any other food program.

"Environmental modifications" means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act (42 USC §1201 et seq.), necessary to ensure the individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals. 12VAC30-120-758 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"Fiscal agent" means an agency or organization that may be contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of the individual who is receiving consumer-directed personal assistance services and consumer-directed respite services.

"HIV-symptomatic" means having the diagnosis of HIV and having symptoms related to the HIV infection.

"Home- and community-based care" means a variety of in-home and community-based services reimbursed by DMAS (case management, personal care, private duty nursing, respite care consumer-directed personal assistance, consumer-directed respite care, and enteral nutrition products) authorized under a Social Security Act §1915 (c) AIDS Waiver designed to offer individuals an alternative to inpatient hospital or nursing facility placement. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid inpatient hospital or nursing facility placement. DMAS, or the designated preauthorization contractor, shall give prior authorization for any Medicaid-reimbursed home and community-based care.

"Human Immunodeficiency Virus (HIV)" means the virus which leads to acquired immune deficiency syndrome (AIDS). The virus weakens the body's immune system and, in doing so, allows "opportunistic" infections and diseases to attack the body.

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"Instrumental activities of daily living" or "IADL" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

"Personal emergency response systems" or "PERS" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. 12VAC30-120-970 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"Participating provider" means an individual, institution, facility, agency, partnership, corporation, or association that has a valid contract with DMAS and meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS to provide Medicaid waiver services.

"Personal assistant" means a domestic servant for purposes of this part and exemption from Worker's Compensation.

"Personal services" or "PAS" means long-term maintenance or support services necessary to enable an individual to remain at or return home rather than enter an inpatient hospital or a nursing facility. Personal assistance services include care specific to the needs of a medically stable, physically disabled individual. Personal assistance services include, but are not limited to, assistance with ADLs, bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical function. When specified, supportive services may include assistance with IADLs that are incidental to the care furnished or that are essential to the health and welfare of the individual. Personal assistance services shall not include either practical or professional nursing services as defined in Chapters 30 and 34 of Title 54.1 §32.1-162.7 of the Code of Virginia and 12VAC5-381-360, as appropriate.

"Personal care agency" means a participating provider that renders services designed to offer an alternative to institutionalization by providing eligible individuals with personal care aides who provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter an inpatient hospital or a nursing facility. Personal care services are provided to individuals in the areas of activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. It shall be provided in home and

community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

"Plan of care" means the written plan developed by the provider related solely to the specific services required by the individual to ensure optimal health and safety for the delivery of home and community-based care.

"Preadmission Screening Authorization Form" means a part of the preadmission screening packet that must be filled out by a Level One screener on a preadmission screening team. It gives preadmission authorization to the provider and the individual for Medicaid services, and designates the type of service the individual is authorized to receive.

"Preadmission screening committee/team" or "PAS committee" or "PAS team" means the entity contracted with DMAS that is responsible for performing preadmission screening. For individuals in the community, this entity is a committee comprised of a nurse from the local health department and a social worker from the local department of social services. For individuals in an acute care facility who require preadmission screening, this entity is a team of nursing and social work staff. A physician must be a member of both the local committee and the acute care team.

"Preadmission screening" or "PAS" means the process to (i) evaluate the functional, nursing, and social needs of individuals referred for preadmission screening; (ii) analyze what specific services the individuals need; (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs; and (iv) develop the service plan.

"Private duty nursing" means individual and continuous nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.

"Program" means the Virginia Medicaid program as administered by the Department of Medical Assistance Services.

"Reconsideration" means the supervisory review of information submitted to DMAS or the designated preauthorization contractor in the event of a disagreement of an initial decision that is related to a denial in the reimbursement of services already rendered by a provider.

"Respite care" means services specifically designed to provide a temporary, periodic relief to the primary caregiver of an individual who is incapacitated or dependent due to AIDS. Respite care services include assistance with personal hygiene, nutritional support and environmental maintenance authorized as either episodic, temporary relief or as a routine periodic relief of the caregiver.

Consumer-directed respite care services may only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the

individual. Respite services are designed to focus on the need of the unpaid caregiver for temporary relief and to help prevent the breakdown of the unpaid caregiver due to the physical burden and emotional stress of providing continuous support and care to the individual.

"Respite care agency" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing eligible individuals with respite care aides who provide respite care services.

"Service plan" means the written plan of services certified by the PAS team physician as needed by the individual to ensure optimal health and safety for the delivery of home and community-based care.

"State Plan for Medical Assistance" or "the Plan" or "the State Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that assesses an individual's social, physical health, mental health, and functional abilities.

Part IV Mental Retardation Waiver

Article 1 Definitions and General Requirements

12VAC30-120-211. Definitions.

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

"Appeal" means the process used to challenge adverse actions regarding services, benefits and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560.

"Assistive technology" or "AT" means specialized medical equipment and supplies to include devices, controls, or appliances, specified in the consumer service plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform

activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the Medicaid State Plan.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county under Chapter 1 (§37.2-100) of Title 37.2 of the Code of Virginia that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the locality that it serves.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the consumer service plan; assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the consumer service plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the consumer service plan.

"Case manager" means the individual on behalf of the community services board or behavioral health authority possessing a combination of mental retardation work experience and relevant education that indicates that the individual possesses the knowledge, skills and abilities as established by the Department of Medical Assistance Services in 12VAC30-50-450.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities under Chapter 5 (§37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion" means, for the purpose of these regulations, a person who provides companion services.

"Companion services" means nonmedical care, support, and socialization, provided to an adult (age 18 and over). The provision of companion services does not entail hands-on care. It is provided in accordance with a therapeutic goal in the consumer service plan and is not purely diversional in nature.

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"Comprehensive assessment" means the gathering of relevant social, psychological, medical and level of care information by the case manager and is used as a basis for the development of the consumer service plan.

"Consumer-directed model" means services for which the individual and the individual's family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the staff.

"Consumer-directed (CD) services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and the individual's family/caregiver, as appropriate, by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.

"Consumer service plan" or "CSP" means documents addressing needs in all life areas of individuals who receive mental retardation waiver services, and is comprised of individual service plans as dictated by the individual's health care and support needs. The individual service plans are incorporated in the CSP by the case manager.

"Crisis stabilization" means direct intervention to persons with mental retardation who are experiencing serious psychiatric or behavioral challenges that jeopardize their current community living situation, by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by the Department of Medical Assistance Services.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DMHMRSAS staff" means persons employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level.

"Developmental risk" means the presence before, during or after an individual's birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through existing diagnostic and evaluative criteria.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts or special opportunities to eligible individuals and the individual's family/caregivers, as appropriate, as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, as appropriate, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's and the individual's family/caregiver's, as appropriate, use of the providers' services.

"Employment assistant" means a person who assists an individual in obtaining or maintaining integrated, competitive employment in the community. This may include assessment, job development, job placement, job training supports, long-term intermittent monitoring, and support to the individual and the facilitation of natural supports in the work environment.

"Enroll" means that the individual has been determined by the case manager to meet the eligibility requirements for the MR Waiver and DMHMRSAS has verified the availability of a MR Waiver slot for that individual, and DSS has determined the individual's Medicaid eligibility for home and community-based services.

"Entrepreneurial model" means a small business employing eight or fewer individuals who have disabilities on a shift and usually involves interactions with the public and with coworkers without disabilities.

"Environmental modifications" means physical adaptations to a house, place of residence, primary vehicle or work site (when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act) that are necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines that

prescribe preventive and treatment services for Medicaid-eligible children as defined in 12VAC30-50-130.

"Fiscal agent" means an agency or organization within DMAS or contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed personal assistance, respite, and companion services.

"Health Planning Region" or "HPR" means the federally designated geographical area within which health care needs assessment and planning takes place, and within which health care resource development is reviewed.

"Health, welfare, and safety standard" means that an individual's right to receive a waiver service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written individual service plan and that services can safely be provided in the community.

"Home- and community-based waiver services" or "waiver services" means the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to persons with mental retardation and children younger than age six who are at developmental risk who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR.)

"ICF/MR" means a facility or distinct part of a facility certified by the Virginia Department of Health, as meeting the federal certification regulations for an Intermediate Care Facility for the Mentally Retarded and persons with related conditions. These facilities must address the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, and must provide active treatment.

"Individual" means the person receiving the services or evaluations established in these regulations.

"Individual service plan" or "ISP" means the service plan related solely to the specific waiver service. Multiple ISPs help to comprise the overall consumer service plan.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

"ISAR" means the Individual Service Authorization Request and is the DMAS form used by providers to request prior authorization for MR waiver services.

"Mental retardation" or "~~MR~~" means ~~mental retardation a disability~~ as defined by the American Association on ~~Mental Retardation~~ (AAMR) Intellectual and Developmental Disabilities (AAIDD).

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and DMHMRSAS, and has a current, signed provider participation agreement with DMAS.

"Pend" means delaying the consideration of an individual's request for services until all required information is received by DMHMRSAS.

"Personal assistance services" means assistance with activities of daily living, instrumental activities of daily living, access to the community, self-administration of medication, or other medical needs, and the monitoring of health status and physical condition.

"Personal assistant" means a person who provides personal assistance services.

"Personal emergency response system (PERS)" is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Preauthorized" means that an individual service has been approved by DMHMRSAS prior to commencement of the service by the service provider for initiation and reimbursement of services.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment. The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.

"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for providing such care.

"Qualified mental retardation professional" or "QMRP" means a professional possessing: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

"Residential support services" means support provided in the individual's home by a DMHMRSAS-licensed residential provider or a DSS-approved provider of adult foster care services. This service is one in which training, assistance, and supervision is routinely provided to enable individuals to

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maintain or improve their health, to develop skills in activities of daily living and safety in the use of community resources, to adapt their behavior to community and home-like environments, to develop relationships, and participate as citizens in the community.

"Respite services" means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care.

"Services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and the individual's family/caregiver, as appropriate, by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for services with an option of a consumer-directed model. These services include companion, personal assistance, and respite services.

"Skilled nursing services" means services that are ordered by a physician and required to prevent institutionalization, that are not otherwise available under the State Plan for Medical Assistance and that are provided by a licensed registered professional nurse, or by a licensed practical nurse under the supervision of a licensed registered professional nurse, in each case who is licensed to practice in the Commonwealth.

"Slot" means an opening or vacancy of waiver services for an individual.

"State Plan for Medical Assistance" or "Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with mental retardation to maintain paid employment.

"Support plan" means the report of recommendations resulting from a therapeutic consultation.

"Therapeutic consultation" means activities to assist the individual and the individual's family/caregiver, as appropriate, staff of residential support, day support, and any other providers in implementing an individual service plan.

"Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses. 12VAC30-120-2010 provides the service description, criteria, service

units and limitations, and provider requirements for this service.

12VAC30-120-213. General coverage and requirements for MR waiver services.

A. Waiver service populations. Home- and community-based waiver services shall be available through a §1915(c) of the Social Security Act waiver for the following individuals who have been determined to require the level of care provided in an ICF/MR.

1. Individuals with mental retardation; or
2. Individuals younger than the age of six who are at developmental risk. At the age of six years, these individuals must have a diagnosis of mental retardation to continue to receive home and community-based waiver services specifically under this program. Mental Retardation (MR) Waiver recipients who attain the age of six years of age, who are determined to not have a diagnosis of mental retardation, and who meet all IFDDS Waiver eligibility criteria, shall be eligible for transfer to the IFDDS Waiver effective up to their seventh birthday. Psychological evaluations (or standardized developmental assessment for children under six years of age) confirming diagnoses must be completed less than one year prior to transferring to the IFDDS Waiver. These recipients transferring from the MR Waiver will automatically be assigned a slot in the IFDDS Waiver, subject to the approval of the slot by CMS. The case manager will submit the current Level of Functioning Survey, CSP and psychological evaluation (or standardized developmental assessment for children under six years of age) to DMAS for review. Upon determination by DMAS that the individual is appropriate for transfer to the IFDDS Waiver, the case manager will provide the family with a list of IFDDS Waiver case managers. The case manager will work with the selected IFDDS Waiver case manager to determine an appropriate transfer date and submit a DMAS-122 to the local DSS. The MR Waiver slot will be held by the CSB until the child has successfully transitioned to the IFDDS Waiver. Once the child has successfully transitioned, the CSB will reallocate the slot.

B. Covered services.

1. Covered services shall include: residential support services, day support, supported employment (both consumer-directed and agency-directed), personal assistance (both consumer-directed and agency-directed), respite services (both consumer-directed and agency-directed), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, prevocational services, personal emergency response systems (PERS), ~~and~~ companion services (both consumer-directed and agency-directed), and transition services.

2. These services shall be appropriate and necessary to maintain the individual in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in ~~Intermediate Care Facilities for the Mentally Retarded~~ an ICF/MR under the State Plan that would have been provided had the waiver not been granted.

3. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility, ICF/MR, or inpatient rehabilitation facility. Individuals with mental retardation who are inpatients of these facilities may receive case management services as described in 12VAC30-50-450. The case manager may recommend waiver services that would promote exiting from the institutional placement; however, these services shall not be provided until the individual has exited the institution.

4. Under this §1915(c) waiver, DMAS waives §1902(a)(10)(B) of the Social Security Act related to comparability.

C. Requests for increased services. All requests for increased waiver services by MR Waiver recipients will be reviewed under the health, welfare, and safety standard. This standard assures that an individual's right to receive a waiver service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written ISP and that services can safely be provided in the community.

D. Appeals. Individual appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

E. Urgent criteria. The CSB/BHA will determine, from among the individuals included in the urgent category, who should be served first, based on the needs of the individual at the time a slot becomes available and not on any predetermined numerical or chronological order.

1. The urgent category will be assigned when the individual is in need of services because he is determined to meet one of the criteria established in subdivision 2 of this subsection and services are needed within 30 days. Assignment to the urgent category may be requested by the individual, his legally responsible relative, or primary caregiver. The urgent category may be assigned only when the individual, the individual's spouse, or the parent of an individual who is a minor child would accept the requested service if it were offered. Only after all individuals in the Commonwealth who meet the urgent criteria have been served can individuals in the nonurgent category be served. Individuals in the nonurgent category are those who meet the diagnostic and functional criteria for the waiver, including the need for services within 30 days, but who do

not meet the urgent criteria. In the event that a CSB/BHA has a vacant slot and does not have an individual who meets the urgent criteria, the slot can be held by the CSB/BHA for 90 days from the date it is identified as vacant, in case someone in an urgent situation is identified. If no one meeting the urgent criteria is identified within 90 days, the slot will be made available for allocation to another CSB/BHA in the Health Planning Region (HPR). If there is no urgent need at the time that the HPR is to make a regional reallocation of a waiver slot, the HPR shall notify DMHMRSAS. DMHMRSAS shall have the authority to reallocate said slot to another HPR or CSB/BHA where there is unmet urgent need. Said authority must be exercised, if at all, within 30 days from receiving such notice.

2. Satisfaction of one or more of the following criteria shall indicate that the individual should be placed on the urgent need of waiver services list:

- a. Both primary caregivers are 55 years of age or older, or if there is one primary caregiver, that primary caregiver is 55 years of age or older;
- b. The individual is living with a primary caregiver, who is providing the service voluntarily and without pay, and the primary caregiver indicates that he can no longer care for the individual with mental retardation;
- c. There is a clear risk of abuse, neglect, or exploitation;
- d. A primary caregiver has a chronic or long-term physical or psychiatric condition or conditions which significantly limits the abilities of the primary caregiver or caregivers to care for the individual with mental retardation;
- e. Individual is aging out of publicly funded residential placement or otherwise becoming homeless (exclusive of children who are graduating from high school); or
- f. The individual with mental retardation lives with the primary caregiver and there is a risk to the health or safety of the individual, primary caregiver, or other individual living in the home due to either of the following conditions:
 - (1) The individual's behavior or behaviors present a risk to himself or others which cannot be effectively managed by the primary caregiver even with generic or specialized support arranged or provided by the CSB/BHA; or
 - (2) There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the primary caregiver even with generic or specialized supports arranged or provided by the CSB/BHA.

F. Reevaluation of service need and utilization review. Case managers shall complete reviews and updates of the CSP and level of care as specified in 12VAC30-120-215 D. Providers

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shall meet the documentation requirements as specified in 12VAC30-120-217 B.

12VAC30-120-225. Consumer-directed model of service delivery.

A. Criteria.

1. The MR Waiver has ~~three~~ four services, companion, personal assistance, ~~and~~ respite, and the individual model of supported employment (either agency-directed or consumer-directed) ~~which that~~ may be provided through a consumer-directed model.

2. Individuals who choose the consumer-directed model must have the capability to hire ~~and~~ train, and fire their own personal ~~assistants or companions~~ assistant, companion, or employment assistant and supervise the assistant's ~~or~~ companion's or employment assistant's performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

3. ~~The~~ If the services model elected by the individual, or the family/caregiver, as appropriate, is not agency directed, ~~then the~~ individual, or if the individual is unable, then family/caregiver, shall be the employer in this service, and therefore shall be responsible for hiring, training, supervising, and firing assistants ~~and~~ companions or employment assistants. Specific employer duties include checking of references of personal assistants/companions; or employment assistants, determining that personal assistants/companions or employment assistants meet basic qualifications, training assistants/companions, or employment assistants, supervising the assistant's/companion's, or employment assistant's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual and the individual's family/caregiver, as appropriate, must have a back-up plan in case the assistant/companion or employment assistant does not show up for work as expected or terminates employment without prior notice.

4. Individuals choosing consumer-directed models of service delivery must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed personal assistance, respite, ~~or~~ companion, or individual supported employment services. The CD services facilitator will be responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the ISP, providing training to the individual and the individual's family/caregiver, as appropriate, on his responsibilities as an employer, and providing ongoing support of the consumer-directed models of services. The CD services facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a

family/caregiver employing the ~~assistant/companion~~ assistant, companion, or employment assistant. If an individual enrolled in consumer-directed services has a lapse in services facilitator for more than 90 consecutive days, the case manager must notify DMHMRSAS and the consumer-directed services will be discontinued.

5. DMAS shall provide for fiscal agent services for consumer-directed individual supported employment services, consumer-directed personal assistance services, consumer-directed companion services, and consumer-directed respite services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle the responsibilities of employment taxes for the individual. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

B. Provider qualifications. In addition to meeting the general conditions and requirements for home- and community-based services participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, the CD services facilitator must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient resources to perform the required activities. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in a human service field working with persons with mental retardation. The facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Types of functional limitations and health problems that may occur in persons with mental retardation, or persons with other disabilities, as well as strategies to reduce limitations and health problems;

(2) Physical assistance that may be required by people with mental retardation, such as transferring, bathing

techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that may be required by people with mental retardation that reduce the need for human help and improve safety;

(4) Various long-term care program requirements, including nursing home and ICF/MR placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, individual supported employment, and companion services;

(5) MR waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in service planning;

(7) Interviewing techniques;

(8) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance, companion services, individual supported employment services, and respite services, including hiring, training, managing, approving time sheets, and firing an assistant/companion or employment assistant;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals and the individual's family/caregivers, as appropriate, and service providers;

(2) Assessing, supporting, observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to individuals with mental retardation; and

(4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, orally and in writing; and

(6) Develop a rapport and communicate with persons of diverse cultural backgrounds.

3. If the CD services facilitator is not a RN, the CD services facilitator must inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed.

4. Initiation of services and service monitoring.

a. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate, to identify the needs, assist in the development of the ISP with the individual and the individual's family/caregiver, as appropriate, and provide employee management training. The initial comprehensive home visit is done only once upon the individual's entry into the consumer-directed model of service regardless of the number or type of consumer-directed services that an individual chooses to receive. If an individual changes CD services facilitators, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.

b. After the initial visit, the CD services facilitator will continue to monitor the companion, ~~or~~ personal assistant, or employment assistant ISP quarterly and on an as-needed basis. The CD services facilitator will review the utilization of consumer-directed respite services, either every six months or upon the use of 300 respite services hours, whichever comes first.

c. A face-to-face meeting with the individual must be conducted at least every six months to reassess the individual's needs and to ensure appropriateness of any CD services received by the individual.

5. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual and the individual's family/caregiver, as appropriate, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical needs, and social needs.

6. The CD services facilitator must be available to the individual by telephone.

7. The CD services facilitator must submit a criminal record check pertaining to the ~~assistant/companion~~ assistant, companion, or employment assistant on behalf of the individual and report findings of the criminal record check to the individual and the individual's family/caregiver, as appropriate, and the program's fiscal

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agent. If the individual is a minor, the ~~assistant/companion~~ assistant, companion, or employment assistant must also be screened through the DSS Child Protective Services Central Registry. ~~Assistants/companions~~ Assistants, companions, and employment assistants will not be reimbursed for services provided to the individual effective the date that the criminal record check confirms an ~~assistant/companion~~ assistant, companion, or employment assistant has been found to have been convicted of a crime as described in §37.2-416 of the Code of Virginia or if the ~~assistant/companion~~ assistant, companion, or employment assistant has a confirmed record on the DSS Child Protective Services Central Registry. The criminal record check and DSS Child Protective Services Central Registry finding must be requested by the CD services facilitator within 15 calendar days of employment. The services facilitator must maintain evidence that a criminal record check was obtained and must make such evidence available for DMAS review.

8. The CD services facilitator shall review timesheets during the face-to-face visits or more often as needed to ensure that the number of ISP-approved hours is not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the individual to resolve discrepancies and must notify the fiscal agent.

9. The CD services facilitator must maintain a list of persons who are available to provide consumer-directed personal assistance, consumer-directed companion, ~~or~~ consumer-directed respite services, or consumer-directed individual supported employment services.

10. The CD services facilitator must maintain records of each individual as described in 12VAC30-120-211, 12VAC30-120-223, and 12VAC30-120-233.

11. Upon the individual's request, the CD services facilitator shall provide the individual and the individual's family/caregiver, as appropriate, with a list of persons who can provide temporary assistance until the ~~assistant/companion~~ assistant, companion, or employment assistant returns or the individual is able to select and hire a new personal ~~assistant/companion~~ assistant, companion, or employment assistant. If an individual is consistently unable to hire and retain the employment of an ~~assistant/companion~~ assistant, companion, or employment assistant to provide consumer-directed personal assistance, companion, ~~or~~ respite, or individual supported employment services, the CD services facilitator will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the individual and the individual's family/caregiver, as appropriate, other service options.

12VAC30-120-229. Day support services.

A. Service description. Day support services shall include a variety of training, assistance, support, and specialized supervision for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. These services are typically offered in a nonresidential setting that allows peer interactions and community and social integration.

B. Criteria. For day support services, individuals must demonstrate the need for functional training, assistance, and specialized supervision offered primarily in settings other than the individual's own residence that allows an opportunity for being productive and contributing members of communities.

C. Types of day support. The amount and type of day support included in the individual's service plan is determined according to the services required for that individual. There are two types of day support: center-based, which is provided primarily at one location/building, or noncenter-based, which is provided primarily in community settings. Both types of day support may be provided at either intensive or regular levels.

D. Levels of day support. There are two levels of day support, intensive and regular. To be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) requires physical assistance to meet the basic personal care needs (toileting, feeding, etc); (ii) has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish his service goals; or (iii) requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral objectives are required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

E. Service units and service limitations. Day support services are billed ~~in units. Units shall be defined as:~~ according to the DMAS fee schedule.

- ~~1. One unit is 1 to 3.99 hours of service a day.~~
- ~~2. Two units are 4 to 6.99 hours of service a day.~~
- ~~3. Three units are 7 or more hours of service a day.~~

Day support cannot be regularly or temporarily provided in an individual's home or other residential setting (e.g., due to inclement weather or individual illness) without prior written approval from DMHMRSAS. Noncenter-based day support services must be separate and distinguishable from either residential support services or personal assistance services. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The supporting documentation must provide an estimate of the amount of day support required by the individual. Service providers are

reimbursed only for the amount and level of day support services included in the individual's approved ISP based on the setting, intensity, and duration of the service to be delivered. This service shall be limited to 780 units, or its equivalent under the DMAS fee schedule, per CSP year. If this service is used in combination with prevocational and/or group supported employment services, the combined total units for these services cannot exceed 780 units, or its equivalent under the DMAS fee schedule, per CSP year.

F. Provider requirements. In addition to meeting the general conditions and requirements for home- and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, day support providers need to meet additional requirements.

1. The provider of day support services must be licensed by DMHMRSAS as a provider of day support services.
2. In addition to licensing requirements, day support staff must also have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations. All providers of day support services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.
3. Required documentation in the individual's record. The provider must maintain records of each individual receiving services. At a minimum, these records must contain the following:
 - a. A functional assessment conducted by the provider to evaluate each individual in the day support environment and community settings.
 - b. An ISP that contains, at a minimum, the following elements:
 - (1) The individual's strengths, desired outcomes, required or desired supports and training needs;
 - (2) The individual's goals and measurable objectives to meet the above identified outcomes;
 - (3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;
 - (4) A timetable for the accomplishment of the individual's goals and objectives as appropriate;
 - (5) The estimated duration of the individual's needs for services; and
 - (6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. Documentation confirming the individual's attendance and amount of time in services and specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units, or their equivalent under the DMAS fee schedule, provided.

d. Documentation indicating whether the services were center-based or noncenter-based.

e. Documentation regarding transportation. In instances where day support staff are required to ride with the individual to and from day support, the day support staff time can be billed as day support, provided that the billing for this time does not exceed 25% of the total time spent in the day support activity for that day. Documentation must be maintained to verify that billing for day support staff coverage during transportation does not exceed 25% of the total time spent in the day support for that day.

f. If intensive day support services are requested, documentation indicating the specific supports and the reasons they are needed. For ongoing intensive day support services, there must be clear documentation of the ongoing needs and associated staff supports.

g. Documentation indicating that the ISP goals, objectives, and activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review must be submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.

h. Copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

12VAC30-120-237. Prevocational services.

A. Service description. Prevocational services are services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services, (excluding supported employment programs). Activities included in this service are not primarily directed at teaching specific job skills but at underlying rehabilitative goals such as accepting supervision, attendance, task completion, problem solving, and safety.

B. Criteria. In order to qualify for prevocational services, the individual shall have a demonstrated need for support in skills

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that are aimed toward preparation of paid employment that may be offered in a variety of community settings.

C. Service units and service limitations. Billing is ~~for one unit of service~~ in accordance with the DMAS fee schedule.

~~1. Units shall be defined as:~~

~~a. One unit is 1 to 3.99 hours of service a day.~~

~~b. Two units are 4 to 6.99 hours of service a day.~~

~~c. Three units are 7 or more hours of service a day.~~

1. This service is limited to 780 units, or its equivalent under the DMAS fee schedule, per CSP year. If this service is used in combination with day support and /or group-supported employment services, the combined total units for these services cannot exceed 780 units, or its equivalent under the DMAS fee schedule, per CSP year.

2. Prevocational services can be provided in center- or noncenter-based settings. Center-based means services are provided primarily at one location/building and noncenter-based means services are provided primarily in community settings. Both center-based or noncenter-based prevocational services may be provided at either regular or intensive levels.

3. Prevocational services can be provided at either a regular or intensive level. For prevocational services to be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) require physical assistance to meet the basic personal care needs (toileting, feeding, etc); (ii) have extensive disability-related difficulties and require additional, ongoing support to fully participate in programming and to accomplish service goals; or (iii) require extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral objectives are required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

4. There must be documentation regarding whether prevocational services are available in vocational rehabilitation agencies through §110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). If the individual is not eligible for services through the IDEA, documentation is required only for lack of DRS funding. When services are provided through these sources, the ISP shall not authorize them as a waiver expenditure.

5. Prevocational services can only be provided when the individual's compensation is less than 50% of the minimum wage.

D. Provider requirements. In addition to meeting the general conditions and requirements for home-based and community-based services participating providers as specified in

12VAC30-120-217 and 12VAC30-120-219, prevocational providers must also meet the following qualifications:

1. The provider of prevocational services must be a vendor of extended employment services, long-term employment services, or supported employment services for DRS, or be licensed by DMHMRSAS as a provider of day support services.

2. Providers must ensure and document that persons providing prevocational services have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations. All providers of prevocational services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

3. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving prevocational services. At a minimum, the records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the prevocational environment and community settings.

b. An ISP, which contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports, and training needs;

(2) The individual's goals and measurable objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives;

(5) The estimated duration of the individual's needs for services; and

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. Documentation indicating that the ISP goals, objectives, and activities have been reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and that the results of these reviews have been submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.

d. Documentation confirming the individual's attendance, amount of time spent in services, and type of services rendered, and specific information regarding the

individual's response to various settings and supports as agreed to in the ISP objectives. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units, or their equivalent under the DMAS fee schedule, provided.

e. Documentation indicating whether the services were center-based or noncenter-based.

f. Documentation regarding transportation. In instances where prevocational staff are required to ride with the individual to and from prevocational services, the prevocational staff time can be billed for prevocational services, provided that billing for this time does not exceed 25% of the total time spent in prevocational services for that day. Documentation must be maintained to verify that billing for prevocational staff coverage during transportation does not exceed 25% of the total time spent in the prevocational services for that day.

g. If intensive prevocational services are requested, documentation indicating the specific supports and the reasons they are needed. For ongoing intensive prevocational services, there must be clear documentation of the ongoing needs and associated staff supports.

h. Documentation indicating whether prevocational services are available in vocational rehabilitation agencies through §110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA).

i. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

12VAC30-120-247. Supported employment services.

A. Service description.

1. Supported employment services are provided in work settings where persons without disabilities are employed. It is especially designed for individuals with developmental disabilities, including individuals with mental retardation, who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential.

2. Supported employment services are available to individuals for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who because of their disability need ongoing support to perform in a work setting.

3. Supported employment can be provided in one of two models. Individual supported employment shall be defined as intermittent support, usually provided one-on-one by a ~~job coach~~ an employment assistant as defined in

12VAC30-120-211 to an individual in a supported employment position. This service can be agency or consumer directed. Group supported employment shall be defined as continuous support provided by staff to eight or fewer individuals with disabilities in an enclave, work crew, bench work, or entrepreneurial model. The individual's assessment and CSP must clearly reflect the individual's need for training and supports.

B. Criteria.

1. Only job development tasks that specifically include the individual are allowable job search activities under the MR waiver supported employment and only after determining this service is not available from DRS.

2. In order to qualify for these services, the individual shall have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports, and that because of his disability, he needs ongoing support to perform in a work setting.

3. A functional assessment must be conducted to evaluate the individual in his work environment and related community settings.

4. The ISP must document the amount of supported employment required by the individual. Service providers are reimbursed only for the amount and type of supported employment included in the individual's ISP based on the intensity and duration of the service delivered.

C. Service units and service limitations.

1. Supported employment for individual job placement is provided in one hour units. This service, including the use of a consumer-directed employment assistant, is limited to 40 hours per week.

2. Group models of supported employment (enclaves, work crews, bench work and entrepreneurial model of supported employment) will be billed ~~at the unit rate. For group models of supported employment, units shall be defined as:~~ according to the DMAS fee schedule.

~~a. One unit is 1 to 3.99 hours of service a day.~~

~~b. Two units are 4 to 6.99 hours of service a day.~~

~~c. Three units are 7 or more hours of service a day.~~

This service is limited to 780 units, or its equivalent under the DMAS fee schedule, per CSP year. If this service is used in combination with prevocational and day support services, the combined total units for these services cannot exceed 780 units, or its equivalent under the DMAS fee schedule, per CSP year.

3. For the individual job placement model, both agency and consumer directed, reimbursement of supported employment will be limited to actual documented

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interventions or collateral contacts by the provider, not the amount of time the individual is in the supported employment situation.

D. Provider requirements. In addition to meeting the general conditions and requirements for home-based and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, supported employment provider qualifications include:

1. Supported Group and agency-directed individual supported employment shall be provided only by agencies that are DRS vendors of supported employment services;

2. Consumer-directed individual supported employment shall be delivered by providers who:

a. Are at least 18 years of age;

b. Are able to read and write English and possess basic math skills;

c. Are capable of following an ISP with minimal supervision;

d. Submit to a criminal history record check within 15 days from the date of employment. The employment assistant will not be compensated for services provided to the individual if the records check verifies the employment assistant has been convicted of crimes described in §37.2-416 of the Code of Virginia;

e. Possess a valid Social Security number.

f. Are willing to attend training at the individual's or family's/caregiver's request or as required by the individual's community employer;

g. Agree to receive annual tuberculosis (TB) screening.

3. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving supported employment services. At a minimum, the records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the supported employment environment and related community settings.

b. Documentation indicating individual ineligibility for supported employment services through DRS or IDEA. If the individual is not eligible through IDEA, documentation is required only for the lack of DRS funding;

c. An ISP that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required/desired supports and training needs;

(2) The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives;

(5) The estimated duration of the individual's needs for services; and

(6) Provider staff responsible for the overall coordination and integration of the services specified in the plan.

d. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and the results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.

e. In instances where supported employment staff are required to ride with the individual to and from supported employment activities, the supported employment staff time can be billed for supported employment provided that the billing for this time does not exceed 25% of the total time spent in supported employment for that day. Documentation must be maintained to verify that billing for supported employment staff coverage during transportation does not exceed 25% of the total time spent in supported employment for that day.

f. In the case of a consumer-directed employment assistant working for the individual's community employer, the employment assistant shall be reimbursed only for time spent providing consumer-directed supports that is not paid by the individual's community employer through wages.

g. There must be a copy of the completed DMAS-122 in the record. Providers must clearly document efforts to obtain the DMAS-122 form from the case manager.

Part VIII

Individual and Family Developmental Disabilities Support Waiver

Article 1

General Requirements

12VAC30-120-700. Definitions.

"Activities of daily living (ADL)" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services.

"Appeal" means the process used to challenge adverse actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110, Eligibility and Appeals, and 12VAC30-20-500 through 12VAC30-20-560.

"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county or a combination of counties or cities or cities and counties under Chapter 6 (§37.2-600 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"CARF" means the Rehabilitation Accreditation Commission, formerly known as the Commission on Accreditation of Rehabilitation Facilities.

"Case management" means services as defined in 12VAC30-50-490.

"Case manager" means the provider of case management services as defined in 12VAC30-50-490.

"Centers for Medicare and Medicaid Services" or "CMS" means the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Community-based waiver services" or "waiver services" means a variety of home and community-based services paid for by DMAS as authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/MR placement.

"Community services board" or "CSB" means the local agency established by a city or county or combination of counties or cities, or cities and counties, under Chapter 5 (§37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion" means, for the purpose of these regulations, a person who provides companion services.

"Companion services" means nonmedical care, supervision and socialization provided to an adult (age 18 and older). The

provision of companion services does not entail hands-on care. It is provided in accordance with a therapeutic goal in the plan of care and is not purely diversional in nature.

"Consumer-directed employee" means, for purposes of these regulations, a person who provides consumer-directed services, personal care, companion services, individual supported employment services, and/or respite care, who is also exempt from workers' compensation.

"Consumer-directed services" means personal care, companion services, individual supported employment services, and/or respite care services where the individual or his family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the employee or employees.

"Consumer-directed (CD) services facilitator" means the provider enrolled with DMAS who is responsible for management training and review activities as required by DMAS for consumer-directed services.

"Crisis stabilization" means direct intervention for persons with related conditions who are experiencing serious psychiatric or behavioral challenges, or both, that jeopardize their current community living situation. This service must provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize individuals and strengthen the current living situations so that individuals may be maintained in the community during and beyond the crisis period.

"Current functional status" means an individual's degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means DMAS employees who perform utilization review, preauthorize service type and intensity, provide technical assistance, and review of individual level of care criteria.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, services and support activities. These services take place outside of the individual's home/residence.

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"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' "; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals or family/caregivers as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual or his family/caregiver, as appropriate, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's or his family/caregiver's, as appropriate, use of the providers' services.

"Employment assistant" means a person who assists an individual in obtaining or maintaining integrated, competitive employment in the community. This may include assessment, job development, job placement, job training supports, long-term intermittent monitoring, and support to the individual and the facilitation of natural supports in the work environment.

"Enroll" means that the individual has been determined by the IFDDS screening team to meet the eligibility requirements for the waiver, DMAS has approved the individual's plan of care and has assigned an available slot to the individual, and DSS has determined the individual's Medicaid eligibility for home and community-based services.

"Entrepreneurial model" means a small business employing eight or fewer individuals with disabilities on a shift and may involve interactions with the public and coworkers with disabilities.

"Environmental modifications" means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines that prescribe specific preventive and treatment services for Medicaid-eligible children as defined in 12VAC30-50-130.

"Face-to-face visit" means the case manager or service provider must meet with the individual in person and that the individual should be engaged in the visit to the maximum extent possible.

"Family/caregiver training" means training and counseling services provided to families or caregivers of individuals receiving services in the IFDDS Waiver.

"Fiscal agent" means an entity handling employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed services.

"Home" means, for purposes of the IFDDS Waiver, an apartment or single family dwelling in which no more than four individuals who require services live with the exception of siblings living in the same dwelling with family. This does not include an assisted living facility or group home.

"Home- and community-based waiver services" means a variety of home and community-based services reimbursed by DMAS as authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/MR placement.

"ICF/MR" means a facility or distinct part of a facility certified as meeting the federal certification regulations for an Intermediate Care Facility for the Mentally Retarded and persons with related conditions. These facilities must address the residents' total needs including physical, intellectual, social, emotional, and habilitation. An ICF/MR must provide active treatment, as that term is defined in 42 CFR 483.440(a).

"IFDDS screening team" means the persons employed by the entity under contract with DMAS who are responsible for performing level of care screenings for the IFDDS Waiver.

"IFDDS Waiver" means the Individual and Family Developmental Disabilities Support Waiver.

"In-home residential support services" means support provided primarily in the individual's home, which includes training, assistance, and specialized supervision to enable the individual to maintain or improve his health; assisting in performing individual care tasks; training in activities of daily living; training and use of community resources; providing life skills training; and adapting behavior to community and home-like environments.

"Instrumental activities of daily living (IADL)" means meal preparation, shopping, housekeeping, laundry, and money management.

"Mental retardation" means a disability as defined by the American Association on ~~Mental Retardation (AAMR)~~ Intellectual and Developmental Disabilities (AAIDD).

"MR Waiver" means the mental retardation waiver.

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS.

"Pend" means delaying the consideration of an individual's request for authorization of services until all required information is received by DMAS.

"Person-centered planning" means a process, directed by the individual or his family/caregiver, as appropriate, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual.

"Personal care provider" means a participating provider that renders services to prevent or reduce inappropriate institutional care by providing eligible individuals with personal care aides to provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable individuals to remain in or return to the community rather than enter an Intermediate Care Facility for the Mentally Retarded. Personal care services include assistance with activities of daily living, instrumental activities of daily living, access to the community, medication or other medical needs, and monitoring health status and physical condition. This does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460.

"Personal emergency response system (PERS)" is an electronic device that enables certain individuals to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Plan of care" means a document developed by the individual or his family/caregiver, as appropriate, and the individual's case manager addressing all needs of individuals of home and community-based waiver services, in all life areas. Supporting documentation developed by waiver service providers is to be incorporated in the plan of care by the case manager. Factors to be considered when these plans are developed must include, but are not limited to, individuals' ages, levels of functioning, and preferences.

"Preauthorized" means the preauthorization agent has approved a service for initiation and reimbursement ~~prior to the commencement~~ of the service by the service provider.

"Primary caregiver" means the ~~main~~ primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for such care.

"Qualified developmental disabilities professional" or "QDDP" means a professional who (i) possesses at least one year of documented experience working directly with individuals who have related conditions; (ii) is one of the following: a doctor of medicine or osteopathy, a registered nurse, a provider holding at least a bachelor's degree in a

human service field including, but not limited to, sociology, social work, special education, rehabilitation engineering, counseling or psychology, or a provider who has documented equivalent qualifications; and (iii) possesses the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

"Related conditions" means those persons who have autism or who have a severe chronic disability that meets all of the following conditions identified in 42 CFR 435.1009:

1. It is attributable to:
 - a. Cerebral palsy or epilepsy; or
 - b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.
2. It is manifested before the person reaches age 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self-care.
 - b. Understanding and use of language.
 - c. Learning.
 - d. Mobility.
 - e. Self-direction.
 - f. Capacity for independent living.

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

"Respite care provider" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing respite care services for unpaid caregivers of eligible individuals.

"Screening" means the process conducted by the IFDDS screening team to evaluate the medical, nursing, and social needs of individuals referred for screening and to determine eligibility for an ICF/MR level of care.

"Skilled nursing services" means nursing services (i) listed in the plan of care that do not meet home health criteria, (ii) required to prevent institutionalization, (iii) not otherwise available under the State Plan for Medical Assistance, (iv) provided within the scope of the state's Nursing Act (§54.1-3000 et seq. of the Code of Virginia) and Drug Control Act

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(§54.1-3400 et seq. of the Code of Virginia), and (v) provided by a registered professional nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state. Skilled nursing services are to be used to provide training, consultation, nurse delegation as appropriate and oversight of direct care staff as appropriate.

"Slot" means an opening or vacancy of waiver services for an individual.

"Specialized supervision" means staff presence necessary for ongoing or intermittent intervention to ensure an individual's health and safety.

"State Plan for Medical Assistance" or "the Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supporting documentation" means the specific plan of care developed by the individual and waiver service provider related solely to the specific tasks required of that service provider. Supporting documentation helps to comprise the overall plan of care for the individual, developed by the case manager and the individual.

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment.

"Therapeutic consultation" means consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, or physical therapy or behavior consultation to assist individuals, parents, family members, in-home residential support, day support and any other providers of support services in implementing a plan of care.

"Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"VDH" means the Virginia Department of Health.

12VAC30-120-710. General coverage and requirements for all home and community-based waiver services.

A. Waiver service populations. Home-based and community-based services shall be available through a §1915(c) waiver. Coverage shall be provided under the

waiver for individuals six years of age and older with related conditions as defined in 12VAC30-120-700, including autism, who have been determined to require the level of care provided in an ICF/MR. The individual must not have a diagnosis of mental retardation as defined by the American Association on ~~Mental Retardation (AAMR)~~ Intellectual and Developmental Disabilities (AAIDD). Mental Retardation (MR) Waiver recipients who are six years of age on or after October 1, 2002, who are determined to not have a diagnosis of mental retardation, and who meet all IFDDS Waiver eligibility criteria, shall be eligible for and shall transfer to the IFDDS Waiver effective with their sixth birthday. Psychological evaluations confirming diagnoses must be completed less than one year prior to the child's sixth birthday. These recipients transferring from the MR Waiver will automatically be assigned a slot in the IFDDS Waiver. Such slot shall be in addition to those slots available through the screening process described in 12VAC30-120-720 B and C.

B. Covered services.

1. Covered services shall include in-home residential supports, day support, prevocational services, supported employment (both agency-directed and consumer-directed), personal care (both agency-directed and consumer-directed), respite care (both agency-directed and consumer-directed), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, personal emergency response systems (PERS), family/caregiver training, ~~and~~ companion services (both agency-directed and consumer-directed), and transition services.

2. These services shall be appropriate and medically necessary to maintain these individuals in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in ICFs/MR under the State Plan that would have been made had the waiver not been granted.

3. Under this §1915(c) waiver, DMAS waives subdivision (a)(10)(B) of §1902 of the Social Security Act related to comparability.

C. Eligibility criteria for emergency access to the waiver.

1. Subject to available funding and a finding of eligibility under 12VAC30-120-720, individuals must meet at least one of the emergency criteria of this subdivision to be eligible for immediate access to waiver services without consideration to the length of time an individual has been waiting to access services. In the absence of waiver services, the individual would not be able to remain in his home. The criteria are as follows:

- a. The primary caregiver has a serious illness, has been hospitalized, or has died;

- b. The individual has been determined by the DSS to have been abused or neglected and is in need of immediate waiver services;
- c. The individual demonstrates behaviors that present risk to personal or public safety;
- d. The individual presents extreme physical, emotional, or financial burden at home, and the family or caregiver is unable to continue to provide care; or
- e. The individual lives in an institutional setting and has a viable discharge plan in place.

2. When emergency slots become available:

- a. All individuals who have been found eligible for the IFDDS Waiver but have not been enrolled shall be notified by either DMAS or the individual's case manager.
- b. Individuals and their family/caregivers shall be given 30 calendar days to request emergency consideration.
- c. An interdisciplinary team of DMAS professionals shall evaluate the requests for emergency consideration within 10 calendar days from the 30-calendar day deadline using the emergency criteria to determine who will be assigned an emergency slot. If DMAS receives more requests than the number of available emergency slots, then the interdisciplinary team will make a decision on slot allocation based on need as documented in the request for emergency consideration. A waiting list of emergency cases will not be kept.

D. Appeals. Individual appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-599.

12VAC30-120-754. Supported employment services.

A. Service description.

1. Supported employment services shall include training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized training to enable an individual to maintain paid employment. Each supporting documentation must confirm whether supported employment services are available to the individual in vocational rehabilitation agencies through the Rehabilitation Act of 1973 or in special education services through 20 USC §1401 of the Individuals with Disabilities Education Act (IDEA). Providers of these DRS and IDEA services cannot be reimbursed by Medicaid with the IFDDS Waiver funds. Waiver service providers are reimbursed only for the amount and type of habilitation services included in the individual's approved plan of care based on the intensity and duration of the service delivered. Reimbursement shall be limited to actual interventions by

the provider of supported employment, not for the amount of time the recipient is in the supported employment environment.

2. Supported employment may be provided in one of two models. Individual supported employment is defined as intermittent support, usually provided one on one by ~~a job coach~~ an employment assistant, as defined in 12VAC30-120-700, for an individual in a supported employment position. This service can be agency or consumer-directed. Group supported employment is defined as continuous support provided by staff for eight or fewer individuals with disabilities in an enclave, work crew, or bench work/entrepreneurial model. The individual's assessment and plan of care must clearly reflect the individual's need for training and supports.

B. Criteria for receipt of services.

1. Only job development tasks that specifically include the individual are allowable job search activities under the IFDDS Waiver supported employment and only after determining this service is not available from DRS or IDEA.

2. In order to qualify for these services, the individual shall have a demonstrated need for training, specialized supervision, or assistance in paid employment and for whom competitive employment at or above the minimum wage is unlikely without this support and who, because of the disability, needs ongoing support, including supervision, training and transportation to perform in a work setting.

3. A functional assessment must be conducted to evaluate each individual in his work environment and related community settings.

4. The supporting documentation must document the amount of supported employment required by the individual. Service providers are reimbursed only for the amount and type of supported employment included in the plan of care based on the intensity and duration of the service delivered.

C. Service units and service limitations.

1. Supported employment for individual job placement is provided in one-hour units. This service, including the use of a consumer-directed employment assistant, is limited to 40 hours per week.

2. Group models of supported employment (enclaves, work crews, bench work, and entrepreneurial model of supported employment) will be billed ~~at the unit rate~~ according to the DMAS fee schedule.

a. One unit is 1 to 3.99 hours of service a day.

b. Two units are 4 to 6.99 or more hours of service a day.

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e. ~~Three units are 7 or more hours of service a day.~~

3. Supported employment services are limited to 780 units per plan of care year. If used in combination with prevocational and day support services, the combined total units for these services cannot exceed 780 units, or its equivalent under the DMAS fee schedule, per plan of care year.

4. For the individual ~~job placement model~~ supported employment services, agency directed or consumer directed, reimbursement ~~of supported employment~~ will be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the individual is in the supported employment situation.

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

1. ~~Supported Group and agency-directed individual supported~~ employment services shall be provided by agencies that are programs certified by ~~CARF~~ the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide supported employment services or are DRS vendors of supported employment services.

2. Consumer-directed individual supported employment shall be delivered by providers who:

- a. Are at least 18 years of age;
- b. Are able to read and write English and possess basic math skills;
- c. Are capable of following an ISP with minimal supervision;
- d. Submit to a criminal history record check within 15 days from the date of employment. The employment assistant will not be compensated for services provided to the individual if the records check verifies the employment assistant has been convicted of crimes described in §37.2-416 of the Code of Virginia;
- e. Possess a valid Social Security number.
- f. Are willing to attend training at the individual's or family's/caregiver's request or as required by the individual's community employer;
- g. Agree to receive annual tuberculosis (TB) screening.

3. Individual ineligibility for supported employment services through DRS or IDEA must be documented in the individual's record, as applicable. If the individual is ~~eligible~~ ineligible to receive services through ~~the Individuals with Disabilities Education Act~~ IDEA documentation is required only for lack of DRS funding.

Acceptable documentation would include a copy of a letter from DRS or the local school system or a record of a ~~phone~~ telephone call (name, date, person contacted) documented in the case manager's case notes, Consumer Profile/Social assessment or on the supported employment supporting documentation. Unless the individual's circumstances change, the original verification may be forwarded into the current record or repeated on the supporting documentation or revised Social Assessment on an annual basis.

~~3.~~ 4. Supporting documentation and ongoing documentation consistent with licensing regulations, if a DMHMRSAS licensed program.

4. 5. For non-DMHMRSAS programs certified as supported employment programs, there must be supporting documentation that contains, at a minimum, the following elements:

- a. The individual's strengths, desired outcomes, required/desired supports and training needs;
- b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;
- c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;
- d. All entities that will provide the services specified in the statement of services;
- e. A timetable for the accomplishment of the individual's goals and objectives;
- f. The estimated duration of the individual's needs for services; and
- g. Entities responsible for the overall coordination and integration of the services specified in the plan of care.

~~5.~~ 6. Documentation must confirm the individual's attendance, the amount of time the individual spent in services, and must provide specific information regarding the individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results should be available in at least a daily note or weekly summary.

~~6.~~ 7. The provider must review the supporting documentation with the individual, and this written review submitted to the case manager, at least semi-annually, with goals, objectives and activities modified as appropriate. For the annual review and in cases where the plan of care is modified, the plan of care must be reviewed with the individual or his family/caregiver, as appropriate.

~~7.~~ 8. In instances where supported employment staff are required to ride with the individual to and from supported employment activities, the supported employment staff time may be billed for supported employment provided

that the billing for this time does not exceed 25% of the total time spent in supported employment for that day. Documentation must be maintained to verify that billing supported employment staff coverage during transportation does not exceed 25% of the total time spent in supported employment for that day.

9. In the case of a consumer-directed employment assistant working for the individual's community employer, the employment assistant shall be reimbursed only for time spent providing consumer-directed supports that is not paid by the individual's community employer through wages.

8- 10. There must be a copy of the completed DMAS-122 form in the record. Providers must clearly document efforts to obtain the DMAS-122 form from the case manager.

12VAC30-120-758. Environmental modifications.

A. Service description. Environmental modifications shall be defined as those physical adaptations to the individual's primary home or primary vehicle used by the individual, documented in the individual's plan of care, that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual to function with greater independence in the primary home and, without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repairs, central air conditioning, etc. Adaptations that add to the total square footage of the home shall be excluded from this benefit, except when necessary to complete an adaptation, as determined by DMAS or its designated agent. All services shall be provided in the individual's primary home in accordance with applicable state or local building codes. All modifications must be prior authorized by the prior authorization agent. Modifications may be made to a vehicle if it is the primary vehicle being used by the individual. This service does not include the purchase of vehicles.

B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modifications of a remedial or medical benefit offered in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program. Environmental modifications shall be covered in the least expensive, most cost-effective manner.

C. Service units and service limitations. Environmental modifications shall be available to individuals who are receiving case management services ~~in addition to at least one other waiver service.~~ To receive environmental modifications in the EDCD and IFDDS waivers, the individual must be receiving at least one other waiver service. A maximum limit of \$5,000 may be reimbursed per plan of care or calendar year, as appropriate to the waiver in which the individual is enrolled. Costs for environmental modifications shall not be carried over from year to year. All environmental modifications must be prior authorized by the prior authorization agent prior to billing. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.

Case managers, or the requesting provider if no case manager is available, must, upon completion of each modification, meet face-to-face with the individual and his family/caregiver, as appropriate, to ensure that the modification is completed satisfactorily and is able to be used by the individual.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-160, 12VAC30-120-730 and, 12VAC30-120-740, and 12VAC30-120-930, as appropriate, environmental modifications must be provided in accordance with all applicable state or local building codes by contractors who have a provider agreement with DMAS. Providers may not be spouses or parents of the individual. Modifications must be completed within the plan of care or the calendar year in which the modification was authorized, as appropriate to the waiver in which the individual is enrolled.

12VAC30-120-762. Assistive technology.

A. Service description. Assistive technology (AT) is available to recipients who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. ~~Assistive technology (AT)~~ AT is the specialized medical equipment and supplies, including those devices, controls, or appliances, specified in the plan of care, but not available under the State Plan for Medical Assistance, that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items.

B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily

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in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. Assistive technology shall be covered in the least expensive, most cost-effective manner.

C. Service units and service limitations. ~~Assistive technology (AT)~~ AT is available to individuals receiving at least one other waiver service and may be provided in the individual's home or community setting. A maximum limit of \$5,000 may be reimbursed per plan of care year or the calendar year, as appropriate to the waiver in which the individual is enrolled or calendar year, as appropriate to the waiver being received. Costs for assistive technology cannot be carried over from year to year and must be preauthorized each plan of care year. AT will not be approved for purposes of convenience of the caregiver/provider or restraint of the individual. An independent, professional consultation must be obtained from qualified professionals who are knowledgeable of that item for each AT request prior to approval by the prior authorization agent, and may include training on such AT by the qualified professional. All ~~assistive technology AT~~ must be prior authorized by the prior authorization agent prior to billing. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.

D. Provider requirements. In addition to meeting the general conditions and requirements for home- and community-based care participating providers as specified in 12VAC30-120-160, 12VAC30-120-730 and, 12VAC30-120-740, assistive technology and 12VAC30-120-930, AT shall be provided by providers having a current provider participation agreement with DMAS as durable medical equipment and supply providers. Independent, professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. Providers that supply ~~assistive technology AT~~ for an individual may not perform assessment/consultation, write specifications, or inspect the ~~assistive technology AT~~ for that individual. Providers of services may not be spouses or parents of the individual. AT must be delivered within the plan of care year, or within a year from the start date of the authorization, as appropriate to the waiver, in which the individual is enrolled.

12VAC30-120-770. Consumer-directed model of service delivery.

A. Criteria.

1. The IFDDS Waiver has ~~three~~ four services, companion, personal care, individual supported employment and

respite services, that may be provided through a consumer-directed model.

2. Individuals who are eligible for consumer-directed services must have the capability to hire and, train, and fire their consumer-directed employees and supervise the employee's work performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

3. Responsibilities as employer. The individual, or if the individual is unable, then a family caregiver, is the employer in this service and is responsible for hiring, training, supervising, and firing employees. Specific duties include checking references of employees, determining that employees meet basic qualifications, training employees, supervising the employees' performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or his family/caregiver, as appropriate, must have an emergency back-up plan in case the employee does not show up for work.

4. DMAS shall contract for the services of a fiscal agent for consumer-directed personal care, companion, individual supported employment and respite care services. The fiscal agent will be paid by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the individual for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

5. Individuals choosing consumer-directed services must receive support from a CD services facilitator. Services facilitators assist the individual or his family/caregiver, as appropriate, as they become employers for consumer-directed services. This function includes providing the individual or his family/caregiver, as appropriate, with management training, review and explanation of the Employee Management Manual, and routine visits to monitor the employment process. The CD services facilitator assists the individual/employer with employer issues as they arise. The services facilitator meeting the stated qualifications may also complete the assessments, reassessments, and related supporting documentation necessary for consumer-directed services if the individual or his family/caregiver, as appropriate, chooses for the CD services facilitator to perform these tasks rather than the case manager. Services facilitation services are provided on an as-needed basis as determined by the individual, family/caregiver, and CD services facilitator. This must be documented in the supporting documentation for consumer-directed services and the services facilitation provider bills accordingly. If an individual enrolled in consumer-directed services has a lapse in consumer-

directed services for more than 60 consecutive calendar days, the case manager must notify DMAS so that consumer-directed services may be discontinued and the option given to change to agency-directed services.

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

1. To be enrolled as a Medicaid CD services facilitation provider and maintain provider status, the CD services facilitation provider must operate from a business office and have sufficient qualified staff who will function as CD services facilitators to perform the service facilitation and support activities as required. It is preferred that the employee of the CD services facilitation provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator has two years of satisfactory experience in the human services field working with individuals with related conditions.

2. The CD services facilitator must possess a combination of work experience and relevant education which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

- (1) Various long-term care program requirements, including nursing home, ICF/MR, and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care services;
- (2) DMAS consumer-directed services requirements, and the administrative duties for which the individual will be responsible;
- (3) Interviewing techniques;
- (4) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed services, including hiring, training, managing, approving time sheets, and firing an employee;
- (5) The principles of human behavior and interpersonal relationships; and
- (6) General principles of record documentation.

(7) For CD services facilitators who also conduct assessments and reassessments, the following is also required. Knowledge of:

- (a) Types of functional limitations and health problems that are common to different disability types and the aging process as well as strategies to reduce limitations and health problems;
- (b) Physical assistance typically required by people with developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;
- (c) Equipment and environmental modifications commonly used and required by people with developmental disabilities that reduces the need for human help and improves safety;
- (d) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning.

b. Skills in:

- (1) Negotiating with individuals or their family/caregivers, as appropriate, and service providers;
- (2) Observing, recording, and reporting behaviors;
- (3) Identifying, developing, or providing services to persons with developmental disabilities; and
- (4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

- (1) Report findings of the assessment or onsite visit, either in writing or an alternative format for persons who have visual impairments;
- (2) Demonstrate a positive regard for individuals and their families;
- (3) Be persistent and remain objective;
- (4) Work independently, performing position duties under general supervision;
- (5) Communicate effectively, orally and in writing;
- (6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds; and
- (7) Interview.

3. If the CD services facilitator is not an RN, the CD services facilitator must inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed.

4. Initiation of services and service monitoring.

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a. If the services facilitator has responsibility for individual assessments and reassessments, these must be conducted as specified in 12VAC30-120-766 and 12VAC30-120-776.

b. Management training.

(1) The CD services facilitation provider must make an initial visit with the individual or his family/caregiver, as appropriate, to provide management training. The initial management training is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation providers, the new CD services facilitator must bill for a regular management training in lieu of initial management training.

(2) After the initial visit, two routine visits must occur within 60 days of the initiation of care or the initial visit to monitor the employment process.

(3) For personal care services, the CD services facilitation provider will continue to monitor on an as needed basis, not to exceed a maximum of one routine visit every 30 calendar days but no less than the minimum of one routine visit every 90 calendar days per individual. After the initial visit, the CD services facilitator will periodically review the utilization of companion services at a minimum of every six months and for respite services, either every six months or upon the use of 300 respite care hours, whichever comes first.

5. The CD services facilitator must be available to the individual or his family/caregiver, as appropriate, by telephone during normal business hours, have voice mail capability, and return phone calls within 24 hours or have an approved back-up CD services facilitator.

6. The CD services fiscal contractor for DMAS must submit a criminal record check within 15 calendar days of employment pertaining to the consumer-directed employees on behalf of the individual or family/caregiver and report findings of the criminal record check to the individual or his family/caregiver, as appropriate.

7. The CD services facilitator shall verify bi-weekly timesheets signed by the individual or his family caregiver, as appropriate, and the employee to ensure that the number of plan of care approved hours are not exceeded. If discrepancies are identified, the CD services facilitator must contact the individual to resolve discrepancies and must notify the fiscal agent. If an individual is consistently being identified as having discrepancies in his timesheets, the CD services facilitator must contact the case manager to resolve the situation.

8. Consumer-directed employee registry. The CD services facilitator must maintain a consumer-directed employee registry, updated on an ongoing basis.

9. Required documentation in individuals' records. CD services facilitators responsible for individual assessment and reassessment must maintain records as described in 12VAC30-120-766 and 12VAC30-120-776. For CD services facilitators conducting management training, the following documentation is required in the individual's record:

a. All copies of the plan of care, all supporting documentation related to consumer-directed services, and all DMAS-122 forms.

b. CD services facilitator's notes recorded and dated at the time of service delivery.

c. All correspondence to the individual, others concerning the individual, and to DMAS.

d. All training provided to the consumer-directed employees on behalf of the individual or his family/caregiver, as appropriate.

e. All management training provided to the individuals or his family/caregivers, as appropriate, including the responsibility for the accuracy of the timesheets.

f. All documents signed by the individual or his family/caregiver, as appropriate, that acknowledge the responsibilities of the services.

Part IX

Elderly or Disabled with Consumer Direction Waiver

12VAC30-120-900. Definitions.

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

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

"Adult day health care center" or "ADHC" means a DMAS-enrolled provider that offers a community-based day program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those elderly and disabled individuals at risk of placement in a nursing facility. The ADHC must be licensed by DSS as an ADHC.

"Adult day health care services" means services designed to prevent institutionalization by providing participants with health, maintenance, and coordination of rehabilitation services in a congregate daytime setting.

"Agency-directed services" means services provided by a personal care agency.

"Americans with Disabilities Act" or "ADA" means the United States Code pursuant to 42 USC §12101 et seq.

"Appeal" means the process used to challenge adverse actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560.

"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

"Barrier crime" means those crimes as defined at §32.1-162.9:1 of the Code of Virginia.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Cognitive impairment" means a severe deficit in mental capability that affects an individual's areas of functioning such as thought processes, problem solving, judgment, memory, or comprehension that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

"Consumer-directed services" means services for which the individual or family/caregiver is responsible for hiring, training, supervising, and firing of the personal care aide.

"Consumer-directed (CD) services facilitator" or "facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the Consumer-Directed Services Plan of Care, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services.

"Designated preauthorization contractor" means DMAS or the entity that has been contracted by DMAS to perform preauthorization of services.

"Direct marketing" means either (i) conducting either directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) using direct mailing; (iii) paying "finders fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals or family/caregivers as inducements to use the providers' services; (v) providing continuous, periodic marketing activities to the same prospective individual or family/caregiver, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other

benefits as a means of influencing the individual's or family/caregiver's use of the providers' services.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by the Department of Medical Assistance Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Elderly or Disabled with Consumer Direction Waiver" or "EDCD waiver" means the CMS-approved waiver that covers a range of community support services offered to individuals who are elderly or disabled who would otherwise require a nursing facility level of care.

"Environmental modifications" means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act (42 USC §1201 et seq.), necessary to ensure the individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals. 12VAC30-120-758 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"Fiscal agent" means an agency or division within DMAS or contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed personal care services and respite services.

"Home-based and community-based waiver services" or "waiver services" means the range of community support services approved by the CMS pursuant to §1915(c) of the Social Security Act to be offered to persons who are elderly or disabled who would otherwise require the level of care provided in a nursing facility. DMAS or the designated preauthorization contractor shall only give preauthorization for medically necessary Medicaid reimbursed home and community care.

"Individual" means the person receiving the services established in these regulations.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping and laundry. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Medication monitoring" means an electronic device, which is only available in conjunction with Personal Emergency Response Systems, that enables certain individuals at high

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risk of institutionalization to be reminded to take their medications at the correct dosages and times.

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS.

"Personal care agency" means a participating provider that provides personal care services.

"Personal care aide" means a person who provides personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter a nursing facility. Personal care services are provided to individuals in the areas of activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. Services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

"Personal emergency response system (PERS)" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"PERS provider" means a certified home health or a personal care agency, a durable medical equipment provider, a hospital, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and services calls), and PERS monitoring. PERS providers may also provide medication monitoring.

"Plan of care" means the written plan developed by the provider related solely to the specific services required by the individual to ensure optimal health and safety while remaining in the community.

"Preadmission screening" means the process to: (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screening; (ii) assist individuals in determining what specific services the individuals need; (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs; and (iv) refer individuals to the appropriate provider for Medicaid-funded nursing facility or home and

community-based care for those individuals who meet nursing facility level of care.

"Preadmission Screening Committee/Team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to §32.1-330 of the Code of Virginia.

"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for providing such care.

"Respite care agency" or "respite care facility" means a participating provider that renders respite services.

"Respite services" means those short-term personal care services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of those unpaid caregivers who normally provide the care.

"State Plan for Medical Assistance" or "State Plan" means the regulations identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Transition coordinator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver, as appropriate, with the activities associated with transitioning from an institution to the community. 12VAC30-120-2000 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that is completed by the Preadmission Screening Team that assesses an individual's physical health, mental health, and social and functional abilities to determine if the individual meets the nursing facility level of care.

12VAC30-120-910. General coverage and requirements for Elderly or Disabled with Consumer Direction Waiver services.

A. EDCD Waiver services populations. Home- and community-based waiver services shall be available through a §1915(c) of the Social Security Act waiver for the following Medicaid-eligible individuals who have been determined to

be eligible for waiver services and to require the level of care provided in a nursing facility:

4. Individuals who are elderly as defined by §1614 of the Social Security Act; or
2. Individuals who are disabled as defined by §1614 of the Social Security Act.

B. Covered services.

1. Covered services shall include: adult day health care, personal care (both consumer-directed and agency-directed), respite services (~~both~~ (consumer-directed, agency-directed, and facility-based), ~~and~~ PERS, assistive technology, environmental modifications, transition coordinator and transition services.

2. These services shall be medically appropriate and medically necessary to maintain the individual in the community and prevent institutionalization.

3. A recipient of EDCD Waiver services may receive personal care (agency- and consumer-directed), respite care (agency- and consumer-directed), adult day health care, transition services, transition coordination, assistive technology, environmental modifications, and PERS services in conjunction with hospice services, regardless of whether the hospice provider receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Services under this waiver will not be available to hospice recipients unless the hospice can document the provision of at least 21 hours per week of homemaker/home health aide services and that the recipient needs personal care-type services that exceed this amount.

4. Under this §1915(c) waiver, DMAS waives §§1902(a)(10)(B) and (C) of the Social Security Act related to comparability of services.

12VAC30-120-920. Individual eligibility requirements.

A. The Commonwealth has elected to cover low-income families with children as described in §1931 of the Social Security Act; aged, blind, or disabled individuals who are eligible under 42 CFR 435.121; optional categorically needy individuals who are aged and disabled who have incomes at 80% of the federal poverty level; the special home and community-based waiver group under 42 CFR 435.217; and the medically needy groups specified in 42 CFR 435.320, 435.322, 435.324, and 435.330.

1. Under this waiver, the coverage groups authorized under §1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of care criteria. The deeming rules are applied to waiver

eligible individuals as if the individual were residing in an institution or would require that level of care.

2. Virginia shall reduce its payment for home and community-based services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and §1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

a. For individuals to whom §1924(d) applies (Virginia waives the requirement for comparability pursuant to §1902(a)(10)(B)), deduct the following in the respective order:

(1) An amount for the maintenance needs of the individual that is equal to 165% of the SSI income limit for one individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for individuals employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% of SSI and (ii) for individuals employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. However, in no case, shall the total amount of income (both earned and unearned) that is disregarded for maintenance exceed 300% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.);

(2) For an individual with only a spouse at home, the community spousal income allowance determined in accordance with §1924(d) of the Social Security Act;

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with §1924(d) of the Social Security Act; and

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third

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party, including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under the state law but not covered under the State Plan.

b. For individuals to whom §1924(d) of the Social Security Act does not apply, deduct the following in the respective order:

(1) An amount for the maintenance needs of the individual that is equal to 165% of the SSI income limit for one individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for individuals employed at least eight but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. However, in no case, shall the total amount of income (both earned and unearned) that is disregarded for maintenance exceed 300% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.);

(2) For an individual with a family at home, an additional amount for the maintenance needs of the family that shall be equal to the medically needy income standard for a family of the same size; and

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the State Plan.

B. Assessment and authorization of home and community-based services.

1. To ensure that Virginia's home and community-based waiver programs serve only Medicaid eligible individuals who would otherwise be placed in a nursing facility, home and community-based waiver services shall be considered only for individuals who are eligible for admission to a nursing facility. Home and community-based waiver services shall be the critical service to enable the individual to remain at home and in the community rather than being placed in a nursing facility.

2. The individual's eligibility for home and community-based services shall be determined by the Preadmission Screening Team after completion of a thorough assessment of the individual's needs and available support. If an individual meets nursing facility criteria, the Preadmission Screening Team shall provide the individual and family/caregiver with the choice of Elderly or Disabled with Consumer Direction Waiver services or nursing facility placement.

3. The Preadmission Screening Team shall explore alternative settings or services to provide the care needed by the individual. When Medicaid-funded home and community-based care services are determined to be the critical services necessary to delay or avoid nursing facility placement, the Preadmission Screening Team shall initiate referrals for services.

4. Medicaid will not pay for any home and community-based care services delivered prior to the individual establishing Medicaid eligibility and prior to the date of the preadmission screening by the Preadmission Screening Team and the physician signature on the Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96).

5. Before Medicaid will assume payment responsibility of home and community-based services, preauthorization must be obtained from the designated preauthorization contractor on all services requiring preauthorization. Providers must submit all required information to the designated preauthorization contractor within 10 business days of initiating care or within 10 business days of receiving verification of Medicaid eligibility from the local DSS. If the provider submits all required information to the designated preauthorization contractor within 10 business days of initiating care, services may be authorized beginning from the date the provider initiated services but not preceding the date of the physician's signature on the Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96). If the provider does not submit all required information to the designated preauthorization contractor within 10 business days of initiating care, the services may be authorized beginning with the date all required information was received by the designated preauthorization contractor, but in no event preceding the date of the Preadmission Screening Team physician's signature on the DMAS-96 form.

6. Once services for the individual have been authorized by the designated preauthorization contractor, the provider/services facilitator will submit a Patient Information Form (DMAS-122), along with a written confirmation of level of care eligibility from the designated preauthorization contractor, to the local DSS to determine financial eligibility for the waiver program and any patient pay responsibilities. After the provider/services facilitator

has received written notification of Medicaid eligibility by DSS and written enrollment from the designated preauthorization contractor, the provider/services facilitator shall inform the individual or family/caregiver so that services may be initiated.

7. The provider/services facilitator with the most billable hours must request an updated DMAS-122 form from the local DSS annually and forward a copy of the updated DMAS-122 form to all service providers when obtained.

8. Home-based and community-based care services shall not be offered or provided to any individual who resides in a nursing facility, an intermediate care facility for the mentally retarded, a hospital, an assisted living facility licensed by DSS ~~or an Adult Foster Care provider certified by DSS, that serves five or more individuals~~, or a group home licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services with exception of transition coordination, transition services, assistive technology and environmental modifications. Additionally, home and community-based care services shall not be provided to any individual who resides outside of the physical boundaries of the Commonwealth, with the exception of brief periods of time as approved by DMAS or the designated preauthorization contractor. Brief periods of time may include, but are not necessarily restricted to, vacation or illness.

9. Certain home-based and community-based services shall not be available to individuals residing in an assisted living facility licensed by DSS that serves four individuals. These services are: respite, PERS, environmental modifications and transition services. Personal care services are limited to five hours per day.

C. Appeals. Recipient appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

12VAC30-120-970. Personal emergency response system (PERS).

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

B. Standards for PERS equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for digital alarm communicator system units and Number 1637 for home

health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.

C. Criteria. PERS services are limited to those individuals ages 14 and older who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision. PERS may only be provided in conjunction with personal care (agency- or consumer-directed), respite (agency- or consumer-directed), or adult day health care. An individual may not receive PERS if he has a cognitive impairment as defined in 12VAC30-120-900.

1. PERS can be authorized when there is no one else, other than the individual, in the home who is competent and continuously available to call for help in an emergency. If the individual's caregiver has a business in the home, such as, but not limited to, a day care center, PERS will only be approved if the individual is evaluated as being dependent in the categories of "Behavior Pattern" and "Orientation" on the Uniform Assessment Instrument (UAI).

2. Medication monitoring units must be physician ordered. In order to receive medication monitoring services, an individual must also receive PERS services. The physician orders must be maintained in the individual's file.

D. Services units and services limitations.

1. A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, adjustments, and monitoring of the PERS. A unit of service equals the one-month rental of PERS, the price of which is set by DMAS. The one-time installation of the unit includes installation, account activation, and individual and caregiver instruction. The one-time installation fee shall also include the cost of the removal of the PERS equipment.

2. PERS service must be capable of being activated by a remote wireless device and be connected to the individual's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be waterproof, automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

3. In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a registered nurse, a licensed practical nurse, or a licensed pharmacist. The units can be refilled every 14 days. There must be documentation of this in the individual's record.

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E. Provider requirements. In addition to meeting the general conditions and requirements for home-based and community-based waiver participating providers as specified in 12VAC30-120-80, 12VAC30-120-160, and 12VAC30-120-930, PERS providers must also meet the following qualifications and requirements:

1. A PERS provider must be either a personal care agency, a durable medical equipment provider, a hospital, a licensed home health provider, or a PERS manufacturer. All such providers shall have the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring;
2. The PERS provider must provide an emergency response center with fully trained operators who are capable of (i) receiving signals for help from an individual's PERS equipment 24 hours a day, 365 or 366 days per year as appropriate; (ii) determining whether an emergency exists; and (iii) notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help;
3. A PERS provider must comply with all applicable Virginia statutes, all applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the services to be performed;
4. The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices, or medication monitoring unit and shall provide temporary equipment while the original equipment is being repaired;
5. The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line within seven days of the request unless there is appropriate documentation of why this timeframe cannot be met. The PERS provider must furnish all supplies necessary to ensure that the system is installed and working properly. The PERS provider must test the PERS device monthly, or more frequently if needed, to ensure that the device is fully operational;
6. The PERS installation shall include local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the telephone be off the hook or in use when the unit is activated;
7. A PERS provider must maintain a data record for each PERS individual at no additional cost to DMAS or the individual. The record must document all of the following:
 - a. Delivery date and installation date of the PERS;

- b. Individual/caregiver signature verifying receipt of the PERS device;

- c. Verification by a test that the PERS device is operational, monthly or more frequently as needed;

- d. Updated and current individual responder and contact information, as provided by the individual or the individual's caregiver; and

- e. A case log documenting the individual's utilization of the system, all contacts, and all communications with the individual, caregiver, and responders;

8. The PERS provider must have backup monitoring capacity in case the primary system cannot handle incoming emergency signals;

9. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) Safety Standard Number 1635 for digital alarm communicator system units and Safety Standard Number 1637 for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring a manual reset by the individual;

10. A PERS provider must furnish education, data, and ongoing assistance to DMAS and the designated preauthorization contractor to familiarize staff with the services, allow for ongoing evaluation and refinement of the program, and instruct the individual, caregiver, and responders in the use of the PERS services;

11. The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by individuals who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24 hours and automatically transmit a low battery alert signal to the response center if the backup battery is low. The emergency response console unit must also be able to self-disconnect and redial the backup monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center;

12. PERS providers must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the monitoring agency's equipment meets the following requirements. The PERS provider must be capable of simultaneously responding to multiple signals for help from individuals'

PERS equipment. The PERS provider's equipment must include the following:

- a. A primary receiver and a backup receiver, which must be independent and interchangeable;
 - b. A backup information retrieval system;
 - c. A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
 - d. A backup power supply;
 - e. A separate telephone service;
 - f. A toll-free number to be used by the PERS equipment in order to contact the primary or backup response center; and
 - g. A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds;
13. The PERS provider must maintain detailed technical and operation manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and recordkeeping and reporting procedures;
14. The PERS provider shall document and furnish within 30 days of the action taken a written report for each emergency signal that results in action being taken on behalf of the individual. This excludes test signals or activations made in error. This written report shall be furnished to the personal care provider, the respite care provider, the CD services facilitation provider, the transition coordinator, case manager, as appropriate to the waiver in which the individual is enrolled or, in cases where the individual only receives ADHC services, to the ADHC provider;
15. The PERS provider is prohibited from performing any type of direct marketing activities to Medicaid individuals; and
16. The PERS provider must obtain and keep on file a copy of the most recently completed Patient Information form (DMAS-122). Until the PERS provider obtains a copy of the DMAS-122 form, the PERS provider must clearly document efforts to obtain the completed DMAS-122 form from the personal care provider, respite care provider, the CD services facilitation provider, the transition coordinator, case manager, or the ADHC provider, as appropriate to the waiver in which the individual is enrolled.

Part X

Day Support Waiver for Individuals with Mental Retardation

12VAC30-120-1500. Definitions.

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

"Appeal" means the process used to challenge adverse actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county under Chapter 6 (§37.2-600 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the locality that it serves.

"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the consumer service plan; assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the consumer service plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the consumer service plan.

"Case manager" means the individual who performs case management services on behalf of the community services board or behavioral health authority, and who possesses a combination of mental retardation work experience and relevant education that indicates that the individual possesses the knowledge, skills and abilities as established by the Department of Medical Assistance Services in 12VAC30-50-450.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities under Chapter 5 (§37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical, and level of care

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information by the case manager and is used as a basis for the development of the consumer service plan.

"Consumer-directed model" means services for which the individual and the individual's family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the staff.

"Consumer-directed (CD) services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and the individual's family/caregiver, as appropriate, by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed supported employment.

"Consumer service plan" or "CSP" means documents addressing needs in all life areas of individuals who receive Day Support Waiver services, and is comprised of individual service plans as dictated by the individual's health care and support needs. The case manager incorporates the individual service plans in the CSP.

"Date of need" means the date of the initial eligibility determination assigned to reflect that the individual is diagnostically and functionally eligible for the waiver and is willing to begin services within 30 days. The date of need is not changed unless the person is subsequently found ineligible or withdraws their request for services.

"Day support services" means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level.

"Day Support Waiver for Individuals with Mental Retardation" or "Day Support Waiver" means the program that provides day support, prevocational services, and supported employment to individuals on the Mental Retardation Waiver waiting list who have been assigned a Day Support Waiver slot.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by the Department of Medical Assistance Services.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DMHMRSAS staff" means persons employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Employment assistant" means a person who assists an individual in obtaining or maintaining integrated, competitive employment in the community. This may include assessment, job development, job placement, job training supports, long-term intermittent monitoring, and support to the individual and the facilitation of natural supports in the work environment.

"Enroll" means that the individual has been determined by the case manager to meet the eligibility requirements for the Day Support Waiver and DMHMRSAS has verified the availability of a Day Support Waiver slot for that individual, and DSS has determined the individual's Medicaid eligibility for home and community-based services.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines that prescribe preventive and treatment services for Medicaid-eligible children as defined in 12VAC30-50-130.

"Home-based and community-based waiver services" or "waiver services" means the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to persons with mental retardation who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

"Individual" means the person receiving the services or evaluations established in these regulations.

"Individual service plan" or "ISP" means the service plan related solely to the specific waiver service. Multiple ISPs help to comprise the overall consumer service plan.

"Intermediate Care Facility for the Mentally Retarded" or "ICF/MR" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an intermediate care facility for the mentally retarded and persons with related conditions. These facilities must address the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, and must provide active treatment.

"Mental retardation" or "MR" means ~~mental retardation a disability~~ as defined by the American Association on ~~Mental Retardation~~ (AAMR) Intellectual and Developmental Disabilities (AAIDD).

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and DMHMRSAS, and has a current, signed provider participation agreement with DMAS.

"Preauthorized" means that an individual service has been approved by DMHMRSAS prior to commencement of the service by the service provider for initiation and reimbursement of services.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services (excluding supported employment programs). The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.

"Slot" means an opening or vacancy of waiver services for an individual.

"State Plan for Medical Assistance" or "Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with mental retardation to maintain paid employment. Supported employment is available as either an individual, group or consumer-directed service. 12VAC30-120-225 provides the service description, criteria, service units and limitations, and provider requirements for the consumer-directed model of this service.

12VAC30-120-1510. General coverage and requirements for Day Support Waiver services.

A. Waiver service populations. Home and community-based waiver services shall be available through a §1915(c) of the Social Security Act waiver for individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR.

B. Covered services.

1. Covered services shall include day support services, prevocational services and supported employment services (both agency-directed and consumer-directed models).
2. These services shall be appropriate and necessary to maintain the individual in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in an

ICF/MR under the State Plan that would have been provided had the waiver not been granted.

3. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility, ICF/MR, or inpatient rehabilitation facility. Individuals with mental retardation who are inpatients of these facilities may receive case management services as described in 12VAC30-50-440. The case manager may recommend waiver services that would promote exiting from the institutional placement; however, these services shall not be provided until the individual has exited the institution.

4. Under this §1915(c) waiver, DMAS waives §1902(a)(10)(B) of the Social Security Act related to comparability.

C. Appeals. Individual appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

D. Slot allocation.

1. DMHMRSAS will maintain one waiting list, the MR Waiver waiting list described in Part IV (12VAC30-120-211 et seq.) of this chapter, which will be used to assign slots in both the MR Waiver and Day Support Waiver. For Day Support Waiver services, slots will be assigned based on the date of need reported by the case manager when the individual was placed on the MR Waiver waiting list. Individuals interested in receiving Day Support Waiver services who are not currently on the MR Waiver waiting list may apply for services through the local CSB and if found eligible will be placed on the MR Waiver waiting list until a slot is available.

2. Each CSB will be assigned one Day Support Waiver slot by DMHMRSAS. The remaining slots will be distributed to the CSBs/BHAs based on the percentage of individual cases when compared to the statewide total of cases on the MR Waiver waiting list. All slots shall be allocated based on the individual's date of need and will remain CSB/BHA slots that, when vacated, will be offered to the next individual on the MR Waiver waiting list from that CSB/BHA based upon the date of need.

3. Individuals may remain on the MR Waiver waiting list while receiving Day Support Waiver services.

E. Reevaluation of service need and utilization review. Case managers shall complete reviews and updates of the CSP and level of care as specified in 12VAC30-120-1520 D. Providers shall meet the documentation requirements as specified in 12VAC30-120-1530 B.

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12VAC30-120-1550. Services: day support services, prevocational services and supported employment services.

A. Service descriptions.

1. Day support means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level.

2. Prevocational services means services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services (excluding supported employment programs). The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.

3. Supported employment services are provided in work settings where persons without disabilities are employed. It is especially designed for individuals with developmental disabilities, including individuals with mental retardation, who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential.

a. Supported employment services are available to individuals for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who because of their disability need ongoing support to perform in a work setting.

b. Supported employment can be provided in one of two models. Individual supported employment shall be defined as intermittent support, usually provided one-on-one by ~~a job coach~~ an employment assistant, as defined in 12VAC30-120-211, to an individual in a supported employment position. This model can be agency or consumer directed. Group-supported employment shall be defined as continuous support provided by staff to eight or fewer individuals with disabilities in an enclave, work crew, bench work, or entrepreneurial model. The individual's assessment and CSP must clearly reflect the individual's need for training and supports.

B. Criteria.

1. For day support services, individuals must demonstrate the need for functional training, assistance, and specialized supervision offered primarily in settings other than the

individual's own residence that allow an opportunity for being productive and contributing members of communities.

2. For prevocational services, the individual must demonstrate the need for support in skills that are aimed toward preparation of paid employment that may be offered in a variety of community settings.

3. For supported employment, the individual shall have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports, and that because of his disability, he needs ongoing support to perform in a work setting.

a. Only job development tasks that specifically include the individual are allowable job search activities under the Day Support waiver supported employment and only after determining this service is not available from DRS.

b. A functional assessment must be conducted to evaluate the individual in his work environment and related community settings.

C. Service types. The amount and type of day support and prevocational services included in the individual's service plan is determined according to the services required for that individual. There are two types of services: center-based, which is provided primarily at one location/building, and noncenter-based, which is provided primarily in community settings. Both types of services may be provided at either intensive or regular levels. For supported employment, the ISP must document the amount of supported employment required by the individual. Service providers are reimbursed only for the amount and type of supported employment included in the individual's ISP.

D. Intensive level criteria. For day support and prevocational services to be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) require physical assistance to meet the basic personal care needs (toileting, feeding, etc); (ii) have extensive disability-related difficulties and require additional, ongoing support to fully participate in programming and to accomplish his service goals; or (iii) require extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral objectives are required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

E. Service units. Day support, prevocational and group models of supported employment (enclaves, work crews, bench work and entrepreneurial model of supported employment) are billed in units. Units shall be defined as: accordance with the DMAS fee schedule.

~~1. One unit is 1 to 3.99 hours of service a day.~~

~~2. Two units are 4 to 6.99 hours of service a day.~~

- ~~3. Three units are 7 or more hours of service a day.~~
- ~~4. Supported employment for individual job placement is provided in one hour units.~~

F. Service limitations.

- 1. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing.
- 2. The supporting documentation must provide an estimate of the amount of services required by the individual. Service providers are reimbursed only for the amount and type of services included in the individual's approved ISP based on the setting, intensity, and duration of the service to be delivered.
- 3. Day support, prevocational and group models of supported employment services shall be limited to a total of 780 units per CSP year, or its equivalent under the DMAS fee schedule. If an individual receives a combination of day support, prevocational and/or supported employment services, the combined total shall not exceed 780 units per CSP year, or its equivalent under the DMAS fee schedule.
- 4. The individual job placement model of supported employment is limited to 40 hours per week.
- 5. For day support services:
 - a. Day support cannot be regularly or temporarily provided in an individual's home or other residential setting (e.g., due to inclement weather or individual illness) without prior written approval from DMHMRSAS.
 - b. Noncenter-based day support services must be separate and distinguishable from other services.
- 6. For the individual job placement model, reimbursement of supported employment will be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the individual is in the supported employment situation.

G. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, service providers must meet the following requirements:

- 1. The provider of day support services must be licensed by DMHMRSAS as a provider of day support services. The provider of prevocational services must be a vendor of extended employment services, long-term employment services, or supported employment services for DRS, or be licensed by DMHMRSAS as a provider of day support services.

2. Supported employment shall be provided only by agencies that are DRS vendors of supported employment services;

3. In addition to any licensing requirements, persons providing day support or prevocational services are required to participate in training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations prior to providing direct services. All providers of services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

4. Required documentation in the individual's record. The provider agency must maintain records of each individual receiving services. At a minimum these records must contain the following:

- a. A functional assessment conducted by the provider to evaluate each individual in the service environment and community settings.
- b. An ISP that contains, at a minimum, the following elements:
 - (1) The individual's strengths, desired outcomes, required or desired supports and training needs;
 - (2) The individual's goals and, a sequence of measurable objectives to meet the above identified outcomes;
 - (3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;
 - (4) A timetable for the accomplishment of the individual's goals and objectives as appropriate;
 - (5) The estimated duration of the individual's needs for services; and
 - (6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

~~c.~~ c. Documentation confirming the individual's attendance and amount of time in services, type of services rendered, and specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units provided.

~~d.~~ d. Documentation indicating whether day support or prevocational services were center-based or noncenter-based.

~~e.~~ e. In instances where staff are required to ride with the individual to and from the service in order to provide

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needed supports as specified in the ISP, the staff time can be billed as day support, prevocational or supported employment services, provided that the billing for this time does not exceed 25% of the total time spent in the day support, prevocational or supported employment activity for that day. Documentation must be maintained to verify that billing for staff coverage during transportation does not exceed 25% of the total time spent in the service for that day.

~~g.~~ f. If intensive day support or prevocational services are requested, there shall be documentation indicating the specific supports and the reasons they are needed. For ongoing intensive services, there must be clear documentation of the ongoing needs and associated staff supports.

~~h.~~ g. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, ~~and~~ annually, ~~and~~ or more often as needed and the results of the review submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual or family/caregiver.

~~i.~~ h. Copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

~~j.~~ i. For prevocational or supported employment services, documentation regarding whether prevocational or supported employment services are available through §110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). If the individual is not eligible for services through the IDEA, documentation is required only for lack of DRS funding. When services are provided through these sources, the ISP shall not authorize such services as a waiver expenditure.

~~k.~~ j. Prevocational services can only be provided when the individual's compensation is less than 50% of the minimum wage.

12VAC30-120-1560. Consumer-directed model of service delivery.

A. Criteria.

1. The MR Day Support Waiver has one service that may be provided through a consumer-directed model. It is individual supported employment services.

2. Individuals who choose the consumer-directed model must have the capability to hire, train, and fire their own personal employment assistant and supervise the employment assistant's performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

3. If the service model elected by the individual or the family/caregiver, as appropriate, is not agency directed, then the individual, or if the individual is unable, then family/caregiver, shall be the employer in this service, and therefore shall be responsible for hiring, training, supervising, and firing employment assistants. Specific employer duties include checking of references of employment assistants, determining that employment assistants meet basic qualifications, training employment assistants, supervising the employment assistant's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual and the individual's family/caregiver, as appropriate, must have a backup plan in case the employment assistant does not show up for work as expected or terminates employment without prior notice.

4. Individuals choosing consumer-directed models of service delivery must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed individual supported employment services. The CD services facilitator will be responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the ISP; providing training to the individual and the individual's family/caregiver, as appropriate, on his responsibilities as an employer; and providing ongoing support of the consumer-directed models of services. The CD services facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver employing the employment assistant. If an individual enrolled in consumer-directed services has a lapse in services facilitator for more than 90 consecutive days, the case manager must notify DMHMRSAS and the consumer-directed services will be discontinued.

5. DMAS shall provide for fiscal agent services for consumer-directed individual supported employment services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle the responsibilities of employment taxes for the individual. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

B. Provider qualifications. In addition to meeting the general conditions and requirements for home-based and community-based services participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, the CD services facilitator must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall

have sufficient resources to perform the required activities. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth of Virginia. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in a human service field working with persons with mental retardation. The facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Types of functional limitations and health problems that may occur in persons with mental retardation or persons with other disabilities, as well as strategies to reduce limitations and health problems;

(2) Physical assistance that may be required by people with mental retardation, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that may be required by people with mental retardation that reduce the need for human help and improve safety;

(4) Various long-term care program requirements, including nursing home and ICF/MR placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, individual supported employment, and companion services;

(5) MR waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in service planning;

(7) Interviewing techniques;

(8) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed services, including hiring, training, managing, approving time sheets, and firing an employee;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals and the individual's family/caregivers, as appropriate, and service providers;

(2) Assessing, supporting, observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to individuals with mental retardation; and

(4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, orally and in writing; and

(6) Develop a rapport and communicate with persons of diverse cultural backgrounds.

3. If the CD services facilitator is not a registered nurse, the CD services facilitator must inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed.

4. Initiation of services and service monitoring.

a. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate, to identify the needs, assist in the development of the ISP with the individual and the individual's family/caregiver, as appropriate, and provide employee management training. The initial comprehensive home visit is done only once upon the individual's entry into the consumer-directed model of service regardless of the number or type of consumer-directed services that an individual chooses to receive. If an individual changes CD services facilitators, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.

b. After the initial visit, the CD services facilitator will continue to monitor the companion, or personal assistant, or employment assistant ISP quarterly and on an as-

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needed basis. The CD services facilitator will review the utilization of consumer-directed individual supported employment services every six months.

c. A face-to-face meeting with the individual must be conducted at least every six months to reassess the individual's needs and to ensure appropriateness of any CD services received by the individual.

5. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual and the individual's family/caregiver, as appropriate, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical needs, and social needs.

6. The CD services facilitator must be available to the individual by telephone.

7. The CD services facilitator must submit a criminal record check pertaining to the employment assistant on behalf of the individual and report findings of the criminal record check to the individual and the individual's family/caregiver, as appropriate, and the program's fiscal agent. If the individual is a minor, the employment assistant must also be screened through the DSS Child Protective Services Central Registry. Employment assistants will not be reimbursed for services provided to the individual effective the date that the criminal record check confirms an employment assistant has been found to have been convicted of a crime as described in §37.2-416 of the Code of Virginia or if the employment assistant has a confirmed record on the DSS Child Protective Services Central Registry. The criminal record check and DSS Child Protective Services Central Registry finding must be requested by the CD services facilitator within 15 calendar days of employment. The services facilitator must maintain evidence that a criminal record check was obtained and must make such evidence available for DMAS review.

8. The CD services facilitator shall review timesheets during the face-to-face visits or more often as needed to ensure that the number of ISP-approved hours is not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the individual to resolve discrepancies and must notify the fiscal agent.

9. The CD services facilitator must maintain a list of persons who are available to provide consumer-directed individual supported employment services.

10. The CD services facilitator must maintain records of each individual as described in 12VAC30-120-211, 12VAC30-120-223, and 12VAC30-120-233.

11. Upon the individual's request, the CD services facilitator shall provide the individual and the individual's family/caregiver, as appropriate, with a list of persons who

can provide temporary assistance until the employment assistant returns or the individual is able to select and hire a new personal employment assistant. If an individual is consistently unable to hire and retain the employment of an employment assistant to provide consumer-directed individual supported employment services, the CD services facilitator will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the individual and the individual's family/caregiver, as appropriate, other service options.

12VAC30-120-2000. Transition coordinator.

A. Service description.

1. Transition coordination means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver, as appropriate, with the activities associated with transitioning from an institution to the community pursuant to the Elderly or Disabled with Consumer Direction waiver.

2. Transition coordination services include, but are not limited to, the development of a transition plan; the provision of information about services that may be needed, in accordance with the timeframe specified by federal law, prior to the discharge date, during and after transition; the coordination of community-based services with the case manager if case management is available; linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation; and the provision of ongoing support for up to 12 months after discharge date.

B. Criteria.

1. In order to qualify for these services, the individual shall have a demonstrated need for transition coordination of any of these services. Documented need shall indicate that the service plan cannot be implemented effectively and efficiently without such coordination from this service. Transition coordination services must be prior authorized by DMAS or its designated agent.

2. The individual's service plan shall clearly reflect the individual's needs for transition coordination provided to the individual, family/caregivers, and providers in order to implement the service plan effectively. The service plan includes, at a minimum: (i) a summary or reference to the assessment; (ii) goals and measurable objectives for addressing each identified need; (iii) the services, supports, and frequency of service to accomplish the goals and objectives; (iv) target dates for accomplishment of goals and objectives; (v) estimated duration of service; (vi) the role of other agencies if the plan is a shared responsibility; and (vii) the staff responsible for coordination and integration of services, including the staff of other agencies if the plan is a shared responsibility.

C. Service units and limitations. The unit of service shall be specified by the DMAS fee schedule. The services shall be explicitly detailed in the supporting documentation. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Transition coordination may not be billed solely for purposes of monitoring. Transition coordination shall be available to individuals who are transitioning from institutional care to the community. Transition coordination service providers shall be reimbursed according to the amount and type of service authorized in the service plan based on a monthly fee for service.

D. Provider requirements. In addition to meeting the general conditions and requirements for home-based and community-based care participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, transition coordinators shall meet the following qualifications:

1. Transition coordinators shall be employed by one of the following: a local government agency; a private, nonprofit organization qualified under 26 USC §501(c)(3); or a fiscal management service with experience in providing this service.

2. A qualified transition coordinator shall possess, at a minimum, a bachelor's degree in human services or health care and relevant experience that indicates the individual possesses the following knowledge, skills, and abilities. These shall be documented on the transition coordinator's job application form or supporting documentation, or observable in the job or promotion interview. The transition coordinator shall be at least 21 years of age.

3. Knowledge. Transition coordinators shall have knowledge of aging, independent living, the impact of disabilities and transition planning; individual assessments (including psychosocial, health, and functional factors) and their uses in service planning, interviewing techniques, individuals' rights, local human and health service delivery systems, including support services and public benefits eligibility requirements, principles of human behavior and interpersonal relationships, interpersonal communication principles and techniques, general principles of file documentation, the service planning process, and the major components of a service plan.

4. Skills. Transition coordinators shall have skills in negotiating with individuals and service providers; observing, and reporting behaviors; identifying and documenting an individual's needs for resources, services and other assistance; identifying services within the established services system to meet the individual's needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the service needs of the individual; and assessing individuals using DMAS' authorized assessment forms.

5. Abilities. Transition coordinators shall have the ability to demonstrate a positive regard for individuals and their families or designated guardian; be persistent and remain objective; work as a team member, maintaining effective interagency and intraagency working relationships; work independently, performing position duties under general supervision; communicate effectively, both verbally and in writing; develop a rapport; communicate with different types of persons from diverse cultural backgrounds; and interview.

12VAC30-120-2010. Transition services.

A. Service description. "Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, which may include an adult foster home, where the person is directly responsible for his own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.

The individual's transition from an institution to the community shall have a transition coordinator in order to receive EDCD Waiver services or a case manager or health care coordinator if he shall be receiving services through either the HIV/AIDS, IFDDS, MR or Technology Assisted Waivers.

B. Criteria for receipt of services. In order to be provided, transition services shall be prior authorized by DMAS or its designated agent. These services include rent or utility deposits, basic furniture and appliances, health and safety assurances, and other reasonable expenses incurred as part of a transition. For the purposes of transition services, an institution means an ICF/MR, a nursing facility, or a specialized care facility/hospital as defined at 42 CFR 435.1009. Transition services do not apply to an acute care admission to a hospital.

C. Service units and limitations.

1. Services are available for one transition per individual and must be expended within nine months from the date of authorization. The total cost of these services shall not exceed \$5,000, per person lifetime limit coverage of transition costs to residents of nursing facilities, specialized care facility/hospitals, or ICF/MR, who are Medicaid recipients and are able to return to the community. The \$5,000 maximum allowance must be expended within nine months from the date of authorization for transition services. It shall not be available to the individual after that period of time. The DMAS designated fiscal agent shall manage the accounting of the transition service. The transition coordinator for the EDCD Waiver or the case manager or health care coordinator, as appropriate to the

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waiver, shall ensure that the funding spent is reasonable and does not exceed the \$5,000 maximum limit.

2. Allowable costs include, but are not limited to:

a. Security deposits that are required to obtain a lease on an apartment or home;

b. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;

c. Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water;

d. Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;

e. Moving expenses;

f. Fees to obtain a copy of a birth certificate or an identification card or driver's license; and

g. Activities to assess need, arrange for, and procure needed resources.

3. The services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, are clearly identified in the service plan and the person is unable to meet such expense, or when the services cannot be obtained from another source. The expenses do not include monthly rental or mortgage expenses, food, regular utility charges, or household items that are intended for purely diversional/recreational purposes. This service does not include services or items that are covered under other waiver services such as chore, homemaker, environmental modifications and adaptations, or specialized supplies and equipment.

D. Provider requirements. Providers are any retail or wholesale vendor, utilities company, or rental landlord identified to supply the needed transition goods or services to the individual and which accepts a voucher for payment from DMAS or its designated agent.

DOCUMENTS INCORPORATED BY REFERENCE

Mental Retardation: Definition, Classification, and Systems of Supports, 10th Edition, 2002, American Association on Mental Retardation.

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DMS-IV-TR), 2000, American Psychiatric Association.

Underwriter's Laboratories Safety Standard 1635, Standard for Safety Digital Alarm Communicator System Units, Third Edition; January 31, 1996, with revisions through August 15, 2005.

Underwriter's Laboratories Safety Standard 1637, Standard for Safety Home Health Care Signaling Equipment, Fourth Edition, December 29, 2006.

NOTICE: The forms used in administering the above regulation are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS

Virginia Uniform Assessment Instrument (UAI) (1994).

Consent to Exchange Information, DMAS-20 (rev. 4/03).

Provider Aide/LPN Record Personal/Respite Care, DMAS-90 (rev. 12/02).

LPN Skilled Respite Record, DMAS-90A (eff. 7/05).

Personal Assistant/Companion Timesheet, DMAS-91 (rev. 8/03).

Questionnaire to Assess an Applicant's Ability to Independently Manage Personal Attendant Services in the CD-PAS Waiver or DD Waiver, DMAS-95 Addendum (eff. 8/00).

Medicaid Funded Long-Term Care Service Authorization Form, DMAS-96 (rev. 10/06).

Screening Team Plan of Care for Medicaid-Funded Long Term Care, DMAS-97 (rev. 12/02).

Provider Agency Plan of Care, DMAS-97A (rev. 9/02).

Consumer Directed Services Plan of Care, DMAS-97B (rev. 1/98).

Community-Based Care Recipient Assessment Report, DMAS-99 (rev. 4/03).

Consumer-Directed Personal Attendant Services Recipient Assessment Report, DMAS-99B (rev. 8/03).

MI/MR Level I Supplement for EDCD Waiver Applicants, DMAS-101A (rev. 10/04).

Assessment of Active Treatment Needs for Individuals with MI, MR, or RC Who Request Services under the Elder or Disabled with Consumer-Direction Waivers, DMAS-101B (rev. 10/04).

AIDS Waiver Evaluation Form for Enteral Nutrition, DMAS-116 (6/03).

Patient Information Form, DMAS-122 (rev. ~~4/98~~ 11/07).

Technology Assisted Waiver/EPSTDT Nursing Services Provider Skills Checklist for Individuals Caring for Tracheostomized and/or Ventilator Assisted Children and Adults, DMAS-259.

Home Health Certification and Plan of Care, CMS-485 (rev. 2/94).

IFDDS Waiver Level of Care Eligibility Form (eff. 5/07).

PATIENT INFORMATION

Medicaid ID: _____ Provider Name _____
 Recipient Name: _____ SSN: _____ DOB: _____
 Address: _____

I. Provider Section

Patient Status: (Complete Appropriate Blocks)

Patient admitted to this facility/service on _____ (date)
 Patient discharged or expired on _____ (date)
 Discharged to: Home Hospital Other Facility Expired

Case in need of review/DMAS 122 requested
 Personal Funds Account balance \$ _____ as of _____ (date).
 Patient's income or deductions have changed: _____

Medicaid Per Diem Rate: \$ _____
 Explain/other: _____

Prepared by Name: _____ Title: _____
 Telephone: _____ Fax Number: _____ Date: _____

II. DSS Section

Eligibility Information: (Complete Appropriate Blocks)

Is eligible for full Medicaid services beginning _____ (date)
 Is eligible for QMB Medicaid only Is eligible for Medicare premium payment only.
 Is ineligible for Medicaid services
 * Is ineligible for Medicaid payment of LTC services from _____ to _____
 Has Medicare Part A insurance Has other health insurance Has LTC insurance

III. Patient Pay Information

	MMYY	MMYY	MMYY
Effective Date	_____	_____	_____
Patient Pay Amount	\$ _____	\$ _____	\$ _____

*See Instructions for distribution on this form.

NOTE: Medicaid long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g., the SSA check received in January is used toward the cost of care in January.

Eligibility Worker Name: _____
 Agency Name: _____ FIPS Code: _____
 Telephone: _____ Fax Number: _____ Date: _____

DMAS-122, Revision 11.28.2007

PATIENT INFORMATION
FORM NUMBER: DMAS-122

PURPOSE OF FORM--To allow the local DSS and the nursing facility or Medicaid Community-based Care provider to exchange information regarding:

1. The Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. A change in the patient's level of care;
4. Admission or discharge of a patient to an institution or Medicaid CBC services, or death of a patient;
5. Other information known to the provider that might cause a change in the eligibility status or patient pay amounts.

USE OF FORM--Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each nursing facility or CBC waiver patient at the time initial eligibility is determined or when a Medicaid enrolled recipient enters a nursing facility or CBC services. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in a change in the amount of patient pay or the patient's eligibility status. The local DSS must send an updated form to the provider at least once a year, even if there is no change in patient pay.

The provider must use the form to show admission date, to request a Medicaid eligibility status, Medicaid recipient I.D., and patient pay amount; to notify the local DSS of changes in the patient's circumstances, discharge or death.

NUMBER OF COPIES--Original and one copy for nursing facility patients and original and two copies for CBC patients.

DISTRIBUTION OF COPIES--For nursing facility patients, send the original to the nursing facility. For Medicaid CBC patients, refer to section M1470.800.B2 in order to determine where the original and any copies of this form are sent. Place a copy of the DMAS-122 forms in the eligibility case file. When a period of disqualification for Medicaid payment of LTC services is established for an individual, send a copy of the DMAS-122 to: DMAS, Long-Term Care, Facility and Home Based Services Unit, 600E Broad Street, Richmond, Virginia 23219.

INSTRUCTIONS FOR PREPARATION OF THE FORM--Complete the heading with the name of the nursing home or Medicaid CBC provider, the address, the patient's name, Social Security number, and Medicaid recipient I.D. number.

Section I must be completed by the provider by checking the appropriate boxes or filling in the appropriate lines corresponding to the change or information that is being reported. The individual that is completing the form on behalf of the provider must furnish their name, title, telephone numbers and the date the form was completed.

Section II must be completed by the local DSS by checking the appropriate boxes or filling in the appropriate lines corresponding to the change or information that is being reported. The Eligibility Worker for the local agency must furnish their name, agency name, agency FIPS code, telephone numbers and the date the form was completed.

Section III, Patient Pay Information --To be completed by the local department of social services Eligibility Worker. Enter month and year in which the patient pay amount is effective. Enter the patient pay amount under the appropriate month and year.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

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

Proposed Regulation

Title of Regulation: 18VAC10-20. Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects (amending 18VAC10-20-670, 18VAC10-20-680, 18VAC10-20-790; adding 18VAC10-20-683, 18VAC10-20-687).

Statutory Authority: §§54.1-201, 54.1-404 and 54.1-404.2 of the Code of Virginia.

Public Hearing Information:

March 19, 2008 - 9 a.m. - Department of Professional and Occupational Regulation, 9960 Mayland Drive, Suite 200, Richmond, VA 23233

Public Comments: Public comments may be submitted until May 2, 2008.

Agency Contact: Mark N. Courtney, Executive Director, Department of Professional and Occupational Regulation, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8514, FAX (804) 527-4294, or email apelscidla@dpor.virginia.gov.

Basis: Section 54.1-404.2 of the Code of Virginia mandates that the board promulgate regulations to create a continuing education program for the renewal and reinstatement of architect, professional engineer, and land surveyor licenses.

Purpose: Chapter 683 of the 2006 Acts of Assembly mandates that the board implement a continuing education program for the renewal and reinstatement of architect, professional engineer, and land surveyor licenses. This regulatory action is intended to fulfill the requirements as established by Chapter 683. Such a program should lead to better educated practitioners, which should, thereby, increase the protection of the health, safety and welfare of the public.

Substance: The board is proposing regulations to implement the continuing education program in accordance with the provisions of §54.1-404.2 of the Code of Virginia. Provisions relating to the continuing education requirements (and the criteria for what is acceptable continuing education activity) will be included as well as relevant administrative requirements (certification of completion, retention of records, grounds for disciplinary action, etc.).

Issues: The public and the Commonwealth should be better served as licensed architects, professional engineers, and land

surveyors will have to show compliance with the board's continuing education requirements, which should result in architects, professional engineers, and land surveyors being better educated and, therefore, less of a threat to the public due to inadequate knowledge. However, the cost of complying with the new requirements will most likely be passed on by licensed architects, professional engineers, and land surveyors to their customers.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Chapter 683 of the 2006 Acts of Assembly requires that the Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers, and Landscape Architects (Board) promulgate regulations that "require the completion of the equivalent of 16 hours per biennium of Board-approved continuing education activities as a prerequisite to the renewal or reinstatement of a license issued to an architect, professional engineer, or land surveyor." Furthermore, "The Board shall establish criteria for continuing education activities including, but not limited to (i) content and subject matter; (ii) curriculum; (iii) standards and procedures for the approval of activities, courses, sponsors, and instructors; (iv) methods of instruction for continuing education courses; and (v) the computation of course credit." The Board proposes regulatory amendments to specifically satisfy the above-referenced requirements of Chapter 683.

Result of Analysis. There is insufficient data to accurately compare the magnitude of the benefits versus the costs. Detailed analysis of the benefits and costs can be found in the next section.

Estimated Economic Impact. As addressed above, pursuant to §54.1-404.2 the Board proposes to require architects, professional engineers, and land surveyors to complete at least 16 credit hours of board-approved continuing education activities for any license renewal or reinstatement. Currently the Board's regulations do not require any continuing education. The proposed regulations state that "Continuing education activities must be related to practice of the profession of the license being renewed, have a clear purpose and objective which will maintain, improve, or expand the skills and knowledge relevant to the licensee's area of practice..."

According to the Department of Professional and Occupational Regulation, the typical cost of continuing education for architects, professional engineers, and land surveyors ranges from \$30 to \$90 per course hour or approximately \$480 to \$1,440 every two years for 16 hours. Internet coursework could qualify for credit if it meets all other requirements;¹ thus, licensees do not necessarily need to incur travel costs to obtain continuing education.

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Time has value for architects, professional engineers, and land surveyors. Thus, in addition to incurring fees, these professionals also incur the cost of up to 16 hours of their time. The mean hourly earnings for architects, professional engineers, and land surveyors in Virginia are \$34.32, \$39.12 and \$22.38, respectively.² Assuming that the value of a licensee's time is equal to her mean hourly wage, then for those who would not have otherwise acquired any continuing education credits, satisfying the 16 hour requirement will cost \$549.12, \$625.92, and \$358.08 for architects, professional engineers, and land surveyors, respectively.

Therefore, for licensees who without the proposed requirement would not participate in any continuing competency activity and who seek to minimize fees and travel costs, compliance will cost approximately \$1029,³ \$1106,⁴ and \$838,⁵ respectively, for architects, professional engineers, and land surveyors. If the Board approves less than 16 hours of Internet courses for any of these professions, then travel costs would need to be added to these estimates. The costs will be proportionately less for those who would have acquired some continuing education credits without the proposed requirement.

The benefit of the proposed continuing competency activity requirement is more difficult to estimate than the cost. Since the continuing competency hours must be spent on field-related topics and have a clear purpose and objective which will maintain, improve, or expand the skills and knowledge relevant to the licensee's area of practice, licensees who participate likely gain some useful knowledge. Nevertheless, the amount of useful field-related knowledge that is gained, i.e., not already known by the licensees, is not obvious. Since the proposed requirement only affects those professionals who would not otherwise have acquired 16 hours of continuing education, those affected implicitly judge that the benefit of the additional continuing education does not exceed the costs. For the total benefit to exceed the total cost overall, there must be significant benefit generated for the outside public (direct clients, people who drive across bridges, etc) by having the professionals participate in the additional continuing education. There are no estimates of the magnitude of this potential benefit available.

Businesses and Entities Affected. The proposed amendments affect the 24,561 professional engineers, 6,673 architects, and 1,438 land surveyors licensed to practice in the Commonwealth, as well as their employers and clients.⁶ Virginia Employment Commission Quarterly Census of Employment and Wages data indicate that 3,803 firms listed under Architectural and Engineering Services (which includes land surveyors) qualified as small businesses. Other small firms, such as small manufacturers for example, mining companies, may employ professional engineers, architects, or land surveyors as well.

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

Projected Impact on Employment. The proposal to require 16 hours of continuing education for architects, professional engineers, and land surveyors will likely have some positive impact on employment for suppliers of continuing education to these professions. The extent of the positive impact depends on how much voluntary continuing education architects, professional engineers, and land surveyors participate in without the requirement. If many of these professionals participate in substantial continuing education with or without the requirement, then the establishment of the requirement will only produce a moderate increase in employment hours for suppliers of continuing education. If a large percentage of architects, professional engineers, and land surveyors would not participate in close to 16 hours or more of continuing education without the requirement, then the proposed requirement will produce more than a moderate increase in employment hours for suppliers of continuing education. Current data is not available on continuing education participation rates.

Effects on the Use and Value of Private Property. The proposal to require architects, professional engineers, and land surveyors to complete at least sixteen continuing education credit hours of board-approved continuing education activities each two-year licensure period will increase costs for those professionals who do not already voluntarily meet this requirement. Presuming that the affected professionals find continuing education activities that have positive value, the net loss to the value of these individuals and their employers will be less than the total fee and time cost associated with the activities.

Suppliers of continuing education will encounter increased demand for their services. Consequently, the value of firms supplying continuing education for architects, professional engineers, and land surveyors will likely rise.

Small Businesses: Costs and Other Effects. The proposed requirement that architects, professional engineers, and land surveyors complete at least sixteen credit hours of board-approved continuing education activities for any license renewal or reinstatement adds fees and time costs for architecture, engineering, and land surveying firms whose employees licensed in these fields do not already acquire 16 hours of continuing education every two years. Other small business which employ architects, professional engineers, or land surveyors are affected as well.

Small Businesses: Alternative Method that Minimizes Adverse Impact. Since the requirement that architects, professional engineers, and land surveyors complete at least sixteen continuing education credit hours of board-approved continuing education activities is pursuant to Chapter 683 of the 2006 Acts of Assembly, there are no alternative methods that minimize adverse impact to small business.

Real Estate Development Costs. By adding to the costs for architecture, engineering, and land surveying firms, the proposed amendments may moderately add to real estate development costs.

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with §2.2-4007.04 of the Administrative Process Act and Executive Order Number 36 (06). Section 2.2-4007.04 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. Further, if the proposed regulation has adverse effect on small businesses, §2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

¹ Source: Department of Professional and Occupational Regulation

² Source: U.S. Department of Labor, Bureau of Labor Statistics, 2006 State Occupational Employment and Wage Estimates. The figure for professional engineers is a weighted (by employment) average of the mean hourly earnings for the several different varieties of engineers listed.

³ Calculation: \$480 (course fees) + \$34.32 (value of one hour of time) x 16 = \$1029.12

⁴ Calculation: \$480 (course fees) + \$39.12 (value of one hour of time) x 16 = \$1105.92

⁵ Calculation: \$480 (course fees) + \$22.38 (value of one hour of time) x 16 = \$838.08

⁶ Number source: Department of Professional and Occupational Regulation

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: Concur with the approval.

Summary:

The proposed amendments establish a continuing education program to require the equivalent of 16 hours per biennium of board-approved continuing education activities for the renewal or reinstatement of architect, professional engineer, and land surveyor licenses. The proposed changes are intended to fulfill the requirements of Chapter 683 of the 2006 Acts of Assembly.

Part XI
Renewal and Reinstatement

18VAC10-20-670. Expiration and renewal.

A. Prior to the expiration date shown on the license, certificate or registration, licenses, certificates or registrations shall be renewed for a two-year period upon completion of a renewal application and payment of a fee established by the board. ~~An applicant must certify continued compliance with the Standards of Practice and Conduct as established by the board.~~ Registrations for professional corporations, professional limited liability companies and business entities shall expire on December 31 of each odd-numbered year. Branch office registrations expire the last day of February of each even-numbered year. If the renewal fee for a branch office is not received by the board within 30 days following the expiration date noted on the registration, a reinstatement fee of \$25 will be required in addition to the renewal fee. Branch offices may not renew until the main office registration is properly renewed.

B. Failure to receive a renewal notice and application shall not relieve the regulant of the responsibility to renew. If the regulant fails to receive the renewal notice, a copy of the license, certificate or registration may be submitted with the required fee as an application for renewal, ~~accompanied by a signed statement indicating that the applicant continues to comply with the Standards of Practice and Conduct of the board under whose authority the license, certificate or registration is issued.~~

C. By submitting the renewal fee, an applicant for renewal is certifying continued compliance with the Standards of Practice and Conduct as established by the board. In addition, by submitting the renewal fee, applicants to renew a license are certifying that they comply with the continuing education requirements as contained in this chapter.

D. Board discretion to deny renewal. The board may deny renewal of a license, certificate or registration for the same reasons as it may refuse initial licensure, certification or registration or discipline a regulant or for noncompliance with the continuing education requirements as contained in this chapter.

~~D. E.~~ If the renewal fee is not received by the board within 30 days following the expiration date noted on the license, certificate or registration, a late renewal fee equal to the regular fee plus \$25 shall be required, unless a reinstatement fee is otherwise noted.

18VAC10-20-680. Reinstatement.

A. If the license, certificate or registration has expired for six months or more, but less than five years, the regulant shall be required to submit a reinstatement application, which shall be evaluated by the board to determine if the applicant meets the renewal requirements. In addition, a reinstatement fee

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equal to the regular renewal fee plus \$100 shall be required. In addition, individual license holders applying for reinstatement are required to provide evidence of compliance with the continuing education requirements as contained in this chapter.

B. If the license, certificate or registration has expired for five years or more, an application for reinstatement shall be required, which shall be evaluated by the board to determine if the applicant remains qualified to be a regulant of the board, and a reinstatement fee equal to the regular renewal fee plus \$250 shall be submitted. In addition, the board may require an individual applicant to submit to an examination. In addition, individual license holders applying for reinstatement are required to provide evidence of compliance with the continuing education requirements as contained in this chapter.

C. Board discretion to deny reinstatement. The board may deny reinstatement of a license, certificate or registration for the same reasons as it may refuse initial licensure, certification or registration or discipline a regulant or for noncompliance with the continuing education requirements as contained in this chapter.

D. The date the renewal application and fee are received in the office of the board shall determine whether a license, certificate or registration shall be renewed without late renewal or reinstatement, or shall be subject to reinstatement application procedures.

E. A license, certificate or registration that is reinstated shall be regarded as having been continuously licensed, certified or registered without interruption. Therefore, the license, certificate or registration holder who is not subject to the licensure for life provisions of §54.1-405 of the Code of Virginia shall remain under the disciplinary authority of the board during the entire period and shall be accountable for his activities during the period. A license, certificate or registration that is not reinstated and is not subject to the licensure for life provisions of §54.1-405 of the Code of Virginia shall be regarded as unlicensed, uncertified or unregistered from the expiration date forward. Nothing in this chapter shall divest the board of its authority to discipline a license, certificate or registration holder for a violation of the law or regulation during the period of time for which the regulant was licensed, certified or registered.

Part XII

Standards of Practice and Conduct

18VAC10-20-683. Continuing education requirements for renewal or reinstatement.

A. Individuals whose licenses expire or who apply to reinstate after (insert date - 12 months after the effective date of these regulations) shall be required to comply with the continuing education provisions of this chapter.

B. Individuals are required to complete at least 16 continuing education credit hours of board-approved continuing education activities for any license renewal or reinstatement.

C. Continuing education activities shall be deemed to be approved provided the following criteria are met:

1. Content and subject matter. Continuing education activities must be related to practice of the profession of the license being renewed, have a clear purpose and objective that will maintain, improve, or expand the skills and knowledge relevant to the licensee's area of practice as defined in Chapter 4 (§54.1-400 et seq.) of Title 54.1 of the Code of Virginia. The required continuing education credit hours may be in areas related to business practices, including project management, risk management, and ethics, which have demonstrated relevance to the licensee's area of practice as defined in Chapter 4 of Title 54.1 of the Code of Virginia.

2. Curriculum. The curriculum of the continuing education activity must be consistent with the purpose and objective of the continuing education activity.

3. Sponsors and instructors. Sponsors of continuing education activities must have sufficient resources to provide the continuing education activity and documentation of completion of the continuing education activity to those individuals who successfully complete the continuing education activity. Course instructors must be competent in the subject being taught, either by education or experience.

4. Methods of instruction for continuing education courses. The method of instruction must be consistent with the purpose and objective of the continuing education activity.

5. Computation of credit.

a. Fifty contact minutes shall equal one continuing education credit hour. For a continuing education course or activity in which individual segments are less than 50 minutes, the sum of the segments shall be totaled for computation of continuing education credit hours for that continuing education course or activity.

b. The sponsor of the continuing education activity must have predetermined the number of continuing education credit hours that an activity shall take to complete. A licensee cannot claim credit for more than the predetermined number of continuing education credit hours if the licensee took more than the predetermined number of hours to complete the continuing education activity.

c. One semester credit hour of approved college credit shall equal 15 continuing education credit hours and one quarter credit hour of approved college credit shall equal 10 continuing education credit hours.

d. For self-directed continuing education activity, there must be an assessment by the sponsor at the conclusion of the activity to verify that the individual has achieved the purpose and objective of the continuing education activity; credit will not be awarded if the individual has not successfully achieved the purpose and objective of the continuing education activity based upon the results of the assessment.

e. A licensee may be granted credit for the initial development or substantial updating of a continuing education activity or his initial teaching of a course that otherwise meets the requirements of this chapter at twice the amount of credit that students of the course or activity would receive. Additional credit for subsequent offerings of the course or activity with the same content will not be permitted.

f. A licensee will not receive credit for completing the same continuing education activity with the same content more than once during the license period immediately prior to the expiration date of the license for renewal or during the two years immediately prior to the date of receipt of a complete reinstatement application.

D. 1. Only continuing education activities completed during the license period immediately prior to the expiration date of the license shall be acceptable in order to renew the license. Continuing education activities utilized to satisfy the continuing education requirements to renew a license shall be valid only for that renewal and shall not be accepted for any subsequent renewal cycles or reinstatement of that license.

2. Individuals shall maintain records of completion of continuing education activities that comply with the requirements of this chapter for three years from the date of expiration of the license for which the continuing education activities are being used to renew the license. Individuals shall provide such records to the board or its duly authorized agents upon request.

E. Notwithstanding the provisions of subsection D of this section, continuing education activities completed during a licensing renewal cycle to satisfy the continuing education requirements of the preceding licensing renewal cycle shall be valid only for that preceding license renewal cycle and shall not be accepted for any subsequent renewal cycles or reinstatement.

F. 1. Each individual license holder applying for reinstatement shall provide, as part of his reinstatement application, evidence of compliance with the continuing education requirements of this chapter. The completion date of continuing education activities submitted in support of a reinstatement application shall not be more than two years old as of the date a complete reinstatement application is received by the board.

2. Continuing education activities utilized to satisfy the continuing education requirements in order to reinstate a license shall be valid only for that reinstatement and shall not be accepted for any subsequent renewal cycles or reinstatement.

G. Periodically, the board may conduct a random audit of its licensees who have applied for renewal to determine compliance. Licensees who are selected for audit shall provide all documentation of all continuing education activities utilized to renew their license within 21 calendar days of receiving notification of audit.

18VAC10-20-687. Exemptions and waivers.

Pursuant to §54.1-404.2 of the Code of Virginia, the board may grant exemptions or waive or reduce the number of continuing education activities required in cases of certified illness or undue hardship. However, such exemptions, waivers, or reductions shall not relieve the individual of their obligation to comply with any other requirements of this chapter including, but not limited to, the provisions of 18VAC10-20-670, 18VAC10-20-680, or 18VAC10-20-683.

18VAC10-20-790. Sanctions.

A. No license, certificate, or registration shall be suspended or revoked, nor shall any regulant be fined unless a majority of the members of the entire board who are eligible to vote, vote for the action. The board may ~~suspend or revoke~~ discipline or sanction, or both, any license holder, certificate holder, or the holder of a certificate of authority or registration, ~~or fine any regulant,~~ if the board finds that:

1. The license, certification or registration was obtained or renewed through fraud or misrepresentation;
2. The regulant has been found guilty by the board, or by a court of competent jurisdiction, of any material misrepresentation in the course of professional practice, or has been convicted, pleaded guilty or found guilty, regardless of adjudication or deferred adjudication, of any felony or misdemeanor which, in the judgment of the board, adversely affects the regulant's ability to perform satisfactorily within the regulated discipline. Any plea of nolo contendere shall be considered a conviction for the purposes of this chapter;
3. The regulant is guilty of professional incompetence, negligence, or gross negligence;
4. The regulant has abused drugs or alcohol to the extent that professional competence is adversely affected;
5. The licensee fails to comply, or misrepresents any information pertaining to their compliance, with any of the continuing education requirements as contained in this chapter;

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6. The regulant violates any standard of practice and conduct, as defined in this chapter; or

6- 7. The regulant violates or induces others to violate any provision of Chapters 1 through 4 of Title 54.1 or Chapters 7 and 13 of Title 13.1 of the Code of Virginia, or any other statute applicable to the practice of the professions herein regulated, or any provision of this chapter.

B. If evidence is furnished to the board which creates doubt as to the competency of a regulant to perform professional assignments, the board may require the regulant to prove competence by interview, presentation or examination. Failure to appear before the board, pass an examination, or otherwise demonstrate competency to the board shall be grounds for revocation or suspension of the license, certification or registration.

VA.R. Doc. No. R07-135; Filed February 11, 2008, 2:59 p.m.

BOARD OF NURSING

Final Regulation

Title of Regulation: 18VAC90-20. Regulations Governing the Practice of Nursing (amending 18VAC90-20-10, 18VAC90-20-35, 18VAC90-20-40 through 18VAC90-20-70, 18VAC90-20-90, 18VAC90-20-95, 18VAC90-20-110 through 18VAC90-20-140, 18VAC90-20-160, 18VAC90-20-190, 18VAC90-20-200, 18VAC90-20-220, 18VAC90-20-230, 18VAC90-20-275, 18VAC90-20-280, 18VAC90-20-300, 18VAC90-20-370, 18VAC90-20-390, 18VAC90-20-410; adding 18VAC90-20-96, 18VAC90-20-151; repealing 18VAC90-20-65).

Statutory Authority: §§54.1-2400 and 54.1-3005 of the Code of Virginia.

Effective Date: April 2, 2008.

Agency Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone 804-367-4515, FAX 804-527-4455, or email jay.douglas@dhp.virginia.gov.

Summary:

The amendments provide more specificity to the requirements for nursing education programs, add an application fee for program approval, set a minimum NCLEX passage rate for approved programs and a minimum number of clinical hours, clarify the responsibilities in the clinical practice of students, provide additional grounds for disciplinary action to address issues relating to unprofessional conduct for nurses, and increase the number of hours for an approved medication administration program from 24 to 32.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's

response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

18VAC90-20-10. Definitions.

In addition to words and terms defined in §54.1-3030 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Accreditation" means having been accredited by the National League for Nursing Accrediting Commission (NLNAC) or by the Commission on Collegiate Nursing Education (CCNE).

"Approval" means the process by which the board or a governmental agency in another state or foreign country evaluates and grants official recognition to nursing education programs that meet established standards not inconsistent with Virginia law.

"Associate degree nursing program" means a nursing education program preparing for registered nurse licensure, offered by a Virginia college or other institution and designed to lead to an associate degree in nursing, provided that the institution is authorized to confer such degree by the State Council of Higher Education.

"Baccalaureate degree nursing program" means a nursing education program preparing for registered nurse licensure, offered by a Virginia college or university and designed to lead to a baccalaureate degree with a major in nursing, provided that the institution is authorized to confer such degree by the State Council of Higher Education.

"Board" means the Board of Nursing.

~~"Clinical nurse specialist" means a licensed registered nurse who holds:~~

~~1. A master's degree from a board approved program which prepares the nurse to provide advanced clinical nursing services; and~~

~~2. Specialty certification from a national certifying organization acceptable to the board or an exception available from March 1, 1990, to July 1, 1990.~~

"Clinical setting" means any location in which the clinical practice of nursing occurs as specified in an agreement between the cooperating agency and the school of nursing.

"Conditional approval" means a time-limited status which results when an approved nursing education program has failed to maintain requirements as set forth in Article 2 (18VAC90-20-70 et seq.) of Part II of this chapter.

"Cooperating agency" means an agency or institution that enters into a written agreement to provide learning experiences for a nursing education program.

"Diploma nursing program" means a nursing education program preparing for registered nurse licensure, offered by a hospital and designed to lead to a diploma in nursing, provided the hospital is licensed in this state.

"NCLEX" means the National Council Licensing Examination.

"NCSBN" means the National Council of State Boards of Nursing.

"National certifying organization" means an organization that has as one of its purposes the certification of a specialty in nursing based on an examination attesting to the knowledge of the nurse for practice in the specialty area and is accredited by a national body recognized by NCSBN.

"Nursing education program" means an entity offering a basic course of study preparing persons for licensure as registered nurses or as licensed practical nurses. A basic course of study shall include all courses required for the degree, diploma or certificate.

"Nursing faculty" means registered nurses who teach the practice of nursing in nursing education programs.

"Practical nursing program" means a nursing education program preparing for practical nurse licensure that leads to a diploma or certificate in practical nursing, provided the school is authorized by the Virginia State Board of Education or the appropriate governmental credentialing agency.

"Preceptor" means a licensed health care provider who is employed in the clinical setting, serves as a resource person and role model, and is present with the nursing student in that setting.

"Primary state of residence" means the state of a person's declared fixed permanent and principal home or domicile for legal purposes.

"Program director" means a registered nurse who holds a current, unrestricted license in Virginia or a multistate licensure privilege and who has been designated by the controlling authority to administer the nursing education program.

"Provisional approval" means the initial status granted to a nursing education program which shall continue until the first class has graduated and the board has taken final action on the application for approval.

"Recommendation" means a guide to actions that will assist an institution to improve and develop its nursing education program.

"Requirement" means a mandatory condition that a nursing education program must meet to be approved.

18VAC90-20-35. Identification; accuracy of records.

A. Any person regulated by this chapter who provides direct patient care shall, while on duty, wear identification ~~which~~ that is clearly visible and indicates the person's first and last name and the appropriate title for the license, certification, or registration issued to such person by the board under which he is practicing in that setting.

B. A licensee who has changed his name shall submit as legal proof to the board a copy of the marriage certificate or court order evidencing the change. A duplicate license shall be issued by the board upon receipt of such evidence and the required fee.

C. Each licensee shall maintain a record of his current mailing address with the board, and any change of address by a licensee shall be submitted in writing to the board within 30 days of such change. All notices required by law and by this chapter to be mailed by the board to any licensee shall be validly given when mailed to the latest address on file with the board.

18VAC90-20-40. Application.

A. An institution wishing to establish a nursing education program shall:

1. Submit to the board, at least 12 months in advance of expected opening date, a statement of intent to establish a nursing education program along with an application fee of \$1,200.
2. Submit to the board evidence documenting adequate resources for the projected number of students and the ability to provide a program that can meet the requirements of Article 2 (18VAC90-20-70 et seq.) of this part to include the following information:
 - a. Organizational structure of the institution and relationship of nursing program therein;
 - b. Purpose and type of program;
 - c. Availability of qualified faculty sufficient to provide classroom instruction and clinical supervision for the number of students specified by the program;
 - d. Budgeted faculty positions sufficient in number to provide classroom instruction and clinical supervision;
 - e. Availability of clinical training facilities for the program as evidenced by ~~letters of support indicating a willingness and the ability to provide a clinical site for training~~ copies of contracts or letters of agreement specifying the responsibilities of the respective parties and indicating sufficient availability of clinical experiences for the number of students in the program;
 - f. Availability of academic facilities for the program, including classrooms, laboratory, and library;

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g. Evidence of financial resources for the planning, implementation and continuation of the program with budget projections for three years; ~~and~~

h. Tentative time schedule for planning and initiating the program; and

i. An enrollment plan specifying the beginning dates and number of students for each class for a two-year period from the date of initial approval.

3. Respond to the board's request for additional information.

B. A site visit may be conducted by a representative of the board.

C. The Education Special Conference Committee (the "committee"), ~~comprised~~ composed of not less than two members of the board, shall, in accordance with §2.2-4019 of the Code of Virginia, receive and review applications and the report of the site visit and shall make recommendations to the board regarding the granting or denial of approval of the program application.

1. If the board accepts the recommendation to approve the program application, the institution may apply for provisional approval of the nursing education program as set forth in this chapter.

2. If the committee recommendation is to deny approval of the program application, no further action will be required of the board unless the program requests a hearing before the board or a panel thereof in accordance with §2.2-4020 and subdivision 9 of §54.1-2400 of the Code of Virginia.

18VAC90-20-50. Provisional approval.

A. The application for provisional approval shall be complete when the following conditions are met:

1. A program director has been appointed, and there are sufficient faculty to initiate the program as required in 18VAC90-20-90; and

2. A written curriculum plan developed in accordance with 18VAC90-20-120 has been submitted.

B. The committee shall, in accordance with §2.2-4019 of the Code of Virginia, make recommendations to the board ~~for the~~ to grant or denial of deny provisional approval.

1. If provisional approval is granted:

a. The admission of students is authorized; and

b. The program director shall submit quarterly progress reports to the board which shall include evidence of progress toward ~~application for program~~ approval and other information as required by the board.

2. If the committee recommendation is to deny provisional approval, no further action will be required of the board

unless the program requests a hearing before the board or a panel thereof in accordance with §2.2-4020 and subdivision 9 of §54.1-2400 of the Code of Virginia.

18VAC90-20-60. Program approval.

A. The application for approval shall be complete when:

1. A self-evaluation report of compliance with Article 2 (18VAC90-20-70 et seq.) of this part has been submitted;

2. The first graduating class has taken the licensure examination, and the cumulative passing rate for the program's first-time test takers taking the NCLEX over the first four quarters following graduation of the first class is not less than 80%; and

3. A satisfactory survey visit and report has been made by a representative of the board verifying that the program is in compliance with all requirements for program approval.

B. The committee shall, in accordance with §2.2-4019 of the Code of Virginia, receive and review the self-evaluation, the NCLEX results and survey reports and shall make a recommendation to the board for the granting or denial of approval or for continuance of provisional approval.

C. If the committee's recommendation is to deny approval, no further action will be required of the board unless the program requests a hearing before the board or a panel thereof in accordance with §2.2-4020 ~~and subdivision 11 of §54.1-2400~~ of the Code of Virginia.

18VAC90-20-65. Continued approval. (Repealed.)

~~For the purpose of continued approval of a program, the board may accept evidence of accreditation by a nursing education accrediting body recognized by the U.S. Department of Education.~~

Article 2

Requirements for Initial and Continued Approval

18VAC90-20-70. Organization and administration.

A. The governing or parent institution offering nursing education programs shall be approved or accredited by the appropriate state agencies or by an accrediting agency recognized by the United States Department of Education.

B. Any agency or institution used for clinical experience by a nursing education program shall be in good standing with its licensing body.

C. The director of the nursing education program shall ~~be~~ hold an unencumbered license as a registered nurse licensed or a multistate licensure privilege to practice nursing in the Commonwealth, with the additional education and experience necessary to administer, plan, implement and evaluate the nursing education program. The program shall provide evidence that the director has authority to:

1. Implement the program and curriculum;

2. Oversee the admission, academic progression and graduation of students;

3. Hire and evaluate faculty; and

4. Recommend and administer the program budget, consistent with established policies of the controlling agency.

D. An organizational plan shall indicate the lines of authority and communication of the nursing education program to the controlling body; to other departments within the controlling institution; to the cooperating agencies; and to the advisory committee, if one exists.

E. There shall be evidence of financial support and resources sufficient to meet the goals of the nursing education program. ~~The program director of the nursing education program shall be responsible for the budget recommendations and administration, consistent with the established policies of the controlling agency.~~

18VAC90-20-90. Faculty.

A. Qualifications.

1. Every member of the nursing faculty, including the program director, shall hold a current, unencumbered license to practice as a registered nurse or a multistate licensure privilege to practice nursing in Virginia. Persons providing instruction in topics other than nursing shall not be required to hold a license as a registered nurse.

2. Every member of a nursing faculty supervising the clinical practice of students shall meet the licensure requirements of the jurisdiction in which that practice occurs.

3. The program director and each member of the nursing faculty shall maintain professional competence through such activities as nursing practice, continuing education programs, conferences, workshops, seminars, academic courses, research projects and professional writing.

4. For baccalaureate degree programs:

a. The program director shall hold a doctoral degree.

b. Every member of the nursing faculty shall hold a graduate degree. Faculty members with a graduate degree with a major other than in nursing shall have a baccalaureate degree with a major in nursing.

5. For associate degree and diploma programs:

a. The program director shall hold a graduate degree, preferably with a major in nursing.

b. The majority of the members of the nursing faculty shall hold a graduate degree, preferably with a major in nursing.

c. Other members of the nursing faculty shall hold a baccalaureate degree, preferably with a major in nursing.

6. For practical nursing programs:

a. The program director shall hold a baccalaureate degree, preferably with a major in nursing.

b. The majority of the members of the nursing faculty shall hold a baccalaureate degree, preferably with a major in nursing.

7. Exceptions to provisions of subdivisions 4, 5, and 6 of this subsection shall be by board approval.

a. Initial request for exception.

(1) The program director shall submit a request for initial exception in writing for consideration ~~at a regular board meeting~~ prior to the term academic year during which the nursing faculty member is scheduled to teach or whenever an unexpected vacancy has occurred.

(2) A description of teaching assignment, a curriculum vitae, and a statement of intent from the prospective faculty member to pursue the required degree shall accompany each request.

b. Request for continuing exception.

(1) Continuing exception will be based on the progress of the nursing faculty member toward meeting the degree required by this chapter during each year for which the exception is requested.

(2) The program director shall submit the request for continuing exception in writing ~~for consideration at a regular board meeting~~ prior to the next term academic year during which the nursing faculty member is scheduled to teach.

(3) A list of courses required for the degree being pursued and college transcripts showing successful completion of a minimum of two of the courses during the past academic year shall accompany each request.

(4) Any request for continuing exception shall be considered by the committee, which shall make a recommendation to the board.

c. The executive director of the board shall be authorized to make the initial decision on requests for exceptions. Any appeal of that decision shall be in accordance with the provisions of the Administrative Process Act (~~§9-6.14.1~~ (§2.2-4000 et seq. of the Code of Virginia)

B. Number.

1. The number of faculty shall be sufficient to prepare the students to achieve the objectives of the educational program and to ensure safety for patients to whom students provide care.

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2. When students are giving direct care to patients, the ratio of students to faculty shall not exceed 10 students to one faculty member, and the faculty shall be on site solely to supervise students.

3. When preceptors are utilized for specified learning experiences in clinical settings, ~~the ratio shall not exceed 15 students to one faculty member~~ may supervise up to 15 students.

C. Functions. The principal functions of the faculty shall be to:

1. Develop, implement and evaluate the philosophy and objectives of the nursing education program;
2. Design, implement, teach, evaluate and revise the curriculum;
3. Develop and evaluate student admission, progression, retention and graduation policies within the framework of the controlling institution;
4. Participate in academic advisement and counseling of students;
5. Provide opportunities for student and graduate evaluation of curriculum and teaching and program effectiveness; and
6. Document actions taken in faculty and committee meetings.

18VAC90-20-95. Preceptorships.

A. Clinical preceptors may be used to augment the faculty and enhance the clinical learning experience. The clinical preceptor shall be licensed at or above the level for which the student is preparing.

B. When giving direct care to patients, students shall be supervised by faculty or preceptors as designated by faculty. In utilizing preceptors to supervise students, the ratio shall not exceed two students to one preceptor at any given time.

C. Faculty shall be responsible for the designation of a preceptor for each student and shall communicate such assignment with the preceptor. A preceptor may not further delegate the duties of the preceptorship.

~~C.~~ D. Preceptorships shall include:

1. Written objectives, methodology, and evaluation procedures for a specified period of time;
2. An orientation program for faculty, preceptors, and students;
3. The performance of skills for which the student has had faculty-supervised clinical and didactic preparation; and
4. The overall coordination by faculty who assume ultimate responsibility for implementation, periodic monitoring, and evaluation.

18VAC90-20-96. Clinical practice of students.

A. In accordance with §54.1-3001 of the Code of Virginia, a nursing student, while enrolled in an approved nursing program, may perform tasks that would constitute the practice of nursing. The student shall be responsible and accountable for the safe performance of those direct patient care tasks to which he has been assigned.

B. Faculty members or preceptors providing supervision in the clinical care of patients shall be responsible and accountable for the assignment of patients and tasks based on their assessment and evaluation of the student's clinical knowledge and skills. Supervisors shall also monitor clinical performance and intervene if necessary for the safety and protection of the patients.

18VAC90-20-110. School records; student records; school bulletin or catalogue.

A. A system of records shall be maintained and be made available to the board representative and shall include:

1. Data relating to accreditation by any agency or body.
2. Course outlines.
3. Minutes of faculty and committee meetings.

B. A file shall be maintained for each student. Each file shall be available to the board representative and shall include the student's:

1. Application;
2. High school transcript or copy of high school equivalence certificate; and
3. Current record of achievement.

A final transcript shall be retained in the permanent file of the institution.

Provision shall be made for the protection of student and graduate records against loss, destruction and unauthorized use.

C. Current information about the nursing education program shall be published periodically and distributed to students, applicants for admission and the board. Such information shall include:

1. Description of the program.
2. Philosophy and objectives of the controlling institution and of the nursing program.
3. Admission and graduation requirements.
4. Fees.
5. Expenses.
6. Financial aid.
7. Tuition refund policy.

8. Education facilities.
9. Student activities and services.
10. Curriculum plan.
11. Course descriptions.
12. Faculty-staff roster.
13. School calendar.
14. Annual passage rates on NCLEX for the past five years.

18VAC90-20-120. Curriculum.

A. Curriculum shall reflect the philosophy and objectives of the nursing education program and shall be consistent with the law governing the practice of nursing.

B. Nursing education programs preparing for ~~practical~~ nursing licensure shall include:

- ~~1. Principles and practice~~ Didactic content and supervised clinical experience in nursing encompassing the attainment and maintenance of physical and mental health and the prevention of illness for individuals and groups throughout the life cycle and in a variety of clinical settings;
- ~~2. Basic concepts~~ Concepts of the nursing process that include conducting a focused nursing assessment of the client status that includes decision making about who and when to inform, identifying client needs, planning for episodic nursing care, implementing appropriate aspects of client care, and contributing to data collection and the evaluation of client outcomes;
- ~~3. Basic concepts~~ Concepts of anatomy, physiology, chemistry ~~and~~ microbiology and the behavioral sciences;
- ~~4. Basic concepts~~ Concepts of communication, growth and development, interpersonal relations, and patient education ~~and cultural diversity, including:~~
 - a. Development of professional socialization that includes working in interdisciplinary teams; and
 - b. Conflict resolution;
- ~~5. Basic concepts~~ Concepts of ethics and the vocational and legal aspects of nursing, including:
 - a. Regulations and sections of the Code of Virginia related to nursing;
 - b. Patient rights; ~~and~~
 - c. Prevention of patient abuse, neglect and abandonment; ~~and~~
 - d. Professional responsibility; and
 - e. History and trends in nursing and health care;

~~6. Basic concepts~~ Concepts of pharmacology, nutrition and diet therapy;

~~7. Concepts of client-centered care, including:~~

- a. Respect for cultural differences, values, preferences and expressed needs;
- b. Promotion of healthy life styles for clients and populations;
- c. Promotion of a safe client environment; and
- d. Prevention and appropriate response to situations of bioterrorism and domestic violence; and

~~8. Development of management and supervisory skills.~~

C. ~~Nursing~~ In addition to meeting curriculum requirements set forth in subsection B of this section, nursing education programs preparing for registered nurse licensure shall also include:

- ~~1. Theory and practice in nursing, encompassing the attainment and maintenance of physical and mental health and the prevention of illness throughout the life cycle for individuals, groups and communities;~~
 - ~~2. Concepts of the nursing process;~~
 - ~~3. Concepts of anatomy, physiology, chemistry, and microbiology;~~
 - ~~4. Sociology, psychology, communications, growth and development, interpersonal relations, group dynamics, cultural diversity and humanities;~~
 - ~~5. Concepts of pharmacology, nutrition and diet therapy, and pathophysiology;~~
 - ~~6. Concepts of ethics, and the professional and legal aspects of nursing, including:~~
 - ~~a. Regulations and sections of the Code of Virginia related to nursing;~~
 - ~~b. Patient rights; and~~
 - ~~c. Prevention of patient abuse, neglect and abandonment.~~
 - ~~7. Concepts of leadership, delegation, management and patient education.~~
1. Didactic content and supervised clinical experiences in conducting a comprehensive nursing assessment that includes:
- a. Extensive data collection, both initial and ongoing, for individuals, families, groups, and communities addressing anticipated changes in client conditions as well as emerging changes in a client's health status;
 - b. Recognition of alterations to previous client conditions;

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c. Synthesizing the biological, psychological and social aspects of the client's condition;

d. Evaluation of the effectiveness and impact of nursing care;

e. Planning for nursing interventions and evaluating the need for different interventions for individuals, groups and communities;

f. Evaluation and implementation of the need to communicate and consult with other health team members; and

g. Use of a broad and complete analysis to make independent decisions and nursing diagnoses;

2. Didactic content and supervised experiences in:

a. Development of clinical judgment;

b. Development of leadership skills and knowledge of the rules and principles for delegation of nursing tasks;

c. Involvement of clients in decision making and a plan of care;

d. Participation in quality improvement processes to measure client outcomes and identify hazards and errors;

3. Concepts of pathophysiology; and

4. Principles of delegation of nursing tasks to unlicensed persons.

D. On and after July 1, 2007, all nursing education programs shall provide instruction in child abuse recognition and intervention.

E. A nursing education program preparing for licensure as a practical nurse shall provide a minimum of 400 hours of direct client care supervised by qualified faculty. A nursing education program preparing for licensure as a registered nurse shall provide a minimum of 500 hours of direct client care supervised by qualified faculty.

18VAC90-20-130. Resources, facilities and services.

A. Periodic evaluations of resources, facilities and services shall be conducted by the administration, faculty, students and graduates of the nursing education program.

B. Secretarial and other support services shall be provided.

C. Classrooms, conference rooms, laboratories, clinical facilities and offices shall be ~~available~~ sufficient to meet the objectives of the nursing education program and the needs of the students, faculty, administration and staff.

D. The ~~library~~ program shall have learning resources that are current, pertinent and accessible to students and faculty, and sufficient ~~in number~~ to meet the needs of the students and faculty.

E. Written agreements with cooperating agencies shall be developed, maintained and periodically reviewed. The agreement shall:

1. Ensure full control of student education by the faculty of the nursing education program, including the selection and supervision of learning experiences.

2. Provide that faculty members or preceptors be present in the clinical setting ~~to which~~ when students are assigned for direct patient care.

3. Provide for cooperative planning with designated agency personnel to ensure safe patient care.

4. Provide that faculty be available to students and preceptors while students are involved in preceptorship experiences.

F. Any observational experiences shall be planned in cooperation with the agency involved to meet stated course objectives.

G. Cooperating agencies shall be approved by the appropriate accreditation, evaluation or licensing bodies, if such exist.

18VAC90-20-140. Program changes.

A. The following shall be reported to the board within 10 days of the change or receipt of a report from an accrediting body:

1. Change in the program director, governing body or parent institution;

2. Change in accreditation status; ~~or~~

3. Change in content of curriculum, faculty or method of delivery that affects 25% or more of the hours of instruction;

4. Change in financial resources that could substantively affect the nursing education program;

5. Change in the physical location of the program; and

~~3-~~ 6. A final report with findings and recommendations from the accrediting body.

B. ~~Curriculum~~ Other curriculum or faculty changes shall be reported to the board with the annual report required in 18VAC90-20-160 A.

18VAC90-20-151. Passage rate on national examination.

A. For the purpose of continued approval by the board, a nursing education program shall maintain a passage rate for first-time test takers on the NCLEX that is not less than 80%, calculated on the cumulative results of the past four quarters in each year.

B. If a program falls below 80% for two consecutive years, the board shall conduct a site visit and place the program on

conditional approval. If a program falls below 80% for three consecutive years, the board may withdraw program approval.

C. For the purpose of program evaluation, the board may provide to the program the examination results of its graduates. However, further release of such information by the program shall not be authorized without written authorization from the candidate.

18VAC90-20-160. Maintaining an approved nursing education program.

A. The program director of each nursing education program shall submit an annual report to the board.

B. Each nursing education program shall be reevaluated as follows:

1. A program that ~~is not accredited as prescribed~~ has not achieved accreditation as defined in 18VAC90-20-65 18VAC90-20-10 shall be reevaluated at least every eight years for a practical nursing program and every six years for a registered nursing program by submission of a comprehensive self-evaluation report based on Article 2 (18VAC90-20-70 et seq.) of this part, and a survey visit by a representative(s) of the board on dates mutually acceptable to the institution and the board.

2. A program that has maintained accreditation as ~~prescribed~~ defined in 18VAC90-20-65 18VAC90-20-10 shall be reevaluated at least every ~~eight~~ 10 years by submission of a comprehensive self-evaluation report as provided by the board. As evidence of compliance with specific requirements of this chapter, the board may accept the most recent study report, site visit report and final decision letter from the accrediting body. The board may require additional information or a site visit to ensure compliance with requirements of this chapter. If accreditation has been withdrawn or a program has been placed on probation, the board shall conduct an on-site survey visit within one year of such action. If a program fails to submit the documentation required in this subdivision, the requirements of subdivision 1 of this subsection shall apply.

C. The Education Special Conference Committee (the "committee"), ~~comprised~~ composed of not less than two members of the board, shall, in accordance with §2.2-4019 of the Code of Virginia, receive and review the self-evaluation and survey reports and shall make a recommendation to the board ~~for to grant of continued or conditional approval, place the program on conditional approval or withdraw approval.~~

1. A nursing education program shall continue to be approved provided the requirements set forth in Article 2 of this part are attained and maintained.

2. If the committee determines that a nursing education program is not maintaining the requirements of Article 2 of this part, the committee shall recommend to the board that the program be placed on conditional approval and the governing institution shall be given a reasonable period of time to correct the identified deficiencies.

a. The committee shall receive and review reports of progress toward correcting identified deficiencies and, when a final report is received at the end of the specified time showing correction of deficiencies, make a recommendation to the board ~~for to grant of~~ continued approval, continue the program on conditional approval or withdraw approval.

b. If the ~~governing institution~~ nursing education program fails to correct the identified deficiencies within the time specified by an order of the board, the board may withdraw the approval following a formal hearing.

c. The governing institution may request a formal hearing before the board or a panel thereof pursuant to §2.2-4020 and subdivision 9 of §54.1-2400 of the Code of Virginia if it objects to any action of the board relating to conditional approval.

D. Interim visits shall be made to the institution by board representatives at any time within the ~~eight-year~~ approval period either by request or as deemed necessary by the board.

18VAC90-20-190. Licensure by examination.

A. The board shall authorize the administration of examinations for registered nurse licensure and examinations for practical nurse licensure.

B. A candidate shall be eligible to take the examination (i) upon receipt by the board of the completed application, fee and an official transcript from the nursing education program; and (ii) when a determination has been made that no grounds exist upon which the board may deny licensure pursuant to §54.1-3007 of the Code of Virginia.

C. To establish eligibility for licensure by examination, an applicant for the licensing examination shall:

1. File the required application, any necessary documentation and fee ~~no later than 60 days prior to the first day of the month in which the applicant expects to take the examination.~~

2. Arrange for the board to receive an official transcript from the nursing education program which shows either:

a. That the degree or diploma has been awarded and the date of graduation or conferral; or

b. That all requirements for awarding the degree or diploma have been met and specifies the date of conferral.

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3. File a new application and reapplication fee if:

a. The examination is not taken within six months of the date that the board determines the applicant to be eligible; or

b. Eligibility is not established within six months of the original filing date.

D. The minimum passing standard on the examination for registered nurse licensure and practical nurse licensure shall be determined by the board.

E. Any applicant suspected of giving or receiving unauthorized assistance during the examination may be noticed for a hearing pursuant to the provisions of the Administrative Process Act (§2.2-4000 et seq. of the Code of Virginia) to determine eligibility for licensure or reexamination.

~~F. The board shall not release examination results of a candidate to any individual or agency without written authorization from the applicant or licensee.~~

~~G. F.~~ Practice of nursing pending receipt of examination results.

1. A graduate who has filed a completed application for licensure in Virginia and has received an authorization letter issued by the board may practice nursing in Virginia from the date of the authorization letter. The period of practice shall not exceed 90 days between the date of successful completion of the nursing education program, as documented on the applicant's transcript, and the publication of the results of the candidate's first licensing examination.

2. Candidates who practice nursing as provided in subdivision 1 of this subsection shall use the designation "R.N. Applicant" or "L.P.N. Applicant" on a nametag or when signing official records.

3. The designations "R.N. Applicant" and "L.P.N. Applicant" shall not be used by applicants who either do not take the examination within 90 days following receipt of the authorization letter from the board or who have failed the examination.

~~H. G.~~ Applicants who fail the examination.

1. An applicant who fails the licensing examination shall not be licensed or be authorized to practice nursing in Virginia.

2. An applicant for licensure by reexamination shall file the required application and reapplication fee no later than 60 days prior to the first day of the month in which the applicant expects to take the examination in order to establish eligibility.

3. Applicants who have failed the examination for licensure in another U.S. jurisdiction but satisfy the

qualifications for licensure in this jurisdiction may apply for licensure by examination in Virginia. Such applicants shall submit the required application and fee. Such applicants shall not, however, be permitted to practice nursing in Virginia until the requisite license has been issued.

18VAC90-20-200. Licensure by endorsement.

A. A graduate of an approved nursing education program who has been licensed by examination in another U.S. jurisdiction and whose license is in good standing, or is eligible for reinstatement, if lapsed, shall be eligible for licensure by endorsement in Virginia, provided the applicant satisfies the same requirements for registered nurse or practical nurse licensure as those seeking initial licensure in Virginia.

1. A graduate of a nursing school in Canada where English was the primary language shall be eligible for licensure by endorsement provided the applicant has passed the Canadian Registered Nurses Examination (CRNE) and holds an unrestricted license in Canada.

2. An applicant for licensure by endorsement who has not passed NCLEX may only be issued a single state license to practice in Virginia.

B. An applicant for licensure by endorsement who has submitted the required application and fee and submitted the required form to the appropriate credentialing agency for verification of licensure may practice for 30 days upon receipt of an authorization letter from the board. If an applicant has not received a Virginia license within 30 days and wishes to continue practice, he shall seek an extension of authorization to practice by submitting a request and evidence that he has requested verification of licensure.

C. If the application is not completed within one year of the initial filing date, the applicant shall submit a new application and fee.

18VAC90-20-220. Renewal of licenses.

A. Licensees born in even-numbered years shall renew their licenses by the last day of the birth month in even-numbered years. Licensees born in odd-numbered years shall renew their licenses by the last day of the birth month in odd-numbered years.

B. No less than 30 days prior to the last day of the licensee's birth month, ~~an application a~~ notice for renewal of license shall be mailed by the board to the last known address of each licensee, who is currently licensed.

C. The licensee shall complete the ~~application~~ renewal form and ~~return~~ submit it with the required fee.

D. Failure to receive the ~~application for~~ renewal form shall not relieve the licensee of the responsibility for renewing the license by the expiration date.

E. The license shall automatically lapse if the licensee fails to renew by the expiration date.

F. Any person practicing nursing during the time a license has lapsed shall be considered an illegal practitioner and shall be subject to prosecution under the provisions of §54.1-3008 of the Code of Virginia.

G. Upon renewal, all licensees shall declare their primary state of residence. If the declared state of residence is another compact state, the licensee is not eligible for renewal.

18VAC90-20-230. Reinstatement of lapsed licenses or license suspended or revoked.

A. A nurse whose license has lapsed may be reinstated within one renewal period by payment of the current renewal fee and the late renewal fee.

B. A nurse whose license has lapsed for more than one renewal period shall:

1. File a reinstatement application and pay the reinstatement fee; and
2. Provide evidence of completing 15 hours of continuing education in nursing approved by a regionally accredited educational institution or professional nursing organization or of passage of National Council Licensing Examination during the period in which the license has been lapsed.

C. The board may waive all or part of the continuing education requirement for a nurse who holds a current, unrestricted license in another state and who has engaged in active practice during the period the Virginia license was lapsed.

D. A nurse whose license has been suspended or revoked by the board may apply for reinstatement by filing a reinstatement application, fulfilling requirements for continuing competency as required in subsection B of this section and paying the fee for reinstatement after suspension or revocation. A nurse whose license has been revoked may not apply for reinstatement sooner than three years from entry of the order of revocation.

E. The board may request additional evidence that the nurse is prepared to resume practice in a competent manner.

18VAC90-20-275. Clinical nurse specialist education programs.

A. An approved program shall be offered by: ~~1. A nationally accredited in a school of nursing that holds accreditation as defined in 18VAC90-20-10 that is within a regionally accredited college or university that offers a master's graduate degree in nursing designed to prepare a registered nurse for advanced practice in a clinical specialty in nursing; or,~~

~~2. B. A college or university that offers a master's degree consistent with the requirements of a national certifying~~

~~organization as defined in 18VAC90-20-10 program that is in the process of obtaining and has not been denied accreditation may be considered by the board as an approved program for the purpose of registering a person who graduated during the accrediting process.~~

18VAC90-20-280. Clinical nurse specialist registration.

A. Initial registration. An applicant for initial registration as a clinical nurse specialist shall:

1. Be currently licensed as a registered nurse in Virginia or hold a current multistate licensure privilege as a registered nurse;
2. Submit evidence of ~~graduation~~ a graduate degree in nursing from an approved program as defined in 18VAC90-20-275;
3. Submit evidence of current specialty certification as a clinical nurse specialist from a national certifying organization ~~as defined in 18VAC90-20-10 acceptable to the board or has an exception available from March 1, 1990, to July 1, 1990;~~ and
4. Submit the required application and fee.

B. Renewal of registration.

1. Registration as a clinical nurse specialist shall be renewed biennially at the same time the registered nurse license is renewed. If registered as a clinical nurse specialist with a multistate licensure privilege to practice in Virginia as a registered nurse, a licensee born in even-numbered years shall renew his license by the last day of the birth month in even-numbered years and a licensee born in odd-numbered years shall renew his license by the last day of the birth month in odd-numbered years.
2. The clinical nurse specialist shall complete the renewal ~~application form~~ and ~~return~~ submit it with the required fee and evidence of current specialty certification unless registered in accordance with an exception.
3. Registration as a clinical nurse specialist shall lapse if the registered nurse license is not renewed or the multistate licensure privilege is lapsed and may be reinstated upon:
 - a. Reinstatement of R.N. license or multistate licensure privilege;
 - b. Payment of reinstatement and current renewal fees; and
 - c. Submission of evidence of continued specialty certification unless registered in accordance with an exception.

18VAC90-20-300. Disciplinary provisions.

A. The board has the authority to deny, revoke or suspend a license or multistate licensure privilege issued, or to

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otherwise discipline a licensee or holder of a multistate licensure privilege upon proof that the licensee or holder of a multistate licensure privilege has violated any of the provisions of ~~§4.1-3007~~ §54.1-3007 of the Code of Virginia. For the purpose of establishing allegations to be included in the notice of hearing, the board has adopted the following definitions:

1. Fraud or deceit in procuring or maintaining a license means, but shall not be limited to:

- a. Filing false credentials;
- b. Falsely representing facts on an application for initial license, reinstatement or renewal of a license; or
- c. Giving or receiving assistance in the taking of the licensing examination.

2. Unprofessional conduct means, but shall not be limited to:

- a. Performing acts beyond the limits of the practice of professional or practical nursing as defined in Chapter 30 (§54.1-3000 et seq.) of Title 54.1 of the Code of Virginia, or as provided by §§54.1-2901 and 54.1-2957 of the Code of Virginia;
- b. Assuming duties and responsibilities within the practice of nursing without adequate training or when competency has not been maintained;
- c. Obtaining supplies, equipment or drugs for personal or other unauthorized use;
- d. Employing or assigning unqualified persons to perform functions that require a licensed practitioner of nursing;
- e. Falsifying or otherwise altering patient, employer, student, or educational program records, including falsely representing facts on a job application or other employment-related documents;
- f. Abusing, neglecting or abandoning patients or clients;
- g. Practice of a clinical nurse specialist beyond that defined in 18VAC90-20-290;
- h. Representing oneself as or performing acts constituting the practice of a clinical nurse specialist unless so registered by the board;
- i. Delegating nursing tasks to an unlicensed person in violation of the provisions of Part VIII (18VAC90-20-420 et seq.) of this chapter;
- j. Giving to or accepting from a patient or client property or money for any reason other than fee for service or a nominal token of appreciation;
- k. Obtaining money or property of a patient or client by fraud, misrepresentation or duress;

l. Entering into a relationship with a patient or client that constitutes a professional boundary violation in which the nurse uses his professional position to take advantage of ~~a patient or client's~~ the vulnerability of a patient, a client or his family, to include but not limited to actions that result in personal gain at the expense of the patient or client, a nontherapeutic personal involvement or sexual conduct with a patient or client;

m. Violating state laws relating to the privacy of patient information, including but not limited to §32.1-127.1:03 of the Code of Virginia; ~~or~~

n. Providing false information to staff or board members in the course of an investigation or proceeding; or

~~n. o.~~ Violating any provision of this chapter.

B. Any sanction imposed on the registered nurse license of a clinical nurse specialist shall have the same effect on the clinical nurse specialist registration.

18VAC90-20-370. Establishing a medication administration training program.

A. A program provider wishing to establish a medication administration training program pursuant to §54.1-3408 of the Code of Virginia shall submit an application to the board at least 90 days in advance of the expected beginning date.

B. The application shall be considered at a meeting of the board. The board shall, after review and consideration, either grant or deny approval.

C. If approval is denied, the program provider may request a hearing before the board, and the provisions of the Administrative Process Act shall apply (~~§9-6.14:1~~ §2.2-4000 et seq. of the Code of Virginia).

18VAC90-20-390. Content.

The curriculum shall include a minimum of ~~24~~ 32 hours of classroom instruction and practice in the following:

1. Preparing for safe administration of medications to clients in specific settings by:
 - a. Demonstrating an understanding of the client's rights regarding medications, treatment decisions and confidentiality.
 - b. Recognizing emergencies and other health-threatening conditions and responding accordingly.
 - c. Identifying medication terminology and abbreviations.
2. Maintaining aseptic conditions by:
 - a. Implementing universal precautions.
 - b. Insuring cleanliness and disinfection.
 - c. Disposing of infectious or hazardous waste.

3. Facilitating client self-administration or assisting with medication administration by:

- a. Reviewing administration records and prescriber's orders.
- b. Facilitating client's awareness of the purpose and effects of medication.
- c. Assisting the client to interpret prescription labels.
- d. Observing the five rights of medication administration and security requirements appropriate to the setting.
- e. Following proper procedure for preparing medications.
- f. Measuring and recording vital signs to assist the client in making medication administration decisions.
- g. Assisting the client to administer oral medications.
- h. Assisting the client with administration of prepared instillations and treatments of:

- (1) Eye drops and ointments.
- (2) Ear drops.
- (3) Nasal drops and sprays.
- (4) Topical preparations.
- (5) Compresses and dressings.
- (6) Vaginal and rectal products.
- (7) Soaks and sitz baths.
- (8) Inhalation therapy.
- (9) Oral hygiene products.

- i. Reporting and recording the client's refusal to take medication.
- j. Documenting medication administration.
- k. Documenting and reporting medication errors.
- l. Maintaining client records according to facility policy.
- m. Sharing information with other staff orally and by using documents.
- n. Storing and securing medications.
- o. Maintaining an inventory of medications.
- p. Disposing of medications.

4. Facilitating client self-administration or assisting with the administration of insulin. Instruction and practice in the administration of insulin shall be included only in those settings where required by client needs and shall include:

- a. Cause and treatment of diabetes.
- b. The side effects of insulin.

c. Preparation and administration of insulin.

18VAC90-20-410. Requirements for protocol for administration of adult immunization.

Pursuant to provisions of §54.1-3408 of the Code of Virginia, a protocol shall be submitted to the board prior to the administration of an adult immunization program ~~which~~ that includes the following:

1. Purpose and objectives of immunization program.
2. Target population.
3. Name and address of medical director.
4. A signed and dated medical directive.
5. Screening criteria for inclusion and exclusion.
6. Informed consent form.
7. Immunization procedures.
 - a. Dosage.
 - b. Single or multiple dose administration.
 - c. Injection site.
 - d. Vaccine storage.
 - e. Biohazardous waste disposal.
 - f. Standard precautions.
8. Post-immunization instructions.
9. Emergency guidelines, including a signed medical directive for emergency treatment.
10. Qualification of immunization providers.
 - a. Virginia licensure as a registered nurse, licensed practical nurse, or pharmacist.
 - b. Supervision of LPN provider.
 - c. Current cardiopulmonary resuscitation training.
11. Resource personnel and supervision.
12. Sample of patient record with date, vaccine, dose, site, expiration date, lot number, and administering person's signature.

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GUIDANCE DOCUMENTS

Sections 2.2-4008 and 2.2-4103 of the Code of Virginia require annual publication in the *Virginia Register* of guidance document lists from state agencies covered by the Administrative Process Act and the Virginia Register Act. A guidance document is defined as "...any document developed by a state agency or staff that provides information or guidance of general applicability to the staff or public to interpret or implement statutes or the agency's rules or regulations..." Agencies are required to maintain a complete, current list of all guidance documents and make the full text of such documents available to the public.

Generally, the format for the guidance document list is: document number (if any), title of document, date issued or last revised, and citation of Virginia Administrative Code regulatory authority or Code of Virginia statutory authority. Questions concerning documents or requests for copies of documents should be directed to the contact person listed by the agency.

DEPARTMENT OF REHABILITATIVE SERVICES

Guidance documents may be viewed during regular work days from 8 a.m. until 4:30 p.m. at the department's central office located at 8004 Franklin Farms Drive, Richmond, VA 23229. For questions about interpretation or implementation, or to request a free copy, please contact the resource person named in the list below by calling (804) 662-7000 (toll free 1-800-552-5019). TTY users call (804) 662-9040 (toll free 1-800-464-9950).

Vocational Rehabilitation Program, including Supported Employment Guidance Documents:

State Plan for the State Vocational Rehabilitation Services Program, effective October 1, 2007 through September 30, 2008, Elizabeth Smith. Also available on DRS website at <http://www.vadrs.org/publications.htm>

Your Path To Work Through Vocational Rehabilitation: A Guide to the Virginia DRS Vocational Rehabilitation Program (customer handbook), revised November 1999, Aileen Colorado. Also available on DRS website at <http://www.vadrs.org/yourpath.htm>

Virginia Department of Rehabilitative Services flyer, revised October 2004, Aileen Colorado. Also available on DRS website at <http://www.vadrs.org/downloads/drsflyer.pdf>

DRS Business Services Packet, revised 2001, Aileen Colorado. Also available on DRS website at <http://www.vadrs.org/downloads/DFBappkit.pdf>

Virginia Guide to Supported Employment and Job Coach Training Services manual, revised January 2004, Scott Fraley. Also available on DRS website at <http://www.vadrs.org/essp/se.htm>

Long Term Employment Support Services Guide, revised August 2007, Jack Hayek or Judy Hill. Also available on DRS website at <http://www.vadrs.org/essp/downloads/LTESSguidelines081707.doc>

New Counselor Skills Supervisor's Checklist, revised July 2004, Susan Burns

Best Practices Manual for Vocational Evaluation, issued 1995, Dale Batten

Self Employment Enterprise Handbook, issued 1999, Sherry Hailey or Lawrence Roberts. Also available on DRS website at <http://www.vadrs.org/vocrehab.htm>

School to Work Transition Services fact sheet, issued 2002, Erica Lovelace

Virginia DRS Transition Services Guide, issued 2007, Erica Lovelace. Also available on DRS website at <http://www.vadrs.org/transitionservices.htm>

The following vocational rehabilitation program guidance documents are updated monthly:

Field Rehabilitation Services Policy and Procedures Manual, first 10 pages front and back are free and \$0.15 each additional page (number of pages varies by policy), Liz Smith. Also available on DRS website at <http://www.vadrs.org/FRS/FRSmanuals/frsmanual.asp>

Training and Facilities Manual, Erica Lovelace for colleges, Carrie Worrell for ESOs, Kenna Bayer for Occupational Training and Driver Training vendors, Patricia Goodall for Life Skills Services vendors, and Theresa Preda for ESOs that provide Independent Living Services

Services Reference Manual, Robert Johnson

Independent Living Services Program Guidance Documents, Theresa Preda:

State Plan for Independent Living, effective October 1, 2005 through September 30, 2008. Also available on DRS website at <http://www.vadrs.org/cbs/downloads/VASPI2008to2010.doc>

Virginia DRS Centers for Independent Living General Policies and Procedures Manual, revised January 2002

Personal Assistance Services Program Guidance Documents, Bill Rhodenhiser.

Also available on DRS website at <http://www.vadrs.org/formscabinet/Formscabinet.asp?pass=et1&t1=PAS&pg=:>

Personal Assistance Services brochure, revised September 19, 2006

Consumer and Personal Assistant Handbook, revised September 19, 2006

Brain Injury Services Program Guidance Documents, Patricia Goodall.

Also available on DRS website at <http://www.vadrs.org/formscabinet/Formscabinet.asp?pass=et1&t1=BI/SCIS&pg=>

Brain Injury Direct Services (BIDS) Fund: BIDS Application Form; BIDS Eligibility Criteria, both revised October 2007

Life Skills Services: Application for Vendorship; Application for Vendorship Cover Letter; Purchase of Services Agreement for the Provision of Life Skills Services, all revised May 2007

Registry Operations: At a Glance, revised November 2005; Program Highlights, revised November 2005. Virginia Central Registry for Brain Injury and Spinal Cord Injury - Hospital Reporting Form, revised 2007; Virginia Central Registry for Brain Injury and Spinal Cord Injury - Self Report Form, revised January 2004

Disability Services Boards Member Handbook, revised 2007, Richard Kriner. Also available on DRS website at <http://www.vadrs.org/cbs/dsc/dsb.htm>

Rehabilitation Services Incentive Fund Guidelines and Application, revised January 2008, Richard Kriner. Also available on DRS website at <http://www.vadrs.org/cbs/dsc/rsif.htm>

Human Research Procedures Manual, issued October 2005, Myra Owens. Also available on DRS website at <http://www.vadrs.org/hrrc/downloads/ProceduresManual.doc>

Woodrow Wilson Rehabilitation Center

Guidance documents may be viewed during regular work days from 8 a.m. until 4:30 p.m. at Woodrow Wilson Rehabilitation Center located in Fishersville, Virginia 22939-0010. For questions about interpretation or implementation, or to request a free copy, please contact the resource person named in the list below by calling toll-free 1 (800) 345-9972 or (540) 332-7000. TTY users call toll free 1 (800) 811-7893 or locally (540) 332-7239.

General Admissions Criteria, Russ Neyman. Available online: <http://wwrc.virginia.gov/Admissions.htm#criteria>

Admissions Criteria for Short Term Rehabilitation Unit, revised November 2005, Marjorie Adcock

Vocational Services Guidance Documents, Rusty Eddins:

PERT Manual, revised November 2007, Rusty Eddins/Ginger Sharrar

PERT Internal Procedures Manual, revised October 2007, Rusty Eddins.

PERT Training and Reference Manual, 2007, Rusty Eddins.

Student Life Guidance Documents, Ellen Murnane:

Student Handbook, revised April 2007, Ellen Murnane. Available only online at: http://www.vadrs.org/formscabinet/.%5Cdocuments%5CPublic%5CWWRC%20Student%20Handbook_WWRC-02.pdf

Other WWRC Guidance Documents:

WWRC Services listing/fee schedule, Pat Swisher, Also available on website at <http://wwrc.virginia.gov/feeschedule.htm>

Psychology Services: Behavioral and Mental Health Services Procedures and Fees; Vendor Application for Licensed Behavioral Health Services Provider, both revised October 2006

WWRC Policies and Procedures Manual, revised monthly as needed, Executive Staff, See Russ Neyman

Unified Case Management Operations Manual, revised March, 2006, Tom Blosser.

WWRC Master Plan, Russ Neyman

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STATE CORPORATION COMMISSION

Bureau of Insurance

February 8, 2008

Administrative Letter 2008-02

TO: All Insurers Licensed to Write Homeowners and/or Private Passenger Automobile Insurance in Virginia

RE: Insurers No Longer Required to Submit VA CP-12 or VA CP-20 Competitive Pricing Forms with Homeowners or Private Passenger Auto Rate Filings; Withdrawal of Administrative Letter 2004-04

Effective immediately, insurers are no longer required to submit a VA CP-12 (05/04) form with each homeowners rate filing or a VA CP-20 (05/04) form with each private passenger auto rate filing. Instead, the Bureau may be contacting insurers once each year to request premium information similar to that which had been provided by insurers in the VA CP-12 (05/04) and VA CP-20 (05/04) forms.

Further, Administrative Letter 2004-04, which established a filing requirement that is no longer applicable, is hereby withdrawn.

Please direct any questions pertaining to this administrative letter to: Rebecca Nichols, CPCU, CIC, CIE, AIC, Principal Insurance Market Examiner, Personal Lines Rates and Forms Section, Property and Casualty Division, telephone (804) 371-9331, or email rebecca.nichols@scc.virginia.gov.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Proposed Consent Special Order - Town of Drakes Branch

Citizens may comment on a proposed consent order for the Town of Drakes Branch, located in Charlotte County, Virginia.

Public comment period: March 3, 2008, to April 2, 2008.

Purpose of notice: To invite the public to comment on a proposed consent order. A consent order is issued to a business owner or other responsible party to perform specific actions that will bring the entity into compliance with the relevant law and regulations. It is developed cooperatively with the Town and entered into by mutual agreement.

Consent order description: The Department of Environmental Quality (DEQ) proposes to issue a consent order to the Town of Drakes Branch to address violations occurring at the Town's Wastewater Treatment Plant. The consent order describes a settlement to resolve effluent limit violations of State Water Control Law.

How a decision is made: After public comments have been considered, DEQ will make a final decision.

How to comment: DEQ accepts comments from the public by email, fax or postal mail. All comments must include the name, address and telephone number of the person commenting and be received by close of business on the final day of the public comment period.

To review the consent order: The public may review the proposed consent order on the DEQ website at www.deq.virginia.gov.

Contact for public comments, document requests and additional information: G. Marvin Booth, III, Department of Environmental Quality, South Central Regional Office, 7705 Timberlake Road, Lynchburg, VA 24502, telephone (434) 582-5120 ext. 6237, FAX (434) 582-5125, or email gmbooth@deq.virginia.gov.

Proposed Consent Special Order - Mr. Montgomery Maxted

Citizens may comment on a proposed consent order for Mr. Montgomery Maxted, who is the owner of a wastewater treatment facility located in Mecklenburg County, Virginia.

Public comment period: March 3, 2008, to April 2, 2008.

Purpose of notice: To invite the public to comment on a proposed consent order. A consent order is issued to a business owner or other responsible party to perform specific actions that will bring the entity into compliance with the relevant law and regulations. It is developed cooperatively with the owner and entered into by mutual agreement.

Consent order description: The Department of Environmental Quality (DEQ) proposes to issue a consent order to Mr. Maxted to address violations occurring at Pine Grove Park Wastewater Treatment Plant. The consent order describes a settlement to resolve effluent limit violations of State Water Control Law.

How a decision is made: After public comments have been considered, DEQ will make a final decision.

How to comment: DEQ accepts comments from the public by email, fax or postal mail. All comments must include the name, address and telephone number of the person commenting and be received by close of business on the final day of the public comment period.

To review the consent order: The public may review the proposed consent order on the DEQ website at www.deq.virginia.gov.

Contact for public comments, document requests and additional information: G. Marvin Booth, III, Department of Environmental Quality, South Central Regional Office, 7705 Timberlake Road, Lynchburg, VA 24502, telephone (434)

582-5120 ext. 6237, FAX (434) 582-5125, or email gmbooth@deq.virginia.gov.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

State Application for Federal Fiscal Year 2008 Grant Award Under Part C of the Individuals with Disabilities Act

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services announces availability and public comment period on Virginia's State Application for Federal Fiscal Year 2008 Grant Award Under Part C of the Individuals with Disabilities Education Act prior to submission to the United States Department of Education.

The Commonwealth of Virginia is making this document available for a 60-day public exposure period beginning February 12, 2008, and concluding on April 11, 2008. There will also be a 30-day public comment period that will begin on March 13, 2008, and conclude on April 11, 2008. The application is available on the website (www.infantva.org) under the section "What's New."

For a printed copy of the application or to submit public comment contact: Karen Durst, Part C Technical Consultant, Department of Mental Health, Mental Retardation And Substance Abuse Services, Infant & Toddler Connection of Virginia, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 786-9844, FAX (804) 371-7959, or email karen.durst@co.dmhmrsas.virginia.gov.

VIRGINIA BOARDS OF NURSING AND MEDICINE

Notice of Periodic Review of Regulations

The Virginia Boards of Nursing and Medicine are conducting a periodic review of its current regulations governing nurse practitioners and are requesting comment on the following current regulations:

18 VAC 90-30, Regulations Governing the Licensure of Nurse Practitioners

18 VAC 90-40, Regulations Governing Prescriptive Authority for Nurse Practitioners

The board will consider whether the existing regulations are essential to protect the health, safety and welfare of the public in providing assurance that licensed practitioners are competent to practice. Alternatives to the current regulations or suggestions for clarification of the regulation will also be received and considered.

Comment begins March 3, 2008, and ends April 2, 2008.

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, Senior Policy Analyst, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463.

Comments may also be emailed to elaine.yeatts@dhp.virginia.gov or FAX (804) 527-4434.

Regulations may be viewed online at www.dhp.virginia.gov or copies will be sent upon request.

Amendment of Water Quality Management Planning Regulation

Notice of action: The State Water Control Board (Board) is considering the amendment of the regulation on water quality management planning in accordance with the Public Participation Procedures for Water Quality Management Planning. A regulation is a general rule governing people's rights or conduct that is upheld by a state agency.

Purpose of notice: The board is seeking comments through the Department of Environmental Quality on the proposed amendment. The purpose of the amendment to the state's Water Quality Management Planning Regulation (9 VAC 25-720) is to adopt 24 Total Maximum Daily Load (TMDL) waste load allocations.

Public comment period: March 3, 2008, to April 2, 2008.

Description of proposed action: DEQ staff will propose amendments of the state's Water Quality Management Planning regulation for the Potomac-Shenandoah River Basin (9VAC25-720-50 A), the Tennessee-Big Sandy river Basin (9VAC25-720-90 A), and the New River Basin (9VAC25-720-130 A). Statutory authority for promulgating these amendments can be found in §62.1-44.15(10) of the Code of Virginia.

Staff intends to recommend (i) that the board approve three TMDL reports as the plans for the pollutant reductions necessary for attainment of water quality goals in the impaired segments, (ii) that the board authorize inclusion of four TMDL reports Plan (A fourth report – "Total Maximum Daily Loads For Polychlorinated Biphenyls (PCBs) Tidal Potomac & Anacostia River Watershed in the District of Columbia, Maryland and Virginia" was previously approved by the board on October 31, 2007) in the appropriate Water Quality Management, and (iii) that the board adopt 24 TMDL waste load allocations as part of the state's Water Quality Management Planning Regulation in accordance with §2.2-4006 A 4 c and §2.2-4006 B of the Code of Virginia.

The four TMDL reports were developed in accordance with federal regulations (40 CFR §130.7) and are exempt from the provisions of Article II of the Virginia Administrative Process Act. The reports were subject to the TMDL public participation process contained in DEQ's Public Participation

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Procedures for Water Quality Management Planning. The public comment process provides the affected stakeholders an opportunity for public appeal of the TMDLs. EPA approved all TMDLs presented under this public notice. The approved reports can be found at <https://www.deq.virginia.gov/TMDLDataSearch/ReportSearch.jsp>.

Affected Waterbodies and Localities:

Potomac - Shenandoah River Basin (9VAC25-720-50 A):

"Total Maximum Daily Loads for the Polychlorinated Biphenyls (PCBs) Tidal Potomac & Anacostia River Watershed in the District of Columbia, Maryland and Virginia"

-Accotink Bay, located in Fairfax County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.0992 G/YR.

-Aquia Creek, located in Stafford County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 6.34 G/YR.

-Belmont Bay/Occoquan Bay, located in Prince William County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.409 G/YR.

-Chopawamsic Creek, located in Prince William County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 1.35 G/YR.

-Coan River, located in Northumberland County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.0 G/YR.

-Dogue Creek, located in Fairfax County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 20.2 G/YR.

-Fourmile Run, located in Arlington, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 11.0 G/YR.

-Gunston Cove, located in Fairfax County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.517 G/YR.

-Hoof Run & Hunting Creek, located in Fairfax County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 36.8G/YR.

-Little Hunting Creek, located in Fairfax County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 10.1 G/YR.

-Monroe Creek, located in Fairfax County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.0177 G/YR.

-Neabsco Creek, located in Fairfax County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 6.63 G/YR.

-Occoquan River, located in Prince William County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 2.86 G/YR.

-Pohick Creek/Pohick Bay, located in Fairfax County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 13.5 G/YR.

-Potomac Creek, located in Stafford County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.556 G/YR.

-Potomac River-Fairview Beach, located in King George County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.0183 G/YR.

-Powells Creek, located in Prince William County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.0675 G/YR.

-Quantico Creek, located in Prince William County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.742 G/YR.

-Upper Machodoc Creek, located in King George County, proposes PCB reductions for portions of the watershed and provides PCB wasteload allocation of 0.0883 G/YR.

Tennessee-Big Sandy river Basin (9VAC25-720-90 A):

"General Standard (Benthic) Total Maximum Daily Load Development for Garden Creek"

-Garden Creek Benthic TMDL, located In Buchanan County, proposes Chloride reductions for portions of the watershed and provides a Chloride wasteload allocation of 358,000 KG/YR.

-Garden Creek Benthic TMDL, located In Buchanan County, proposes TDS reductions for portions of the watershed and provides a TDS wasteload allocation of 474,000 KG/YR.

"General Standard (Benthic) Total Maximum Daily Load Development for Knox Creek and PawPaw Creek"

-Knox Creek Benthic TMDL, located In Buchanan County, proposes TDS reductions for portions of the watershed and provides a TDS wasteload allocation of 1,110 T/YR.

-PawPaw Creek Benthic TMDL, located In Buchanan County, proposes sediment reductions for portions of the watershed and provides a sediment wasteload allocation of 4.99 T/YR.

New River Basin (9VAC25-720-130 A):

"General Standard (Benthic) Total Maximum Daily Load Development for Laurel Fork"

-Laurel Fork Benthic TMDL, located in Sussex County, proposes sediment reductions for portions of the watershed and provides a sediment wasteload allocation of 21 T/YR.

How to comment: The DEQ accepts written comments by email, fax and postal mail. All written comments must include the full name, address and telephone number of the person commenting and be received by DEQ by 5 p.m. on the last day of the comment period.

How a decision is made: After comments have been considered, the board will make the final decision. Citizens who submit statements during the comment period may address the board members during the board meeting at which a final decision is made on the proposal.

To review documents: The TMDL reports and the proposed regulatory amendments are available on the DEQ website at <https://www.deq.virginia.gov/TMDLDataSearch/ReportSearch.h.jsp> and by contacting the DEQ representative named below. The electronic copies are in PDF format and may be read online or downloaded.

Contact for public comments, document requests and additional information: David S. Lazarus, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4299, FAX (804) 698-4116, or email dslazarus@deq.virginia.gov.

Approval of Water Quality Management Planning Actions

Notice of action: The State Water Control Board (board) is considering the approval of four TMDL implementation plans (TMDL IPs) and granting authorization to include the TMDL implementation plans in the appropriate Water Quality Management Plans (WQMPs).

Purpose of notice: The board is seeking comment on the proposed approvals and authorizations. The purpose of these actions is to approve four TMDL IPs as Virginia's plans for the management actions necessary for attainment of water quality goals in several impaired waterbodies. These actions are taken in accordance with the Public Participation Procedures for Water Quality Management Planning.

Public comment period: March 3, 2008, to April 2, 2008.

Description of proposed action: DEQ staff intends to recommend (i) that the DEQ Director approve the TMDL IPs listed below as Virginia's plans for the management actions necessary for attainment of water quality goals in the impaired segments, and (ii) that the DEQ Director authorize inclusion of the TMDL IPs in the appropriate WQMPs. No regulatory amendments are required for these TMDL IPs.

At previous meetings, the board voted unanimously to delegate to the DEQ Director the authority to approve TMDL implementation plans, provided that a summary report of the action the director plans to take is presented to the board prior to the director approving the TMDL IPs. The TMDLs IPs included in this public notice will be approved using this delegation of authority.

The TMDL IPs listed below were developed in accordance with the 1997 Water Quality Monitoring, Information and Restoration Act (WQMIRA, §§62.1-44.19:4 through 62.1-44.19:8 of the Code of Virginia) and federal recommendations. The TMDL IPs were developed in accordance with DEQ's Public Participation Procedures for Water Quality Management Planning. Extensive public participation was solicited during the development of the plans, and the public comment process provided the affected stakeholders with opportunities for comment on the proposed plans. The final TMDL IPs can be found at <http://www.deq.virginia.gov/tmdl/iprpts.html>.

Affected Waterbodies and Localities:

In the New River Basin:

1. "Back Creek Watershed TMDL Implementation Plan" – proposes management actions needed to restore the primary contact (swimming) use and restore the benthic community in Back Creek, Pulaski County

In the Tennessee Big Sandy River Basin

2. "Upper Clinch River TMDL Implementation Plan" – proposes management actions needed to restore the benthic community in the Upper Clinch River, Tazewell County
3. "Knox and PawPaw Creeks TMDL Implementation Plan" – proposes management actions needed to restore the primary contact (swimming) and the benthic community in Knox and PawPaw Creeks, Buchanan County"
4. "Beaver Creek TMDL Implementation Plan" – proposes management actions needed to restore the primary contact (swimming) use and restore the benthic community in Beaver Creek, Washington County

How to comment: The DEQ accepts written comments by email, fax and postal mail. All written comments must include the full name, address and telephone number of the person commenting and be received by DEQ by 5 p.m. on the last day of the comment period.

How a decision is made: After comments have been considered, the board will make the final decision.

To review documents: The TMDL implementation plans are available on the DEQ website at <http://www.deq.virginia.gov/tmdl/iprpts.html> and by contacting the DEQ representative named below. The

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electronic copies are in PDF format and may be read online or downloaded.

Contact for public comments, document requests and additional information: David S. Lazarus, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4299, FAX (804) 698-4116, or email dslazarus@deq.virginia.gov.

Approval of Water Quality Management Planning Actions

Notice of action: The State Water Control Board (board) is considering the approval of thirty-six Total Maximum Daily Load (TMDL) reports and one TMDL modification, and granting authorization to include the TMDL reports in the appropriate Water Quality Management Plans (WQMPs).

Purpose of notice: The board is seeking comment on the proposed approvals and authorizations. The purpose of these actions is to approve 38 TMDL reports as Virginia's plans for the pollutant reductions necessary for attainment of water quality goals in several impaired waterbodies. These actions are taken in accordance with the Public Participation Procedures for Water Quality Management Planning.

Public comment period: March 3, 2008, to April 2, 2008.

Description of proposed action: DEQ staff intends to recommend (i) that the DEQ Director approve the TMDL reports listed below as Virginia's plans for the pollutant reductions necessary for attainment of water quality goals in the impaired segments, and (ii) that the DEQ Director authorize inclusion of the TMDL reports in the appropriate WQMPs. No regulatory amendments are required for these TMDLs and their associated waste load allocations.

At previous meetings, the board voted unanimously to delegate to the DEQ Director the authority to approve TMDLs that do not include waste load allocations requiring regulatory adoption by the board, provided that a summary report of the action the director plans to take is presented to the board prior to the director approving the TMDL reports. The TMDLs included in this public notice will be approved using this delegation of authority.

The TMDLs listed below were developed in accordance with Federal Regulations (40 CFR §130.7) and are exempt from the provisions of Article II of the Virginia Administrative Process Act. The TMDLs have been through the TMDL public participation process contained in DEQ's Public Participation Procedures for Water Quality Management Planning. The public comment process provides the affected stakeholders an opportunity for public appeal of the TMDLs. EPA approved all TMDL reports presented under this public notice. The approved reports can be found at <https://www.deq.virginia.gov/TMDLDataSearch/ReportSearch.jsp>.

Affected Waterbodies and Localities:

Potomac River & Shenandoah River Basins:

1. "Bacteria Total Maximum Daily Load Development for Primary Contact Use and Shellfish Harvest Impairments on the Nansemond River and Mattox Creek Watersheds"

- 5 bacteria TMDLs, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments and to address VDH Shellfish Area Condemnations

2. "Bacteria Total Maximum Daily Load Development for the NF Shenandoah River, Stony Creek and Mill Creek"

- 3 bacteria TMDLs, located in Rockingham, Shenandoah, and Broadway Counties, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments

3. "Bacteria Total Maximum Daily Load Development for Hogue Creek"

- 1 bacteria TMDL, located in Frederick County, propose bacteria reductions for portions of the watershed to address primary contact (swimming use) impairments

4. "Total Maximum Daily Load Development for Primary Contact Use Impairments Broad Run, South run, Popes Head Creek, Kettle Run, Little Bull Run, Bull Run, and the Occoquan River Watershed"

- 9 bacteria TMDLs, located in Prince William and Fauquier Counties, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments

In the James River Basin:

5. "Bacteria TMDLs for Nansemond River and Shingle Creek, Suffolk, Virginia"

- 2 bacteria TMDLs, located in Suffolk, proposes bacteria reductions for portions of the watersheds to address a primary contact (swimming use) impairment

6. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Nansemond River"

- 1 bacteria TMDL, located in Suffolk, propose bacteria reductions for portions of the watershed to address VDH Shellfish Area Condemnations

7. "Bacteria TMDLs for Totier Creek, Ballinger Creek, Rock Island Creek, Slate River, Austin Creek, Frisby Branch, North River, and Troublesome Creek, in Albemarle and Buckingham Counties, Virginia"

- 9 bacteria TMDLs, located in Albemarle and Buckingham Counties, proposes bacteria reductions

for portions of the watersheds to address a primary contact (swimming use) impairment

8. "Bacteria TMDLs for Blackwater Creek, Fishing Creek, Ivy Creek, James River, Burton Creek, Judith Creek, and Tomahawk Creek, in Lynchburg, Virginia"

- 7 bacteria TMDLs, located in Lynchburg City, proposes bacteria reductions for portions of the watersheds to address a primary contact (swimming use) impairment

9. "Bacteria Total Maximum Daily Load Development for Primary Contact Use –White Oak Swamp, Fourmile Creek, and Tuckahoe Watershed"

- 6 bacteria TMDLs, located in Henrico and Goochland Counties, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments and to address VDH Shellfish Area Condemnations

10. "Total Maximum Daily Load Development for Primary Contact Use Impairments in Fourmile Creek Watershed"

- 11 bacteria TMDLs, located in Louise, Orange, Caroline, Hanover, King William, and New Kent Counties, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments

In the Roanoke River Basin:

11. "Bacteria TMDLs for the Banister River, Cherrystone Creek, Whitehorn Creek, Polecat Creek, Stinking River, and Sandy Creek"

- 8 bacteria TMDLs, located in Pittsylvania, Henry, Halifax and Mecklenburg Counties, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments

12. "Bacteria TMDL for Great Creek, Mecklenburg County, Virginia"

- 1 bacteria TMDL, located in Mecklenburg County, proposes bacteria reductions for portions of the watershed to address a primary contact (swimming use) impairment

In the Tennessee-Big Sandy River Basin:

13. "General Standard (Benthic) and Bacteria Total Maximum Daily Load Development for Garden Creek"

- 2 TMDLs, located in Buchanan County, proposes chloride and TDS reductions for portions of the watershed to address an aquatic life use (benthic) impairment and bacteria reductions for portions of the watershed to address primary contact (swimming use)

14. "Bacteria and Benthic Total Maximum Daily Load Development for Knox and PawPaw Creeks"

- 3 bacteria and benthic TMDLs, located in Buchanan County, propose bacteria reductions for portions of the watershed to address primary contact (swimming use) impairments and proposes sediment and TDS reductions for portions of the watersheds to address an aquatic life use (benthic) impairment

In the Chowan River Basin:

15. "Total Maximum Daily Load Development for Primary Contact Use Impairments in Roses Creek" modification

- 1 bacteria TMDL modification, located in Brunswick, Alberta Counties, propose bacteria reductions for portions of the watershed to address primary contact (swimming use) impairments

In the Chesapeake Bay-Small Coastal-Eastern Shore Basin:

16. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Barnes Creek, Pierce Creek, Nomini Creek, Buckner Creek, North Prong, Currioman Bay"

- 6 bacteria TMDLs, located in Westmoreland County, propose bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

17. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Ball, Mill, and Cloverdale Creeks"

- 3 bacteria TMDLs, located in Northumberland County, propose bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

18. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Church, Warehouse, Nassawadox, Westerhouse (a & b) Creeks and Holly Grove Cove"

- 6 bacteria TMDLs, located in Northumberland County, proposes bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

19. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – The Gulf"

- 1 bacteria TMDL, located in Northampton County, propose bacteria reductions for portions of the watershed to address VDH Shellfish Area Condemnations

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20. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Cherrystone Inlet: Kings Creek"

- 1 bacteria TMDL, located in Northumberland, propose bacteria reductions for portions of the watershed to address VDH Shellfish Area Condemnations

21. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Old Plantation Creek"

- 1 bacteria TMDL, located in Northumberland, propose bacteria reductions for portions of the watershed to address VDH Shellfish Area Condemnations

22. "Total Maximum Daily Loads for the Shellfish Harvest Impairments in Folly Creek, Deep Creek, Hunting Creek, Bagwell Creek, Swans Gut, and Greenbackville Harbor"

- 6 bacteria TMDLs, located in Accomack County, propose bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

23. "Total Maximum Daily Load Reports for Shellfish Areas Listed Due to Bacteria Contamination -Horn Harbor, Doctors Creek and Davis Creek"

- 3 bacteria TMDLs, located in Mathews County, propose bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

24. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Chesconessex Creek"

- 1 bacteria TMDL, located in Accomack County, propose bacteria reductions for portions of the watershed to address VDH Shellfish Area Condemnations

25. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination -Edwards Creek, Queens Creek, Stutts Creek, Morris Creek and Billups Creek"

- 5 bacteria TMDLs, located in Mathews County, propose bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

26. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination and for Recreational Bacteria Impairments – Parker Creek, Assawoman Creek, and Little Mosquito Creek"

- 6 bacteria TMDLs, located in Accomack County, propose bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

In the Rappahannock River Basin:

27. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Corrotoman River Watershed, Rappahannock River Basin"

- 9 bacteria TMDLs, located in Lancaster County, propose bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

28. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Carter Creek and Eastern Branch"

- 3 bacteria TMDLs, located in Lancaster County, propose bacteria reductions for portions of the watershed to address VDH Shellfish Area Condemnations

29. "Bacteria Total Maximum Daily Load) Development for Blue Run, Rapidan River, March Run, UT to Rapidan River, and Cedar Run"

- 6 bacteria TMDLs, located in Orange, Greene, Madison, Albemarle, Spotsylvania and Culpeper Counties, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments

30. "Total Maximum Daily Load Development for Primary Contact Use Impairments on Little Dark Run and the Robinson River"

- 2 bacteria TMDLs, located in Madison County, propose bacteria reductions for portions of the watershed to address primary contact (swimming use) impairments

31. "Total Maximum Daily Load for Primary Contact Use Impairments in the York River Basin"

- 6 bacteria TMDLs, located Orange and Louisa Counties, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments

32. "Total Maximum Daily Load Development for Primary Contact Use Impairments on Matadequin and Mechumps Creek"

- 2 bacteria TMDLs, located in Hanover County, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments

33. "Total Maximum Daily Loads for Bacteria Recreation Use Impairments on The Rappahannock River and Six Tributaries: Hughes River, Hazel River, Rush river, Craig Run, Browns Run and March Run"

- 10 bacteria TMDLs, located in Culpeper, Fauquier, Madison and Rappahannock Counties, propose bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

In the New River Basin:

34. "Total Maximum Daily Load Development for Primary Contact Use and Aquatic Life Impairments in Laurel Fork Watershed"

- 1 bacteria TMDL, located in Tazewell and Pocahontas Counties, propose bacteria reductions for portions of the watershed to address primary contact (swimming use) impairments and sediment reductions to address aquatic life

In the York River Basin:

35. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Aberdeen, Jones, Timberneck, Cedarbush and NS Carter Creeks"

- 5 bacteria TMDLs, located in Gloucester County, propose bacteria reductions for portions of the watersheds to address VDH Shellfish Area Condemnations

36. "Total Maximum Daily Load Development for Primary Contact Use Impairments in Pamunkey River Basin"

- 11 bacteria TMDLs, located in Louise, Orange, Caroline, Hanover, King William, and New Kent Counties, propose bacteria reductions for portions of the watersheds to address primary contact (swimming use) impairments

37. "Total Maximum Daily Load Report for Shellfish Areas Listed Due to Bacteria Contamination – Sarah Creek and Perrin River"

- 2 bacteria TMDLs, located in Gloucester County, propose bacteria reductions for portions of the watershed to address VDH Shellfish Area Condemnations

How to comment: The DEQ accepts written comments by email, fax and postal mail. All written comments must include the full name, address and telephone number of the person commenting and be received by DEQ by 5 p.m. on the last day of the comment period.

How a decision is made: After comments have been considered, the board will make the final decision.

To review documents: The TMDL reports and TMDL implementation plans are available on the DEQ website at <https://www.deq.virginia.gov/TMDLDataSearch/ReportSearch.h.jsp> and by contacting the DEQ representative named below. The electronic copies are in PDF format and may be read online or downloaded.

Contact for public comments, document requests and additional information: David S. Lazarus, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4299, FAX (804) 698-4116, or email dslazarus@deq.virginia.gov.

STATE WATER CONTROL BOARD

Consent Order - Beasley Concrete

Purpose of notice: To seek public comment on a proposed consent order from the Department of Environmental Quality for a facility in Kilmarnock, Virginia.

Public comment period: March 3, 2008, to April 2, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to Beasley Concrete to address violations of environmental law and regulation. The consent order describes a settlement to resolve unauthorized wastewater discharge violations that occurred at the facility in Kilmarnock, Virginia. The order requires wastewater treatment system modifications and payment of a civil charge.

How to comment: DEQ accepts comments from the public by email, 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: Frank Lupini, Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Glen Allen, VA 23060, telephone (804) 527-5093, FAX (804) 527-5106, or email felupini@deq.virginia.gov.

Consent Order - Capital Concrete, Inc.

Purpose of notice: To seek public comment on a proposed consent order from the Department of Environmental Quality for a location in Norfolk, Virginia.

Public comment period: March 3, 2008, to April 2, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to Capital Concrete, Inc. to address alleged violations of Virginia State Water Control Law. The location where the alleged violations occurred is 400 Stapleton Avenue, Norfolk. The consent order describes a settlement to resolve alleged violations of the facility

General Notices/Errata

Virginia Pollutant Discharge Elimination System General Permit for Concrete Products Facilities number VAG11 through registration number VAG110036.

How to comment: DEQ accepts comments from the public by email, 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: John M. Brandt, Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Blvd, Virginia Beach, VA 23462, telephone (757) 518-2010, FAX (757) 518-2003, or email jmbrandt@deq.virginia.gov.

Consent Order - Town of Craigsville

Purpose of notice: To invite citizens to comment on a proposed consent order for a facility in Augusta County, Virginia.

Public comment period: March 3, 2008, to April 3, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to the Town of Craigsville to address alleged permit violations. The location of the facility where the alleged violations occurred is at the Town of Craigsville's STP in Augusta County, Virginia. The consent order describes a settlement to resolve these violations.

How to comment: DEQ accepts comments from the public by email, 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: Steven W. Hetrick, Department of Environmental Quality, Valley Regional Office, Post Office Box 3000, Harrisonburg, VA 22801-9519, telephone (540) 574-7833, FAX (540) 574-7878, or email swhetrick@deq.virginia.gov.

Consent Order - D. D. Jones Transfer and Warehouse Company, Incorporated

Purpose of Notice: To seek public comment on a proposed consent order from the Department of Environmental Quality for two locations in Chesapeake, Virginia.

Public comment period: March 3, 2008, to April 2, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to D. D. Jones Transfer and Warehouse Company, Incorporated, to address alleged violations of Virginia State Water Control Law. The locations where the alleged violations occurred are 630 22nd Street and 719 Wilson Road, Chesapeake. The consent order describes a settlement to resolve alleged violations of the facility Virginia Pollutant Discharge Elimination System General Permit VAR05.

How to comment: DEQ accepts comments from the public by email, 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: Paul R. Smith, Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Blvd, Virginia Beach, VA 23462, telephone (757) 518-2020, FAX (757) 518-2003, or email prsmith@deq.virginia.gov.

Consent Order - Heritage Land Investments, LLC

Purpose of notice: To invite citizens to comment on a proposed consent order for a facility in Page County, Virginia.

Public comment period: March 3, 2008, to April 3, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to Heritage Land Investments, LLC to address alleged unauthorized stream work violations. The location of the facility where the alleged violations occurred is at a Valleyburg Road development site near Luray in Page County, Virginia. The consent order describes a settlement to resolve these violations.

How to comment: DEQ accepts comments from the public by email, 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: Steven W. Hetrick, Department of Environmental Quality, Valley Regional Office, Post Office Box 3000, Harrisonburg, VA 22801-9519, telephone (540) 574-7833, FAX (540) 574-7878, or email swhetrick@deq.virginia.gov.

Consent Order - Mowery Oil Company, Inc.

Purpose of notice: To invite citizens to comment on a proposed consent order for a facility.

Public comment period: March 3, 2008, to April 3, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to Mowery Oil Company, Inc. to address alleged violations of the regulations. The location of the UST facility where the alleged violations occurred is in Shenandoah County, Virginia. The consent order describes a settlement to resolve these violations.

How to comment: DEQ accepts comments from the public by email, 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: David C. Robinett, Department of Environmental Quality, Valley Regional Office, Post Office Box 3000, 4411 Early Road, Harrisonburg, VA 22801-9519, telephone (540) 574-7862, FAX (540) 574-7878, or email dcrobinett@deq.virginia.gov.

Consent Order - Plasser American Corporation

Purpose of notice: To seek public comment on a proposed consent order from the Department of Environmental Quality for a location in Chesapeake, Virginia.

Public comment period: March 3, 2008, to April 2, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to Plasser American Corporation, to address alleged violations of Virginia State Water Control Law. The location where the alleged violations occurred is 2001 Myers Road, Chesapeake. The consent order describes a settlement to resolve alleged violations of the facility Virginia Pollutant Discharge Elimination System General Permit VAR05.

How to comment: DEQ accepts comments from the public by email, 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: Paul R. Smith, Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Blvd, Virginia Beach, VA 23462, telephone (757) 518-2020, FAX (757) 518-2003, or email prsmith@deq.virginia.gov.

Consent Order - Quarles Petroleum, Inc.

Purpose of notice: To invite citizens to comment on a proposed consent order for a facility.

Public comment period: March 3, 2008, to April 3, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to Quarles Petroleum, Inc. to address alleged violations of the regulations. The location of the UST facility where the alleged violations occurred is in Harrisonburg City, Virginia. The consent order describes a settlement to resolve these violations.

How to comment: DEQ accepts comments from the public by email, 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: David C. Robinett, Department of Environmental Quality, Valley Regional Office, Post Office Box 3000, 4411 Early Road, Harrisonburg, VA 22801-9519, telephone (540) 574-7862, FAX (540) 574-7878, or email dcrobinett@deq.virginia.gov.

Consent Order - SMG LLC

Purpose of notice: To invite citizens to comment on a proposed consent order for the sewage treatment plant at a mobile home park in Louisa County, Virginia.

Public comment period: March 4, 2008, through April 3, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to SMG LLC to address alleged violations of Virginia's State Water Control Law and regulations. SMG LLC is a company that owns the 605 Village Mobile Home Park with a sewage treatment plant on site located in Louisa County, Virginia. The consent order describes a settlement to resolve wastewater violations.

How to comment: DEQ accepts comments from the public by email, 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: Trisha Eyler, Department of Environmental Quality, Northern Virginia Regional Office, 13901 Crown Court, Woodbridge, VA 22193, telephone (703) 583-3829, FAX (703) 583-3871, or email treyler@deq.virginia.gov.

General Notices/Errata

Consent Order - Sandy's MHC, LLC

Purpose of notice: To invite citizens to comment on a proposed consent order for a facility in Frederick County, Virginia.

Public comment period: March 3, 2008, to April 3, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to the Sandy's MHC, LLC to address alleged permit effluent limitation violations. The location of the facility where the alleged violations occurred is at the Sandy's MHC, LLC's STP near White Post in Frederick County, Virginia. The consent order describes a settlement to resolve these violations.

How to comment: DEQ accepts comments from the public by email, 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: Steven W. Hetrick, Department of Environmental Quality, Valley Regional Office, Post Office Box 3000, Harrisonburg, VA 22801-9519, telephone (540) 574-7833, FAX (540) 574-7878, or email swhetrick@deq.virginia.gov.

Consent Order - Security Storage & Van Company

Purpose of notice: To seek public comment on a proposed consent order from the Department of Environmental Quality for a location in Norfolk, Virginia.

Public comment period: March 3, 2008, to April 2, 2008.

Consent order description: The State Water Control Board proposes to issue a consent order to Security Storage & Van Company of Norfolk, Virginia, to address alleged violations of Virginia State Water Control Law. The location where the alleged violations occurred is 5786 Sellger Drive, Norfolk. The consent order describes a settlement to resolve alleged violations of the facility Virginia Pollutant Discharge Elimination System General Permit VAR05.

How to comment: DEQ accepts comments from the public by email, 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: Paul R. Smith, Department of

Environmental Quality, Tidewater Regional Office, 5636 Southern Blvd, Virginia Beach, VA 23462, telephone (757) 518-2020, FAX (757) 518-2003, or email prsmith@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.

Filing Material for Publication in the Virginia Register of Regulations

Agencies are required to use the Regulation Information System (RIS) when filing regulations for publication in the Virginia Register of Regulations. The Office of the Virginia Register of Regulations implemented a web-based application called RIS for filing regulations and related items for publication in the Virginia Register. The Registrar's office has worked closely with the Department of Planning and Budget (DPB) to coordinate the system with the Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.

The Office of the Virginia Register is working toward the eventual elimination of the requirement that agencies file print copies of regulatory packages. Until that time, agencies may file petitions for rulemaking, notices of intended regulatory actions and general notices in electronic form only; however, until further notice, agencies must continue to file print copies of proposed, final, fast-track and emergency regulatory packages.